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Global Alcohol Producers, Science, and Policy: The Case of the International Center for Alcohol Policies

In this article, I document strategies used by alcohol producers to influence national and global science and policy.

Their strategies include producing scholarly publications with incomplete, distorted views of the science underlying alcohol policies; pressuring national and international governmental institutions; and encouraging collaboration of public health researchers with alcohol industry–funded organizations and researchers.

I conclude with a call for an enhanced research agenda drawing on sources seldom used by public health research, more focused resourcing of global public health bodies such as the World Health Organization to counterbalance industry initiatives, development of technical assistance and other materials to assist countries with effective alcohol-control strategies, and further development of an ethical stance regarding collaboration with industries that profit from unhealthy consumption of their products. (*Am J Public Health.* 2012:80–89. doi:10.2105/AJPH.2011.300269)

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THERE IS GROWING RECOGNItion among public health authorities in the United States and globally that the harmful use of alcohol is a global public health issue of serious proportion. At the global level, the most recent estimates attribute to alcohol 4.6% of the global burden of disease and disability, roughly the same level as tobacco. Alcohol use is also responsible for 3.8% of global deaths.[1] In the United States, excessive alcohol use causes 79 000 deaths per year, according to the Centers for Disease Control and Prevention (CDC).[2] In the United Kingdom, the House of Commons Health Committee reported early in 2010 that alcohol consumption has nearly tripled since 1947, and deaths from liver cirrhosis had quintupled between 1970 and 2006.[3] In Russia, more than half of male deaths between the ages of 15 and 54 in the 1990s were caused by alcohol use.[4] In Brazil, nearly 18% of male disability-adjusted life years are attributable to alcohol use; the analogous statistic in Thailand matches that of the United States at 12%.[1] Although female mortality rates attributable to alcohol are lower, a review of the evidence from developing country settings concluded that, throughout the world, although men do more of the drinking, women disproportionately suffer the consequences, through impact on family budgets, domestic violence, and so on.[5]

There is also a growing consensus about how to prevent and reduce alcohol problems. The World Health Organization (WHO) has sponsored periodic research reviews assessing the global research evidence regarding effective approaches. The most recent review, published in 2010, recommends the following interventions: minimum legal purchase age laws, government monopolies of retail sales, restrictions on hours or days of sale, outlet density restrictions, alcohol taxes, random breath testing and lower blood alcohol concentration limits for drivers, administrative suspension of driving licenses for exceeding those limits, graduated licensing for novice drivers, and brief

interventions (preferably in primary care settings) for hazardous drinkers.[6] The CDC does systematic reviews for its *Guide to Community Preventive Services*. Its alcohol reviews have found restricting outlet density, maintaining limits on hours and days of sale, increasing alcohol taxes, and enhanced enforcement of laws banning sales to minors to be effective.[7] *The Lancet* in 2009 published a review of the most effective and cost-effective strategies. Raising the price of alcohol and banning advertising led the list in the latter category.[8]

The WHO both at its headquarters and in its regional offices has begun to develop comprehensive strategies to address harmful use of alcohol. In Geneva, 2009 and 2010 witnessed an intensive period of research and consultation that resulted in the passage by the World Health Assembly of the first-ever Global Strategy to Reduce the Harmful Use of Alcohol. The strategy marks a commitment by the health ministers of 193 Member States to take action in 10 areas, including alcohol pricing, marketing, and physical availability.[9] The regional strategies in some cases endorse these even more strongly. For example, the Western Pacific Regional Strategy, recognizing that alcohol consumption in the region is increasing, calls for the establishment of alcohol taxation systems, the regulation or as appropriate banning of alcohol marketing, and regulation of times and places for sale of alcohol.[10] The African regional strategy observed that "adequate polices were few," called for regulation of "the content and scale of alcohol marketing," stated that "taxation should be increased," and encouraged Member States to "restrict the times and places of sale."[11(p2–6)]

Leading global alcohol producers welcomed WHO's strategy, calling it "an important and constructive step forward in helping address alcohol issues around the world" and pledging to

> work constructively with WHO and Member States to help promote implementation of the strategy by supporting and contributing to feasible and effective policies that help reduce harmful drinking.[12]

In contrast to leading tobacco companies, whose 1994 denial that nicotine was addictive "penetrated the smoke screen" of their relationship with public health and made clear that collaboration was not an option,[13] alcohol companies are on record as seeking a different route.

I explored how industry-funded organizations have acted in the context of efforts to reduce alcohol-related harms. What strategies has industry employed in response to the public health initiatives? What has been the relationship of industry to public health evidence? I also examined the relationship of leading alcohol producers with public health science as exemplified in particular by the activities of their "alcohol policy think tank" (as the Global Alcohol Producers Group Web site refers to it), the International Center for Alcohol Policies (ICAP). Sources examined included the publications of the ICAP itself, tax filings in the United States by the ICAP, and comments of industry leaders about the ICAP and about alcohol policy found in searches for any of the words "alcohol," "alcohol policy," or "International Center" in the internal tobacco industry documents available from legal settlements at the University of California at San Francisco. Comparison of ICAP research and policy statements with findings from the WHO and other public health bodies and researchers showed how the industry has simultaneously cast itself as representing public health and ignored key findings of public health research regarding effective approaches to the prevention and reduction of alcohol-related problems.

THE GLOBAL ALCOHOL INDUSTRY

According to market research estimates, the total alcoholic drinks market was worth $979 billion in 2007, with the global beer trade worth an estimated $498 billion and the spirits trade worth $216 billion.[14-16] In general, the high-income country markets for alcohol are "mature," and consumption in those countries is for the most part decreasing. By contrast, in the low- and middle-income countries, alcohol consumption is increasing, and these are the places the industry views as its best chance for growth.[5] This was exemplified in the industry by statements such as Seagram's in its annual report in 1996: "Our single biggest opportunity is global expansion."[17]

Pursuing this opportunity has led to unprecedented globalization of the industry, to the point where a relatively small number of beer and distilled spirits companies dominate global trade in alcohol.[18] Particularly in the case of beer, the 1990s and early 2000s witnessed successive waves of mergers and acquisitions, resulting in the dominance of the global beer trade by a small number of companies, as measured by the concentration of ownership in the trade, which nearly tripled as the share of the market held by the 10 largest companies grew from 28% in 1979–1980 to 72% in 2008.

The global spirits industry has also experienced rapid concentration. As shown in Table 2, in recent years the 10 leading producers have consistently controlled more than 40% of sales (by volume).

This growing concentration of the beer and distilled spirits industries has created an unprecedented concentration of resources at global and national levels for participating in and influencing policy debates regarding alcohol.

THE INTERNATIONAL CENTER FOR ALCOHOL POLICIES

To this end, in 1995, 10 of the world's largest distilled spirits and beer marketers at that time (Allied Domecq Spirits and Wine [as of 2006 split up between Pernod Ricard, Diageo, and Beam Global Spirits and Wine], Bacardi-Martini, Brown-Forman, Coors Brewing Company, Guinness PLC [now part of Diageo], Heineken NV, International Distillers and Vintners [now part of Diageo], Miller Brewing Company [now controlled by SABMiller, a conglomerate formed by joining Miller with South African Breweries, with the Philip Morris successor company Altria retaining a 20% interest], Joseph E. Seagram & Sons [whose spirits brands were acquired primarily by Pernod Ricard and Diageo in 2000], and South African Breweries [now SABMiller]) banded together to found the ICAP. One of these companies, Miller Brewing, was then controlled by tobacco giant Philip Morris. In the

1996 Philip Morris CEO briefing book that came to light as one of many internal tobacco industry documents released after the Master Settlement Agreement between US state attorneys general and tobacco companies, there is a section explaining Miller's involvement in the ICAP as follows:

> As Miller continues to expand internationally, we will need a better grasp on how different governments may regulate our products . . . [this is] the latest initiative in managing worldwide issues, and assisting our sales and marketing group in an increasingly competitive marketplace.[22(p6)]

To lead the ICAP, the alcohol industry turned to Marcus Grant, a former member of the staff of the WHO. As has been described in greater detail elsewhere,[23] Grant had come to the WHO in 1983 as the organization was experiencing pressure from conservative, pro-business governments in the United States and the United Kingdom, in part because of the WHO's stance in support of protests against the marketing of infant formula in developing countries. The US government made it clear to WHO leadership that it opposed programs that were not in line with the principles of private enterprise. In the face of this pressure, the WHO in 1983 cancelled a major project investigating the marketing strategies of alcohol transnational corporations, focusing particularly on their plans to globalize the alcohol market. Grant began his work for the WHO as a consultant, developing a report that would downplay this project's findings regarding the impact of the transfer of aggressive marketing techniques perfected in developed countries to less-resourced countries. He joined the WHO staff and stayed until 1994, when he resigned to become a consultant to Seagram, Guinness, International Distillers and Vintners, and Hiram Walker (all of which are now part of either Diageo or Pernod Ricard).

This consultation led to the inception of the ICAP. In a letter announcing the formation of the ICAP in 1995, Grant outlined 4 goals for the new organization: (1) elaborating a more integrated approach to alcohol policy, involving all interested sectors; (2) developing a common language for promoting more effective dialogue; (3) encouraging initiatives designed to meet the needs of developing countries; and (4) promoting responsible lifestyles (letter from M. Grant to D. H. Jernigan, April 7, 1995).

As ICAP activities would demonstrate, these goals require some translation. A subsequent ICAP brochure described the first goal as an effort to reassess "current theories with a primary focus on the differences between positive and negative patterns of drinking."[24] This emphasis on the patterns of drinking (as opposed to population levels of consumption) and positive effects of alcohol use would be a major ICAP focus in its first decade, developed in a 1998 conference titled "Permission for Pleasure," and a subsequent edited collection of essays titled, *Alcohol and Pleasure: A Health Perspective*.[25] "Involving all interested sectors" would in practice mean pushing for and engaging in active alcohol industry involvement in public health policymaking regarding alcohol, directing debate over alcohol policy into areas where the alcohol industry could agree, and thus focusing on education and identification and treatment of the heaviest drinkers (among the least effective and least cost-effective approaches to alcohol problems[8]) and staying away from population-level strategies such as increased taxes or restrictions on marketing or physical availability. The second goal would seek to remove phrases troubling to the industry such as "alcohol and other drugs" from the official lexicon (see section, "Influencing Public Health Decision-Makers at the Global and National Levels"). The third would aim to protect the industry's ability to expand in areas where its potential for growth was greatest, by influencing and encouraging weak alcohol policies in this region.[26] The fourth goal would in practice mean promoting drinking and the drinker's right to obtain alcohol.

The actual work of the ICAP is described through examination of its voluminous output of scientific conferences, book-length collections of articles, issue reports and briefing papers, and other written products from 1998 to 2010. Additional information about ICAP activities has been gleaned from its reports to the US Internal Revenue Service on the annual forms that body requires that every not-for-profit organization submit to it on an annual basis. Insights also come from analyses others have done of specific aspects of the ICAP's work.[26–28]

Becoming the Industry's Voice in Public Health

> I believe that I have contributed more to public health in my 5 years at ICAP than in double that time in WHO.[29(p2)] (ICAP founding director Marcus Grant, 2000)

Much of the ICAP's activities have focused on countering the influence of the WHO and leading alcohol researchers by essentially functioning like a WHO unit on alcohol, with certain key omissions. Building on Grant's decade of experience at the WHO in creating and distributing edited collections of contributions by scholars from around the world, the ICAP would commission and produce 10 such book-length collections between 1998 and 2010, as well as 2 other monographs, 6 briefing papers for consultation with the WHO, 20 brief issue reports, 4 in-depth ICAP reviews of issues in alcohol policy, 5 periodic reviews of drinking and culture, 8 peer-reviewed journal articles written by ICAP staff and paid consultants, 1 special issue of a journal devoted to alcohol and harm reduction, and 22 charters, working papers, progress reports, and other brief policy statements or guides to policy implementation. It also produced 4 policy guides, 9 health briefing papers, 8 issue briefing papers, and 4 policy tool kits, "guides for implementation of interventions to reduce harmful drinking." During the same period WHO headquarters in Geneva put out 17 publications about alcohol. Whereas the ICAP publications all focused on some aspect of drinking patterns and alcohol policy, 4 WHO publications looked at aspects of identification and treatment of alcohol use disorders, a topic to which the ICAP has devoted little attention.

To produce its monographs, the ICAP initially tried to recruit current WHO staffers as writers, reviewers, and advisors. Its publications mirrored some of the publications being put out in the same period by the WHO. However, the WHO publications avoided inclusion of works by industry representatives, and ICAP publications were often collaborations between

TABLE 1—Concentration of Ownership in the Global Beer Industry, 1979–1980 Versus 2008

Corporation (Headquarters)	Global Market Share, % (Ranking)	
	1979–1980	2008
AB/Inbev (Belgium)	6.5 (1; AB)	24.2 (1)
SABMiller (United Kingdom)	4.8 (2; Miller)	12.3 (2)
Heineken NV (Netherlands)	2.8 (4)	9.4 (3)
Carlsberg Breweries A/S (Denmark)	3.1 (3)	7.4 (4)
China Resources Enterprise Ltd (China)	[a]	4.2 (5)
Molson Coors Brewing Co (United States)	[a]	3.2 (6)
Tsingtao Brewery Co Ltd (China)	[a]	3.1 (7)
Grupo Modelo (Mexico)	1.3 (12)	3.1 (8)
Beijing Yanjing Beer Group (China)	[a]	2.5 (9)
FEMSA (Mexico)	0.84 (20)	2.4 (10)
Total market share of top 10 companies	28.0	72.0

Source. 1979–1980 data from Cavanagh and Clairmonte[19]; 2008 data from Impact Databank.[20]
[a]Did not exist or not in the top 30 in 1979–1980.

academics and industry representatives that would conclude the opposite of what WHO publications were concluding. It performed "literature reviews" that were incomplete, not subject to traditional peer review, and either supportive of industry positions or emphasizing high levels of disagreement among scientists. Finally, it provided model national and global alcohol policies based on the least effective strategies, and offered technical assistance in how to adopt and implement these policies.

These publications were distinguished not by what was in them, which often included useful contributions to various aspects of alcohol studies, but by what was not: they excluded or attempted to refute evidence regarding the most effective strategies to reduce and prevent alcohol-related harm. In replicating the work of the WHO, the ICAP's efforts to recruit current WHO staffers working on alcohol issues were unsuccessful, so it relied on employees in other sectors (such as the Department of Mental Health, which at the time was separate from the Program on Substance Abuse), employees in WHO regional offices, and retired WHO officials. As Table 3 illustrates, 7 of the ICAP's 10 book-length collections included contributors with ties to the WHO. The ICAP also drew contributors from well-respected institutions such as Brown University, the Canadian Centre on Substance Abuse, the University of Sydney, the University of the South Pacific (Fiji), the National Council Against Addiction (Mexico), the Addiction Research Foundation (Toronto, Canada), the University of Zimbabwe, Johns Hopkins University, University College (Dublin, Ireland), and the University of Chile. Nine of the 10 edited collections also included at least 1 chapter written by someone who had previously been or was currently employed in strategic affairs, corporate social responsibility, or a similar capacity for an alcohol company.

Although the WHO was producing fewer publications during this period, several ICAP publications seemed to attempt to counter or pre-empt similar WHO publications. For instance, in 1994 the European office of the WHO had sponsored a group of 17 scientists from 9 countries to produce a comprehensive review of the global research literature on alcohol and public health.[30] The book made a strong, evidence-based argument for population-level strategies such as excise tax increases and controls over physical availability. The ICAP's first policy manifesto appeared in 1998, and was titled *Drinking Patterns and Their Consequences.*[31] It sought to reframe the debate from societal measures to individual patterns of drinking, which could be harmful or beneficial. This reframing also shifted the focus from the product and the practices of the industry to the behavior of individual drinkers. The WHO also sponsored a group of 12 researchers—6 from well-resourced and 6 from less-resourced countries—to produce a book on alcohol and public health in developing societies.[5] The ICAP produced its own edited collection titled *Alcohol and Emerging Markets: Patterns, Problems and Responses.*[32] The WHO has devoted significant resources in the past decade to better measurement of alcohol's role in the global burden of disease, and this has been reflected in WHO[33,34] as well as in various other research publications.[1] Whereas WHO estimates have placed alcohol's role in the global burden of disease on a par with that of tobacco, the ICAP, in a publication of its own titled *Alcohol Consumption and the Burden of Disease,*[35] focused on the limitations of the study, including claiming (incorrectly) that the estimates had failed to take into account different patterns of drinking. In fact, the WHO-sponsored study developed and tested a scale for classifying country-level patterns of drinking, and incorporated that measure into its calculations in combination with measures of population-level consumption of alcohol.[36–38]

Two other ICAP publications directly addressed the well-documented public health strategies of increasing alcohol taxes and restricting physical availability. There is broad consensus in the alcohol research field that increasing alcohol excise taxes is an effective tool for reducing alcohol problems.[39] The National Research Council and Institute of Medicine included tax increases as part of its comprehensive program for reducing underage drinking.[40] A recent meta-analysis combined data from 112 studies of alcohol prices to conclude that, like sales of other commodities, alcohol sales increase when prices fall, and decrease when prices (or taxes) increase, and that tax increases affect heavy as well as other drinkers.[41] Systematic reviews of the literature by the CDC[42] as well as the international group of researchers sponsored by the WHO[43] have reached similar conclusions. Despite this high level of agreement among public health scholars and organizations, the ICAP report states that

> [t]he effectiveness of taxation and pricing policies as public health and social tools for reducing consumption, abuse and problems has been much debated,[44(p3)]

and that "[t]here is evidence that taxation does not effectively target those who abuse alcohol or who have risky drinking

TABLE 2—Concentration of Ownership in the Distilled Spirits Industry, 2006 Versus 2008

Corporation (Headquarters)	Global Market Share, % (Ranking) 2006	2008
Diageo plc (United Kingdom)	10.8 (1)	10.2 (1)
Pernod Ricard (France)	8.3 (2)	8.9 (2)
United Spirits Ltd (India)	6.7 (3)	7.9 (3)
Bacardi (Bermuda)	3.7 (4)	3.4 (4)
Beam Global Spirits & Wine (United States)	3.7 (5)	3.3 (5)
Central European Distribution Corp (Poland)	1.8 (7)	2.1 (6)
Brown-Forman (United States)	1.9 (6)	1.9 (7)
Gruppo Campari (Italy)	1.7 (9)	1.7 (8)
Sazerac Co Inc (United States)	1.7 (10)	1.5 (9)
Suntory (Japan)	1.8 (8)	1.5 (10)
Total share of top 10	41.8	42.5

Source. Data from Impact Databank.[21]

problems."[44(p6)] It concludes by warning that "taxation is a blunt tool and does not differentiate between problematic and unproblematic drinking patterns."[44(p11)]

A CDC systematic review of the literature on the relationship between physical availability of alcohol and health outcomes found

> sufficient evidence of a positive association between outlet density and excessive alcohol consumption and related harms to recommend limiting alcohol outlet density through the use of regulatory authority (e.g., licensing and zoning) as a means of reducing or controlling excessive alcohol consumption and related harms.[45(p570)]

Again, other reviews of the global literature have corroborated this finding.[6,46] The ICAP review of the same literature states that "a debate has been developing around the effectiveness of availability control measures," claims that "[t]here is evidence that efforts by those desiring to circumvent existing controls has fueled organized crime" (with the cited source being an article by a Diageo employee published in another ICAP collection), and concludes that

> As research has increasingly demonstrated, harmful outcomes of alcohol consumption are more closely associated with particular drinking patterns among specific groups, not with overall consumption. As a result, gross-level measures such as availability controls may not be sufficient . . . .[47(p9)]

In the past 15 years, the WHO has also embarked on a series of exercises in global epidemiologic surveillance, which have produced several survey-based global status reports on alcohol, alcohol policy, and alcohol and youth.[48–51] The ICAP in turn partnered with and later adopted as a subsidiary the London-based Center for Information on Beverage Alcohol, which has produced tables on alcohol policies and related issues for various ICAP reports. A close analysis of the methodology used to produce the WHO alcohol policies report with that of the ICAP on the same topic concluded that

> The ICAP report, in particular, seems to present conclusions that are inconsistent with its own data or unwarranted because of faulty survey methodology.[28(p136)]

The ICAP has also produced a series of briefing papers, reviews of alcohol policy issues that claim to be surveys of the research literature. Unlike systematic reviews, such as those done by CDC's Guide to Community Preventive Services,[42,52] or meta-analyses, such as the tax study described previously drawing on 112 studies of alcohol prices,[41] the ICAP reviews provide no detail on the methods used in identifying studies or assessing their findings. The ICAP papers focus on the disagreements and inconclusiveness of alcohol policy research. For instance, the ICAP briefing paper on health warning labels on alcohol reflects "the equivocal nature of the contemporary HWL [health warning label] debate."[53(p6)] The ICAP's report on alcohol and pregnancy concludes that

> many feel there is insufficient evidence regarding moderate consumption of alcohol during pregnancy and the effect it may have on a developing fetus . . . .[54(p1)]

An ICAP report on estimating costs associated with alcohol consumption remarks that "some economists argue that taxes are not the most effective way to discourage problem drinking."[55(p5)] Other reports reflect the alcohol industry's interest in promoting alcohol consumption. For instance, the ICAP report on safe drinking levels concludes by noting that "both the UK and the US guidelines draw attention to the health benefits of moderate alcohol consumption."[56(p4)] The ICAP report on drinking age limits states that some "argue that a minimum drinking age of 21 is impractical" and that "the emphasis should be less on stigmatizing alcohol and more on promoting responsible consumption of alcohol."[57(p9)]

The ICAP has also created and disseminated model alcohol policies for less-resourced countries and has offered expert technical assistance in implementing those policies.[26] The seminal work on alcohol policies, *Alcohol Control Policies in Public Health Perspective*,[58] is known within the field as the "purple book." The ICAP developed its own "blue book," an Internet-based set of "practical guides for alcohol policy and targeted interventions."[59] In keeping with the ICAP's overall goals, described previously, the ICAP blue book is based on 3 central elements:

> drinking patterns and their outcomes as a sound scientific basis for policy development; targeted interventions that address specific 'at-risk' populations, potentially harmful contexts and drinking patterns; and partnerships that allow the inclusion of the public and private sectors, the community, and civil society all working toward a common goal.[60(p1)]

Described as "a new way to address the role of alcohol in society," the blue book offers 23 "modules" for policy development. Conspicuously missing from these modules is any mention of 3 of the most effective policy approaches to alcohol problems: taxation, restrictions on advertising and marketing, and limits on physical availability.[6]

Influencing Public Health Decision-Makers

Publications are perhaps the most public activity engaged in by the ICAP. At least as important

TABLE 3—ICAP Monographs and Industry and WHO-Linked Contributors, 1998–2010

Year	ICAP Publications	Contributors		
		Total	Alcohol Industry	WHO-Affiliated
1998	*Drinking Patterns and Their Consequences*	28	4	1
1998	*Alcohol and Emerging Markets: Patterns, Problems and Responses*	19	1	1
1999	*Alcohol and Pleasure: A Health Perspective*	38	2	2
2001	*Learning About Drinking*	18	1	0
2004	*Moonshine Markets: Issues in Unrecorded Alcohol Beverage Production*	25	0	0
2005	*Corporate Social Responsibility: The Need and Potential for Partnership*	20	6	2
2006	*Drinking in Context*	13	1	1
2008	*Swimming With Crocodiles: The Culture of Extreme Drinking*	19	3	0
2009	*Working Together to Reduce Harmful Drinking*	8	4	1
2010	*Expressions of Drunkenness (Four Hundred Rabbits)*	11	3	1

Note. ICAP = International Center for Alcohol Policies; WHO = World Health Organization.

have been its efforts to influence public health officials. ICAP staff are frequent visitors to the WHO in Geneva and a reliable presence during WHO Executive Board and World Health Assembly meetings. During debates over the recently adopted WHO Global Strategy to Reduce the Harmful Use of Alcohol, the ICAP was a leading voice advocating a greater role for "economic operators" in designing alcohol policies and programs. This advocacy led to the delay and near-failure in 2007 and 2008 of efforts to create the Global Strategy.[61] The ICAP has also sent representatives to numerous less-resourced countries to provide "technical assistance" regarding alcohol policy.[26]

In the United States, during the Clinton administration, the ICAP convened with the federal Center for Substance Abuse Prevention (CSAP) a "Joint Working Group on Terminology." The purpose of the group was to

> review current terminology used by public health advocates and others in relation to alcohol abuse; to identify key concepts so as to achieve a better understanding of different definitions; and to explore opportunities for promoting greater consensus on terminology, taking into account international and cross-cultural definitions.[62(p7)]

The Working Group produced a report, with a forward by Karol Kumpfer, PhD, the CSAP director, and Adrian Botha, chairman of the ICAP Board of Directors and an official of South African Breweries. Regarding whether to use the term "alcohol and other drugs," which was standard CSAP usage at that time, the report stated:

> Perhaps the only simple answer to the question whether alcohol is a drug, is an incomplete one: "Yes, but . . . ." Much more to the point is the subsidiary "Why does it matter?"[62(p29)]

Beyond this, however, the report describes no commitments being made on either side of the debate, concluding by saying only that

> If semantics are driving and keeping us apart, let us think through new phrases that will help frame new ways of doing 'win–win' business together.[62(p31)]

A speech by a leading industry official to the World Association of Alcohol Beverage Industries in 1996 revealed what actually happened in those meetings. In a transcript of her speech available in the internal documents released as part of the tobacco Master Settlement Agreement, Patti McKeithan, the vice president of corporate relations for Miller Brewing, stated:

> As you will recall, CSAP is the organization that popularized the term "alcohol and other drugs." We have long fought against the use of this term, which incorrectly and unjustly equates our products with illegal drugs. I am pleased to be able to tell you that . . . working through ICAP . . . we have been able to reach an agreement with CSAP . . . by which they have changed their editorial guidelines . . . to discontinue use of this expression . . . using instead the term "substance abuse." This is a major victory, and was achieved through patient negotiation . . . and the force of logic. It is truly a triumph of alcohol education . . . and should help us dial down the rhetoric of the anti-alcohol lobby.[63(p12)]

Encouraging Public Health Collaboration

A guest editorial in the journal *Addiction* in 2000 began by warning,

> Alcohol producers are engaged in a campaign to capture the hearts and minds of alcohol researchers and public health people, as part of a major effort to win the war of ideas that shapes alcohol policy at national and international level.[27(p179)]

Some of the ICAP's efforts to promote and implement collaboration between industry and public health have already been described in this article. In a field where such collaboration is customarily provided gratis or for modest sums, the ICAP in the late 1990s was paying more than $13 000 for a chapter-sized contribution (letter from M. Grant and ICAP social policy specialist E. Houghton to D. Everett, executive director, Community Agency for Social Enquiry, Johannesburg, South Africa, August 7, 1997).

Two other substantial efforts deserve scrutiny. The first was the creation in 1997 of The Dublin Principles of Cooperation Among the Beverage Alcohol Industry, Governments, Scientific Researchers, and the Public Health Community. Not surprisingly, these principles argued "that academic and scientific communities should be free to work together with the beverage alcohol industry, governments and non-governmental organizations" to contribute to a better understanding of "the relationships among alcohol, health and society."[64(p640)] The principles were published in the journal *Alcohol & Alcoholism*, accompanied by an editorial that predicted that time would tell whether the industry's "involvement in the Dublin Conference was a genuine attempt at meeting their social responsibilities, or merely a publicity exercise."[65(p637)] Internal tobacco documents show that executives in that industry also found the principles of interest: David O'Reilly, now head of public health and scientific affairs at British American Tobacco, discovered the

principles in 2000 and wrote to colleagues at British American Tobacco, "They make interesting reading. Something to aspire to?"[66(p1)]

In 1999, as the WHO was initiating negotiations on the Framework Convention on Tobacco Control, the ICAP began a series of regional and global consultations of its own that would culminate in a document titled, *The Geneva Partnership on Alcohol: Toward a Global Alcohol Charter*.[67] Despite the inclusion of "Geneva" in the document's title (based on a meeting held in Geneva to review its contents), there was no involvement in this "global charter" from staff at the WHO in Geneva, the most obvious "Geneva partner." Although it was subsequently struck from the final document, early drafts of the charter stated that, "Public policies should not treat alcohol differently from similar products, except where a compelling reason to do so exists"; "Consumers have a right to reasonable access to beverage alcohol"; and "those who make a well-informed choice to drink responsibly should not be subjected to pressures to refrain" (D. H. J., personal collection, undated).

Costs

As a not-for-profit organization, the ICAP is required to file with the US Internal Revenue Service annual Form 990s detailing its income and expenses. At the time of the study, these forms were available online for 2004, 2006, 2007, and 2008. They show an annual organizational budget of $1.9 million in 2004, and close to $2.7 million in 2006, 2007, and 2008.[68–71] ICAP President Marcus Grant received $444 855 in compensation for his services in 2008. In that year, the organization also reported spending $571 945 to "allow the Center to work more closely with other similar Asian organizations by complementing and supporting their ongoing work," $341 860 to "intensify a dialogue with the World Health Organization, in order to encourage a more balanced approach to alcohol policy," and $317 058 on scientific reviews to

> undertake a critical examination of existing evidence on the contribution of drinking to the global disease burden and set a novel agenda for future research; to assess the viability of current policy approaches and to offer pragmatic alternatives; to help position drinking patterns within a broader social, economic, and political context.[71(p2)]

THE TOBACCO CONNECTION

The ICAP experience reflects both direct connections to and lessons learned from the tobacco industry. Philip Morris was among the founding companies of the ICAP. Guy Smith, the current executive vice president responsible for corporate relations and marketing public relations for Diageo, the world's largest spirits producer, was previously the vice president–corporate affairs and senior public affairs and public relations officer for the Philip Morris Companies from 1975 to 1992. Between his service at Philip Morris and joining Diageo, he ran a consulting business in Washington, DC, "focused on reputation and crisis management."[72]

The ICAP and its alcohol industry sponsors apparently learned from tobacco that industry must be out front in terms of social responsibility, able to foreshadow and pre-empt public health initiatives, as the ICAP has consistently done with its publications and other activities mirroring the work of the WHO. Industry arguments must be "science-based" and clothed in research credentials, as the ICAP has done with its many briefing papers and policy reviews. Rather than direct confrontation with public health, which the ICAP has studiously avoided, partnership is critical. Finally, the industry must consistently emphasize alcohol education. As Miller's vice president of corporate relations told a meeting of alcohol industry executives in 1996, when the beer company was still under the control of Philip Morris,

> First, we must continue to educate consumers to drink our products responsibly . . . . Second, we must continue to educate the public . . . that there is a vast difference . . . between consumption . . . and abuse . . . of our products . . . and between alcohol . . . and illegal drugs . . . . And third, we must continue to educate policy makers . . . that we . . . and the 100 million Americans who drink alcohol beverages . . . don't need higher taxes . . . and more restrictive regulations . . . . For our industry, a positive image . . . based on accurate information about our products . . . is not a luxury . . . but a necessity . . . a necessity for survival . . . . This is hardball . . . and we've got to play to win."[63(pp3-18)]

THE PUBLIC HEALTH RESPONSE

What should the public health response be to the efforts to influence science and policy made by the alcohol industry through organizations like the ICAP? First, we need to use and expand on public health research tools to build greater awareness of and sophistication about such organizations. As Jahiel has pointed out, this work requires use of sources not usually examined by epidemiologists, such as trade journals, reports to stockholders and the Securities and Exchange Commission, and newsletters advising investors on stocks, and careful analysis of scientific reports and other publications released by corporations and their allies.[73] Given the ICAP's prodigious written output, application of tools such as ethnographic content analysis[74] and discourse analysis,[75] which have been useful in studying tobacco industry–funded products,[76] may also be useful in analyzing how research findings may be distorted on behalf of corporate interests.[27]

Second, it is critical that public health organizations such as the WHO and its regional offices receive sufficient resources to provide a substantial and substantive public health voice, particularly in less-resourced countries, and that scarce resources be used to best effect. Others have documented the work of the ICAP in sub-Saharan Africa to promote weak national alcohol policies[26]; these efforts too often fill a vacuum created by underresourced public health sectors in these countries and regions. In light of the findings in this article, there is particular need for aggressive public communications to put forward the public health view of the problem and the most effective approaches to it. Technical assistance and mini-grants to independent organizations in resource-poor countries are needed so that industry-funded organizations like the ICAP cannot take advantage of an underresourced public health sector to put forward industry constructions of the problem.[77]

As countries seek to implement the WHO's Global Strategy to Reduce Alcohol-Related Harm, it is also critical that they not avoid some of the more controversial but also more effective public health strategies such as taxation and regulation of physical availability and marketing, despite the industry's efforts to direct attention away from these approaches. *The Lancet*[78] and the American Public Health Association[79] have called for the development of a Framework Convention on Alcohol Control. Such a convention may be one avenue toward this, but a complementary path lies in the development of case studies, practical guides, and other forms of off-the-shelf technical assistance materials to assist countries to move in these regulatory directions.

Finally, the public health response requires clear recognition of the ethical issues and practical limitations of collaboration with entities such as the alcohol beverage industry. In the United States, underage and excessive drinkers account for half of the alcohol consumption.[80] This context creates a clear conflict of interest between public health and alcohol companies. In 2001, the health ministers of the European Union adopted a declaration on alcohol and young people, the preamble to which stated that "[p]ublic health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests."[81] This was reiterated in the European Alcohol Action Plan, endorsed in September 2011 by the 53 Member States of the WHO's European Region:

> [T]he Regional Office will strengthen its processes of consultation and collaboration with NGOs and relevant professional bodies that are free of conflict of interest with the public health interest . . . guided by the principle that public policies and interventions to prevent and reduce alcohol-related harm should be guided and formulated by public health interests and based on clear public health goals and the best available evidence.[82(p25)]

The ICAP and other alcohol industry organizations continue to argue, advocate, and promote the alcohol industry's involvement in medicine and public health. However, at least 1 prominent public health researcher and editor has argued that the industry's tactics may bring it even closer to the tobacco industry in reputation. As Griffith Edwards, then-editor of the journal *Addiction*, wrote in the *British Medical Journal* in 1998:

> So, should researchers take research money from a tainted industry which exploits vulnerable populations, mounts attacks on valid research and independent researchers, and which, through its front organisations, tries to distort the truth? . . . If the drinks industry goes on behaving in Britain and in other countries in its present unethical manner, it will inevitably and deservedly, join the tobacco industry in a pariah status.[83(p336)] ■

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