Written evidence submitted by the Commercial Determinants Research Group at the London School of Hygiene & Tropical Medicine, and the University of Edinburgh (PHS0623)

Analysing the alcohol industry's claims and use of evidence at the HoC Health and Social Care Committee Inquiry on Prevention in health and social care HC141 (6th February 2024)

Introduction

On 6th February 2024, the Inquiry on Prevention in Health and Social Care took its first oral evidence in relation to alcohol harms. This evidence was given by the Director of Strategy and Policy at The British Beer and Pub Association (BBPA) (Andy Tighe), the Chief Executive at Drinkaware (Karen Tyrell), the Chief Executive at The National Organisation for FASD (Sandra Ionno Butcher), and the Chief Executive at The Portman Group (Matt Lambert). All those presenting were directly associated with or part of the alcohol industry, or have received funding from them. For example, although they repeatedly claim to be independent, Drinkaware is primarily funded by the alcohol industry and also state that they work with the industry in their charity activities (see: https://www.drinkaware.co.uk/about-us/what-we-do). The Portman Group is the Alcohol Industry's self-regulatory body. No declarations of funding, or conflicts of interest were made by any of the participants, nor was the session explicitly described as collecting evidence from alcohol industry-related stakeholders.

The evidence presented by the alcohol industry participants contained a wide range of serious inaccuracies and misrepresentations. These include misrepresentations of the evidence about alcohol harms, and about how such harms may be effectively prevented. This is particularly concerning as this was the first alcohol-related session, and while the Chair noted that this was 'just the start' of the work of the committee, the fact that it was the first session is itself important, because this misinformation provides the basis on which subsequent sessions and lines of questioning and inquiry are then based. In particular, the evidence presented by the panel of industry-related actors repeatedly downplayed the nature and trends in alcohol harms in ways that are consistent with what is known about how the alcohol industry seeks to influence regulation. The harms driven by the alcohol industry and how the UK currently regulates its products and practices represent one of the leading public health issues in the UK and any framing, such as this, that downplays the serious nature of the problem is deeply concerning from a public health perspective.

Other simply erroneous or misleading statements were also made, which would perhaps not have been obvious to the committee, or to watching members of the public, but which are worth noting considering the importance of the committee's remit. We have therefore prepared this briefing note which identifies specific pieces of misinformation presented by the panel, explains why they are problematic, and places them in the wider context of alcohol industry misinformation. The purpose of this note is partly to correct the record, but also because it may be helpful for committee members in future sessions.

The briefing note is prepared by public health researchers at the London School of Hygiene and Tropical Medicine (LSHTM) and the University of Edinburgh. We are a research group (the LSHTM Commercial Determinants Research Group: https://www.lshtm.ac.uk/research/centres-projects-groups/cdrg) with experience of analysing misinformation from the alcohol, tobacco, gambling and many other industries. A range of mixed methods analyses by the group and by a range of other academic experts, which have been peer-reviewed and published in leading public health journals, have shown how the alcohol industry and the charities and other groups that it funds downplay and

misrepresent alcohol harms in ways that align with commercial incentives. In doing so they misinform the public about how alcohol increases the risk of cancers,(1, 2) the risks of drinking in pregnancy,(3) (4) and the risk of cardiovascular disease (5). This misinformation has been found to be disseminated by Drinkaware in particular to adults and to school children, but also by the Portman Group.(1)

Some of these misinformation strategies are well-known and well-documented internationally; the strategies are common across the alcohol, tobacco, gambling and other industries, and their trade associations and other third-party organisations. Those working in public health are experienced in identifying instances of misinformation in the evidence presented by the panel to the committee by alcohol industry representatives. We give examples of these below, along with references to the relevant evidence.

It may be useful to start with the general approach of the alcohol industry to alcohol harms: in particular, its selective focus on treatment, rather than prevention, contrary to the intended focus of the session.

(i) Focus on treatment rather than prevention

There are mentions of prevention made by panel members in the session. However (as will be noted later) the preferred prevention measures they refer to have a weak evidence base, and are of limited effectiveness. Instead the alcohol industry prefers that policymakers do *not* focus on prevention, but on the treatment of harms once they have already occurred. This is because the effective prevention of alcohol harms would mean people drinking less, with a significant negative financial impact on the industry. In contrast, the costs of dealing with alcohol harms once they occur - including treatment - are borne by the NHS, the police and other services.

This may explain the repeated statements by the panel about, for example, *"assertive outreach, directly working with those who present at A&E and are drinking to high harm levels on a regular basis"* and *"co-ordination between all of the social services, the health services and, sometimes, the police, encouraging families to get involved and getting active treatment"* (Q242, Portman Group). In effect, the industry argument is that the rest of society should pick up the bill for the harms that the industry causes – ideally, after they have already been caused, and after the profits have already been made.

The shifting of responsibility away from the industry can also be seen in the Portman Group representative's statement about the increase in drinking during the pandemic. The increase in consumption among heavy drinkers during the period (described in https://www.sheffield.ac.uk/news/shifts-alcohol-consumption-during-pandemic-could-lead-thousands-extra-deaths-england) is put down to *'what happened to us in those two years in terms of lack of support from friends and family, and lack of access to health services and advice and so forth"*. (Portman Group, Q351). However this is only part of the story. 'What happened to us' during the pandemic also includes the rapid shift in alcohol marketing to target people drinking at home during lockdown, the deployment of alcohol industry corporate social responsibility strategies, the promoting of alcohol delivery services, and encouraging the stockpiling of alcohol.(6)

(ii) The fallacy of 'responsible drinking'

The alcohol industry presents alcohol harms as a matter of individual responsibility, and typically seeks to avoid or dispute its role in creating those harms, for example through advertising and marketing, pricing strategies, and obstruction of effective public health policies. This explains the

panellists' focus on 'responsible drinking' which appears frequently in the transcript. "Responsible drinking" is a strategically ambiguous term employed by the industry to frame the harms in a way favourable to its commercial interests and which assigns blame on individuals, but which has no basis in public health evidence.(7, 8)

(iii) Disputing the CMO's guidelines

Implicit in this is that the alcohol industry disputes the idea that quantitative guidelines - like the CMO's guidelines for lower risk drinking – are needed at all; instead, we just need everyone to be 'responsible'. This deflects attention from the need for regulation of the industry activities to protect the public and prevent harm. However, the alcohol industry has a long track record of disputing that alcohol is inherently harmful and instead it defines the consumption patterns of a particular group of people as harmful which are again strategically ambiguously defined as "excessive" or "harmful" levels.

This can be seen clearly in the statements by the Portman representative who, refers to *"a group of somewhere between 16% and 18% are drinking above the CMO's guidelines, and somewhere between 3% and 4% are drinking to harmful levels. For women, that is 35 units and above. For men, it is 55 units and above."*

This is a remarkably misleading statement – repeated later in the session. It misrepresents both the evidence on alcohol harms, and the CMO's guidelines. It is simply false that only 3% and 4% are drinking to harmful levels. In fact there is no safe level of alcohol consumption; the CMO's guidelines are for *lower risk* drinking. Moreover there is no cut-off for harms at "55 units and above". The Portman representative should be requested to clarify this misrepresentation. However, his statement is very consistent with the alcohol industry's wider denial and misrepresentation of the evidence on alcohol harms, described later below. It is also consistent with a wider industry approach of focussing only on what it refers to as 'excessive drinking' – people drinking at the highest levels and who are often portrayed as being inherently faulty and in need of medical treatment.

There is also the related point, made by the Chair, that there is a "safe level" of drinking: *"whereas for some people there is a safe level of drinking"* (Q345). This statement seems plausible, but it is a widely held misconception. Alcohol causes cancer and, like tobacco smoking, there is no obvious safe level of drinking, as was established by the modelling which was done for the most recent revision of the CMO's guidelines.(9) For example, the risk of breast cancer starts from the first unit of alcohol consumed. This is why the guidelines refer to drinking at 'safer' levels recognising that people may still wish to consume alcohol – and this is the level at which the 14 units a week guideline for men and women is set. Below this level, the risk is "low" – but the risk is not absent. In short, there is no 'safe' level of drinking - but it is possible to drink at "lower" risk. The differences in these concepts are extremely important, particularly given the agenda of the committee which is the prevention of harm.

(iv) The alcohol industry's preferred solutions: information, awareness, education and "talking"

In terms of prevention itself, the alcohol industry is known to prefer solutions for which there is limited evidence that they work – typically, providing information and education. The 'best buys' - the prevention measures for which there is strongest evidence - are restrictions on marketing, availability, accessibility and the pricing of alcohol (e.g. Minimum Unit Pricing).(9) However such policy measures risk impacting on the profits of alcohol industry actors, so it is unsurprising that industry would prefer and actively promote measures which are likely to be ineffective, but which involve plenty of talking:

"we would like to be able to reach more actively and talk to [people] about their relationship with alcohol" (Drinkaware, Q335)

"Our view is that we should all feel more comfortable as a society with talking about alcohol" (Drinkaware Q336)

"having more open conversations about alcohol" (Drinkaware, Q346), and

"communicating more actively with those 8 million people and encouraging people to check their drinking from time to time" (Drinkaware, Q336).

Superficially it seems reasonable to promote talking and communicating about alcohol, even via ill-defined measures like these. But the evidence is clear that this is not enough, and when it is used to displace effective preventive measures, (sometimes called 'policy substitution'(10)) it becomes a red herring and is harmful. Furthermore, the talking is also highly selective; preventive measures which actually work are not talked about by the panellists, other than to dispute the evidence:

"The Scottish Government's own evaluation has shown that there is inconclusive evidence on whether that discourages drinking at the highest level—the harmful drinkers" (Portman Group, Q351).

It is useful to compare this statement with the actual findings of the final report of the evaluation of Minimum Unit Pricing (MUP):

"Evidence shows that MUP has had a positive impact on health outcomes, including addressing alcohol-related health inequalities. It has reduced deaths directly caused by alcohol consumption by an estimated 13.4% and hospital admissions by 4.1%, with the largest reductions seen in men and those living in the 40% most deprived areas".[https://publichealthscotland.scot/news/2023/june/minimum-unit-pricing-reduces-alcohol-related-harm-to-health/]

The Portman Group here appear to have cherry-picked one specific finding. In fact, one of the most striking aspects of the whole session is the cherry-picking of positive trends by industry representatives – in particular, the immediate emphasis, right from the start of the session, on positive trends in harms, and positive trends in young people's drinking.

This dilutes any later discussion of the harms – for example the fact that alcohol-related deaths have risen by 89% in the past 20 years.(11) Cherry-picking positive trends in young people's drinking minimises and deflects from what the Public Accounts Committee have called 'a deepening public health crisis'. This is not unusual; Portman's communications have been previously noted to selectively emphasise positive trends and include implausible unevidenced claims about the effectiveness of industry initiatives.(12)

In any case, the evidence is incorrect. The Drinkaware representative said that *"Sadly, alcohol-related deaths are at an all time high of about 9,500 per year*." In fact the Local Alcohol Profiles for England show that alcohol-related deaths are over twice that, at 20,970 in 2021. She appears to have confused the lower number of alcohol-specific deaths (9641, based on ONS data) with the higher number of alcohol-related deaths. "Alcohol-specific" deaths include conditions that can only be caused by alcohol, and thus the number omits cancers and CVD for example; "alcohol-related" deaths include these, plus deaths from any cause that can be attributed to alcohol, including heart disease and various cancers. (13)

(v) Claiming that industry-funded schemes and initiatives are effective despite the evidence

While the alcohol industry rejects the 'best buys', such as restrictions on marketing and MUP, it proposes instead its own alternative ineffective or unevidenced solutions. These include its own industry schemes: NoLo alcohol products; and initiatives like Drinkaware itself (which a 2012 presentation from the Wine and Spirits Trade Association (WSTA) has described, with unusual candour, as an "alternative to MUP").

The evidence is clear that industry self-regulation of marketing has a poor record – contrary to the BBPA representatives claims that it is 'held up as a 'gold standard'. For example a review in 2016 concluded that "Recent reviews have indicated that self-regulated alcohol marketing codes are violated routinely, alcohol advertisements regularly contain content appealing to vulnerable populations, and youth populations are exposed to disproportionately large amounts of alcohol advertising… Moreover, the World Health Organization (WHO) has concluded that industry self-regulation may result in loss of governmental policy control".(14)

Nothing has changed since then to alter that conclusion. A 2021 commentary noted that "The UK's current complaints-led self-regulatory approach fails to protect consumers and vulnerable groups from being exposed to influential alcohol marketing. There are few meaningful sanctions to deter brands and companies from violating existing codes, processes are retrospective, reactive and slow, and the codes fail in their stated aim of protecting young people."(15)

The Portman Group's own role in this has also been criticised for its lack of independence, lack of transparency, ineffectiveness and failure to protect children from irresponsible marketing.(16, 17)

The Portman representative also advised that he would argue for "*encouraging awareness of the Chief Medical Officers' guidelines*". However this was not Portman's approach when the CMOs' lower risk guidance was actually published. It has been noted that "…the Portman Group did not recommend that members or other companies carry the revised content on product labels and sought to undermine them via high-level political lobbying".(18)

In the case of no and low alcohol (NoLo) products, also discussed at the session, the evidence is still evolving, but there is no clear evidence that drinkers are 'switching' to NoLo products, as opposed to adding them to their existing drinking repertoire; there is certainly little evidence that they will have an significant effect on people drinking at harmful levels; (e.g. see: https://www.ias.org.uk/2022/03/22/help-or-harm-exploring-the-expanding-no-and-low-alcohol-market-in-the-uk/). There is, however, good evidence that they are used by the industry for 'alibi marketing' - that is, to permit advertising of a brand when advertising of full-strength products would not be permitted. The use of such products to evade marketing restrictions has been documented for Carlsberg (19) and for Guinness 0.0, which was specifically mentioned in the session.(20) Alcohol Change UK recently concluded that "An increase in the use of alcohol-free and low-alcohol drinks could have positive, negative or neutral impacts on a consumer's risk of harm" (see:).(21)

The other industry priority is of course alcohol labelling, which is self-regulated through the Portman Group. Questioned by the committee on lack of compliance with labelling guidance, the Portman representative disputed this, and said *"Our best practice guidelines advise the whole industry to have a pregnancy warning and unit advice, with the Drinkaware logo and the chief medical officer's guidelines".* (Portman Group, Q380)

In fact, Portman's own market survey found that only 57.1% of products meet best practice in terms of grouping and clarity.(22)

The provision of alcohol labelling was also evaluated independently as part of the Responsibility Deal evaluation. This found that *"Clarity is difficult to assess, but existing guidelines on packaging inserts for medicines may provide an appropriate reference point, suggesting a minimum font size of 9–12-point. By comparison, more than half the products in this sample used a font size <6mm, with a mean font size of 8.17-point. Similarly, the pregnancy logos were on average about 5mm in diameter, with comparable guidelines suggesting that precautionary statements should be no smaller than ×10mm*".(23)

The evaluation therefore concluded that alcohol labelling information frequently falls short of best practice, with fonts and logos smaller than would be accepted on other products with health effects.

(vi) Disputing the evidence on harms

The panel was also asked about the harms of drinking in pregnancy. On this issue, for example, the Drinkaware representative said:

"not drinking when you are thinking about becoming pregnant or are pregnant are important messages that are not necessarily getting to as many people as they possibly can"(Drinkaware, Q336).

Drinkaware's own information on drinking in pregnancy which it provides to the public has been analysed in depth and found to be seriously misleading. The analysis showed how it and other industry organisations use a range of misinformation strategies to undermine trust in information on pregnancy, and in Drinkaware's case, it diluted the information on their website with trivia and made it more difficult to locate. These are both well-known alcohol industry misinformation strategies.(3)

Disputing the evidence on drinking in pregnancy, or omitting it entirely, is a particular focus of alcohol industry information materials. This is assumed to be because of the perceived need to prevent the female consumers from being concerned about the effects of alcohol on health. The female market for alcohol is one which alcohol producers are particularly keen to develop.(24, 25) Female drinkers who are well-informed about alcohol's effects on their health are not good for the alcohol industry's finances.

(vii) Alcohol industry activities in schools

The NOFASD representative also mentioned the Chief Medical Officer's guidance on alcohol use in Pregnancy, noting that "*20% of the population still do not know about it. It is not necessarily being taught in PSHE in schools*". [Q343]

Schools are indeed an important consideration, particularly because UK primary and secondary schools are provided with problematic materials by organisations who receive, or have received alcohol industry funding. The content of the materials produced by Drinkaware, the Alcohol Education Trust (now called "the talkabout trust") and the Smashed programme, which is funded by Diageo (a Portman Group member) has been analysed. The analysis found that the materials contain

misinformation on drinking in pregnancy – selectively omitting key information, and promoting and normalising alcohol consumption. Drinkaware's educational materials, which the charity retracted after the study was published, selectively omitted the risk of drinking in pregnancy and the risks and impacts of Foetal Alcohol Spectrum Disorders (FASD). (26) The same study also revealed that Drinkaware materials involved teaching school children how to pour a standard drink and some of the materials contained cancer misinformation.

This is consistent with industry misinformation aimed at adults: alcohol industry health information omits entirely or distorts the evidence on cancers. Both the Portman Group and Drinkaware have previously been shown to do this, including, in the case of the Portman Group, in its submission to the consultation on the CMO's alcohol guidelines.(1)

Conclusions

There is now a substantial body of independent evidence demonstrating that, like the tobacco, fossil fuel and other industries, it is the alcohol industry's practices and their products that are the problem, and where prevention is needed. These unethical practices, rather than people and their so-called "irresponsible" drinking, represent a major threat to public health in the UK. It may be useful for the committee to review the evidence on harmful industries, and how they interfere with effective prevention measures. This may help with developing policies to achieve the type of prevention of harm that has been observed in the area of tobacco control, such as in the World Health Organisation Framework Convention on Tobacco Control (see: https://fctc.who.int/who-fctc/overview). In the case of tobacco that has only been achieved by recognising the role of the irresponsible industry as a driver of harm and as one whose interests are in direct conflict with the public's health.

Finally, it needs to be remembered that the alcohol industry practices outlined above – undermining effective policies, promoting ineffective self-regulatory measures, and promoting misinformation about alcohol harms to the public and to schoolchildren – have real consequences, and harm real people; industry misinformation and disinformation about cancers, and about drinking in pregnancy, does not simply result in a misinformed public: it results in real cases of cancer, and real children with FASD.

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