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# Policy actors' perceptions of conflicts of interest and alcohol industry engagement in UK policy processes

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I, Katherine Severi (née Brown), confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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# Abstract

**Introduction:** Alcohol industry organisations occupy a prominent position in UK alcohol policy settings, but their involvement has been contested by public health bodies on the basis that a conflict of interest (COI) exists between industry economic objectives and public health goals. It has been argued that a number of alcohol policy failures have been due to alcohol industry involvement in and/or influence over policy making processes, however the issue of alcohol industry COI is conceptually ill-defined and empirically under-researched. This qualitative study investigates understandings of COI, and the implications of engagement with alcohol industry, among UK alcohol policy actors (i.e. decision makers and advocates). More specifically, it explores how different policy actors perceive the risks and benefits associated with alcohol industry involvement in public policy.

**Methods:** Semi-structured interviews with a range of policy actors (n=26) including medical professionals, parliamentarians, civil servants, academic researchers, health campaigners and alcohol industry representatives were conducted between January-September 2018. Due to a low response rate, interviews with alcohol industry representatives were supplemented with a documentary analysis of industry sources. Interviews were transcribed verbatim and data were subjected to detailed thematic analysis. The Advocacy Coalition Framework (ACF) was applied to explore how beliefs of policy actors converged and diverged between and across different sectors.

**Results:** All participants identified the existence of COI in alcohol policy settings although many struggled to articulate a clear definition of this. Risks associated with engaging alcohol industry bodies in policy processes were identified by the majority of interviewees. Two competing advocacy coalitions were identified: a "public health coalition" and an "industry partnership coalition". Beliefs about risks linked to alcohol industry engagement varied between these two coalitions according to the type of industry actor, type of engagement, type of alcohol policy and the stage of policy process. Members of competing coalitions expressed some shared beliefs about certain policy scenarios. Multinational alcohol producers were identified as presenting the greatest risk, with industry involvement in the early stages of the policy cycle identified as especially problematic. Some participants identified risks with involving any non-governmental actors in policy making, although the threat to public health was deemed greatest with commercial alcohol industry involvement.

**Conclusions:** Findings from this research underline that alcohol policy is a complex and contested space in which policy actors identify varying risks and COI associated with alcohol industry engagement. Guidelines on how to identify, manage and protect against COI in alcohol policy settings, informed by the experiences and perceptions of policy actors, would assist both decision makers and non-governmental actors in managing potential COI in order to promote public health.

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# Table of contents

## List of figures

## List of tables

## List of Abbreviations

| | |
|---|---|
| ABV | Alcohol by Volume |
| ACF | Advocacy Coalition Framework |
| ALMR | Association for Licensed Multiple Retailers |
| APPG | All Party Parliamentary Group |
| BBC | British Broadcasting Corporation |
| BBPA | British Beer and Pub Association |
| CAP | Community Alcohol Partnership |
| CDC | Centres for Disease Control |
| CEO | Chief Executive Officer |
| CMO | Chief Medical Officer |
| COI | Conflict of Interest |
| CSR | Corporate Social Responsibility |
| DALY | Disability Adjusted Life Year |
| FAS | Foetal Alcohol Spectrum Disorder |
| FCTC | Framework Convention on Tobacco Control |
| FMCG | Fast Moving Consumer Good |
| IAS | Institute of Alcohol Studies |
| IEA | Institute for Economic Affairs |
| IPA | Interpretative Policy Analysis |
| MUP | Minimum Unit Pricing |
| NCD | Non-Communicable Disease |
| NGO | Non-governmental Organisation |
| NHS | National Health Service |
| NTE | Night-time Economy |
| OECD | Organisation for Economic and Community Development |
| ONS | Office for National Statistics |
| OPA | Organisational Policy analysis |
| PHE | Public Health England |
| RDAN | Responsibility Deal Alcohol Network |
| RSPH | Royal Society for Public Health |
| SAPRO | Social Aspects Public Relations Organisation |
| SNP | Scottish National Party |
| SWA | Scotch Whisky Association |
| UK | United Kingdom of Great Britain and Northern Ireland |
| USA | United States of America |
| WHO | World Health Organisation |

# 1. Introduction

Harms associated with alcohol use are an important health concern both in the UK and globally.[1] These include both individual health harms and wider societal harms that affect those beyond the drinker.[2] International evidence indicates the most effective policy interventions to reduce alcohol harm are population level supply-chain restrictions on the price, availability and promotion of alcohol products.[3] The World Health Organisation (WHO) identifies these three policy levers as 'best buy' interventions and they are included in the policy framework recommended in the 2010 WHO Global Strategy to reduce alcohol harms.[4] This policy framework also encompasses provision of treatment and specialist support for at-risk drinkers, drink driving counter measures and consumer information and awareness about alcohol harms.[4] However, WHO surveillance reports indicate that the uptake and application of these policy recommendations by governments around the world, including the UK Government, is limited and that progress in reducing rates of alcohol harm has been slow since the Strategy's publication.[5] These upstream, population-level policy measures are widely opposed by the global alcohol industry which favours instead targeted, individual-level measures and self-regulatory regimes for which there is only limited supporting evidence.[6]

Previous UK alcohol policy strategies and initiatives have failed to achieve significant reductions in alcohol harms.[7] Studies suggest this lack of effectiveness is due, at least in part, to alcohol industry involvement in the policy process and their ability to shape the policy agenda towards industry-favoured but ineffective measures.[8] Consequently, researchers and health campaign groups have called for alcohol industry representatives to be excluded from health policy processes.[9] Examples of alcohol industry obstruction of public health goals include: a legal challenge launched by the Scotch Whisky Association (SWA) against the Scottish Government to prevent the introduction of Minimum Unit Pricing (MUP) for alcohol in Scotland;[10] substantial lobbying activity that reportedly led to the reversal of the decision to introduce MUP in England[6, 11] and participation in the UK Government's Public Health Responsibility Deal: a partnership agreement that saw industry voluntary pledges achieve little to no reduction in alcohol harm.[12] Public health actors have consistently argued that alcohol industry involvement in public health policy represents a conflict of interest (COI) because of private companies' fiduciary responsibility to maximise shareholder value and thus to prioritise profits over public health goals.[13] Despite this perceived COI, alcohol industry groups continue to occupy a prominent place in UK alcohol policy.[14] This study seeks to explore how UK alcohol policy actors understand the concept of COI in relation to alcohol industry engagement in public health policy.

International guidelines exist to protect public health policy from commercial vested interests in relation to tobacco control, infant formula and foods high in fat, salt and sugar.[15, 16] However, there is no equivalent of these in the field of alcohol policy and there is little

guidance available for managing COI when engaging alcohol industry bodies in public policy processes. The lack of established principles for policymaker engagement with the alcohol industry means that, unlike areas such as tobacco control, there is also no internationally agreed definition of COI in this context. Furthermore, a relative lack of research exists on this topic and little is known about how alcohol policy actors view alcohol industry engagement in the policy process and how different groups of policy actors define and coalesce around ideas of COI in this context. This thesis addresses the identified gap in knowledge by exploring UK alcohol policy actors' perceptions and understandings of COI and alcohol industry engagement in public health policy processes. For the purpose of this thesis, policy actors are defined as individuals and organisations directly involved in influencing and shaping policy decisions. These include decision-makers such as politicians and government officials, and actors that work to influence policy decisions such as academics and pressure groups (both commercial and not-for profit). Semi-structured interviews were conducted with a range of policy actors including civil servants, parliamentarians, medical professionals, alcohol researchers, health campaigners and alcohol industry representatives to explore their understanding of the concept of COI and their beliefs about alcohol industry involvement in the public health policymaking process. While the focus of the thesis is on the UK context, the issues addressed and the potential findings are widely applicable given the similar lack of engagement with COI and the alcohol industry in other national settings, and the lack of global norms, standards and guidelines in this area identified above.

Central to this study is the concept of meaning making and how individuals subjectively construct meanings and beliefs relating to different contexts depending on a range of factors including their individual beliefs, values, judgements and personal experiences. In public policy settings, conflicts over meaning are at the heart of political debates.[17] An acknowledgement that multiple, concurrent meanings exist amongst different policy actors is essential to understanding the development of policy processes and the emergence of policy decisions. The Advocacy Coalition Framework (ACF), which assesses how policy actors coalesce around ideas and beliefs, was therefore chosen as the main theoretical framework employed in this study. The analysis aims to identify how beliefs regarding COI and alcohol industry engagement in policy converge and diverge among and between different stakeholder groups or advocacy coalitions.[18] Two competing advocacy coalitions were identified: a "public health coalition" and an "industry partnership coalition." Membership of each coalition was determined according to shared beliefs about the nature of alcohol harm in the UK and the appropriate government policy response.

The policy stages model was used as a heuristic device to illicit policy actor views of COI and alcohol industry engagement at different stages of the policy process and Hillman and Hitt's taxonomy on corporate political power was used to explore policy actors' beliefs about COI linked to different alcohol industry engagement activities.[19, 20] The WHO Global Alcohol Strategy policy framework acted as a guide to explore views on alcohol industry involvement

in different types of policy.[4] Participants were also invited to share their beliefs about alcohol industry's interaction with policymakers in different policy settings including formal and informal engagement activities.

The following sections of this chapter provide an overview of the alcohol policy context under investigation, including the most recent data on alcohol harm and evidence to support public health policy interventions. It also provides background information on how the issue of COI is addressed in other policy contexts. Findings from a narrative literature review are presented, which provides contextual information on alcohol industry involvement in public health policy processes and associated COI. The aims and objectives and the scope of this thesis are described, and this introduction chapter ends with a summary overview of the thesis structure.

## 1.1. Background

### 1.1.1. Alcohol harms and policy interventions

Globally, alcohol is the third leading risk factor for mortality and morbidity, associated with three million deaths each year and responsible for 5.1% of the global burden of disease as measured in disability adjusted life years (DALYs).[21] In England, alcohol places a significant burden on the NHS and public services, with 1.3 million hospital admissions and 22,000 deaths attributable to alcohol each year, alongside more than one million crimes.[2] There is also evidence to indicate alcohol puts significant strain on the economy and workplace productivity: In 2015 there were 167,000 years of working life lost to alcohol related disorders and the annual social costs associated with alcohol harm in the UK are estimated at between £21-52 billion.[22]

The World Health Organisation (WHO) has identified ten policy areas that Member States can take action on to reduce harmful use of alcohol, in its 2010 Global Alcohol Strategy.[4] These ten policy areas are based on international evidence of effectiveness and are listed below in figure 1. The policy areas identified are closely aligned to an international systematic review of the literature pertaining to the evidence of effectiveness and cost-effectiveness of interventions to reduce alcohol harm.[1] In 2012, WHO published an action plan on preventing and controlling non-communicable diseases.[3] For reducing harmful use of alcohol, WHO lists regulations to raise the **price**, restrict the **availability** and curtail the **marketing** of alcoholic products as the top three 'best buy' policies[3] based on their strong evidence of cost-effectiveness.[1]

Public Health England (PHE) published a review of the evidence to support the effectiveness of policies to reduce alcohol harm in the English context in 2016.[2] This review corroborated the evidence presented by WHO, finding the strongest evidence of effectiveness for policies

that reduced alcohol affordability, availability and promotion. It also found evidence that alcohol industry involvement in policymaking was problematic due to their active opposition to the 'best buy' policies identified above. A number of tactics employed by the alcohol industry to influence the policymaking process were described and compared with those used by the tobacco industry. Such tactics were reportedly designed to promote less effective policy solutions with a weak evidence base and obstruct effective solutions, due to an inherent COI between alcohol industry economic objectives and public health goals.[23] The PHE evidence review acknowledged research findings which recommended "policymakers need to be aware of these [strategies] in order to understand how the alcohol industry may try to influence the policymaking process" and "the similarities [between the alcohol industry and tobacco industry] suggest that alcohol policy may benefit from reproducing efforts in tobacco control aimed at excluding corporate actors from the policy process and enhancing transparency".[23]



*Figure 1: WHO policy recommendations to reduce harmful use of alcohol*

The WHO Global Alcohol Strategy acknowledges that the goals of alcohol industry 'economic operators' can be perceived as in conflict with public health measures to reduce harmful use of alcohol. It states that 'policy-makers face the challenge of giving an appropriate priority to the promotion and protection of population health while taking into account other goals, obligations… and interests'.[4] However, in spite of an apparent conflict, WHO stipulates that

multi-sectoral action, including engagement with economic operators, is essential to the success of the Global Strategy in achieving its aims. In the UK, alcohol industry representatives are commonly involved in public policy initiatives purported to reduce harm and this has led to objections and protests by members of the public health community who have raised concerns about the alcohol industry's COI between commercial profits and public health gains.[7, 24] More information on the UK alcohol policy context is provided below.

There is an apparent tension between government institutions calling for alcohol industry involvement in policies to reduce harm, and public health representatives calling for restrictions on industry engagement: The WHO Global Alcohol Strategy states appropriate engagement of civil society and economic operators is 'essential',[4] leading international researchers and alcohol control advocates to call for clear guidance on managing COI associated with alcohol industry involvement in policies to reduce harm.[9, 25] This study explores how UK policy actors perceive COI in relation to alcohol industry engagement in order to form a greater understanding of how policy decisions are taken and how public health goals are valued compared to economic objectives.

### 1.1.2. Policy developments during period of study

After completion of the data collection phase of this study, a series of events resulted in PHE publishing guidelines for engaging with industry stakeholders.[26] The development of these guidelines was in response to negative reaction from the public health community to a partnership between PHE and the alcohol industry-funded body Drinkaware. This partnership comprised a jointly-branded communications campaign advising consumers to reduce their alcohol consumption by taking 'drink-free days'.[27] The Co-Chair of PHE's Alcohol Leadership Board, the accountable body for the collective programme of work on delivering PHE's alcohol programme,[28] resigned in September 2018 following a number of representations to PHE from academics, public health professionals and NGOs protesting at the industry partnership.[24] The primary concern of these stakeholders was that the alcohol industry-funded Drinkaware had a COI in the communication of health advice due to its obligations to funders. Non-governmental members of the PHE Alcohol Leadership Board demanded that PHE develop guidelines on engagement with unhealthy commodity industry stakeholders to identify and manage COI in future partnerships.[29] PHE published this guidance in July 2019. These guidelines outline PHE's position that:

> although industry objectives are often at odds with efforts to improve public health, it is recognised that some industries and commercial organisations can play a role in counteracting the negative impact of the products and services they profit from.[26]

These guidelines, therefore, recommend that PHE engagement with alcohol industry actors is restricted to:

a dialogue and exchange of information for achieving positive outcomes for public health. Engagement with the alcohol industry will not lead to or imply partnership, collaboration or any other similar type of engagement that could give the impression of a formal relationship […] because there is a danger such engagements would put at risk the integrity, credibility and independence of PHE's work.[26]

These events and developments highlight that the issue of COI and UK government interaction with alcohol industry bodies is a topical and highly contested issue. This confirms the need for research in this space and therefore the salience of this study to current policy debates. The events leading up to the development of the PHE guidelines occurred after interviews with key informants had taken place, therefore this study does not seek to assess their perceived relevance and/or efficacy among stakeholders. Given that the guidelines are restricted to PHE only, and have not been adopted across government, there remains a need to further our understanding of policy actors' perceptions of engaging the industry.

### 1.1.3. Definitions of COI

A COI can be identified as a set of conditions in which professional judgement concerning one interest or responsibility can be unduly influenced by another interest or responsibility.[30] This definition applies to both individuals and institutions and can affect all sectors of the economy, including business, research and medicine. For example, previous studies indicate how financial COI can introduce bias into research and influence prescribing patterns of physicians.[31] Regulations seeking to protect against COI often focus on financial conflicts, with institutions prohibiting the acceptance of funding from certain bodies or setting caps on funding from organisations before mandatory public declarations of funding are required.[15, 30] However, considering COI in purely financial terms has been criticised as too narrow an approach.[32] Non-financial relationships between individuals and institutions can create COI: these include close personal attachments, undue political pressure exerted by a company or a company's close participation in what WHO terms "quasi-official roles" such as membership of advisory groups or governmental fora.[16]

At present, there is no internationally recognised consensus definition of COI related to alcohol industry engagement with public policy, however definitions exist for other areas of public health. The WHO Framework Convention of Tobacco Control (FCTC) is guided by the principle that "there is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests" and includes guidance on how to manage COI by excluding the tobacco industry from certain policy settings.[15] In addition, a set of definitions for COI was developed to inform a WHO technical report on addressing and managing COI in nutrition programmes.[16] These nutrition guidelines addressed financial and non-financial COI and identified three types of COI: 'actual', 'perceived' and 'outcomes

based'. The Organisation for Economic Co-operation and Development (OECD) developed guidelines on managing COI in the public sector, which similarly identify a variety of types of COI: 'actual', 'apparent' and 'potential'.[33] These guidelines are designed to assess the private interests of individual officials working in the public sector, therefore deal with individual COI. The OECD definitions of COI are based on the assumption that 'a reasonable person, knowing the relevant facts, would conclude that the official's "private-capacity interest" could improperly influence the official's conduct or decision-making'.[33] A comparison between the WHO and OECD definitions of COI is provided in Figure 2.

| WHO technical report on managing COI in nutrition programmes | OECD toolkit for managing COI in public sector |
|---|---|
| An **actual conflict of interest** arises when a vested interest has the potential to unduly influence official or agency judgement/action through the monetary or material benefits it confers on the official or agency | An **actual conflict of interest** exists when there is, in fact, an unacceptable possibility of conflict between a public official's interests as a private citizen and their duty as a public or civil servant |
| A **perceived conflict of interest** arises when a vested interest has the potential to unduly influence official or agency judgement/action through non-monetary or non-material influences it exerts on the official or agency | An **apparent conflict of interest** can be as seriously damaging to the public's confidence in a public official, or the official's agency, as an actual conflict |
| An **outcome-based conflict of interest** arises when a vested interest, involved in the policymaking or policy-implementation process, seeks outcomes that are inconsistent with the demonstrable public interest | A **potential conflict of interest** may exist where an official has private-capacity interests which could cause a conflict to arise at some time in the future |

*Figure 2: Definitions of COI according to reports by WHO and OECD*

From these definitions, it is evident that COI can take several forms, both monetary/material, and non-monetary/non-material. However, the absence of guidelines or principles for engaging with the alcohol industry in public health policy settings means there are no agreed definitions for COI specific to the alcohol policy context, and norms and guidelines from other areas of public health policy such as tobacco control are not widely used or drawn upon. This leads to a suboptimal understanding of the concept of COI and any risks associated with engaging alcohol industry actors in public health policy processes. As a first step to exploring the need for COI guidelines in alcohol policy settings, it is necessary to investigate how alcohol policy actors understand COI and how this affects their professional conduct, including decisions to engage with industry actors. As discussed below, alcohol industry actors are currently afforded high levels of access to the UK public policy process and evidence suggests that their involvement in policy initiative leads to suboptimal policy outcomes.[11, 14, 34, 35]

## 1.2. Literature review

For the purposes of this thesis, a narrative literature review was conducted to provide context and background to the key issues under investigation. The areas of focus were alcohol industry involvement in public health policy processes and COI in alcohol policy. The aim of exploring the literature on these two related issues was to identify evidence of the impact of alcohol industry involvement in public health policy and whether COI are identified as a barrier to policy progress. It sought to explore what perceptions exist about the nature of alcohol industry involvement in public health policy processes and whether such perceptions vary according to different stakeholder groups. This search did not aim to identify literature relating to the involvement of other health harming industries in public health policies, given that the alcohol industry was the main focus of the study. However, reference to how other industries such as tobacco, gambling, sugar-sweetened beverages and foods high in sugar, salt and fat (HFSSF) impacted health policy outcomes, and any existing or recommended guidelines for addressing COI related to such industries, were recorded.

A narrative, rather than a systematic, review was identified as a more appropriate means of gathering relevant background information to provide context. The aim of the narrative review was to inform the study design and refine the research questions addressed rather than answer a specific question or to exhaustively capture the state of the art in the literature in this area (which would be the objective of a systematic review).[36] This approach is in keeping with standard scholarly practise in the social sciences to situate research within the relevant bodies of literature[37, 38]. Given the significant time and resources required to undertake a systematic review, and the constraints faced by a single researcher in the timeframe available for this thesis, it was felt that a narrative literature review best served the objectives of the project with little additional benefit gained from undertaking a systematic review.

Google Scholar was used to map the terrain of literature in advance of more structured searches of Web of Science and EMBASE. All searches used the key words "alcohol industry" AND "policy". This review included primary studies and editorials in peer reviewed journals and non-peer reviewed reports and articles from what is termed 'grey literature'. The added value of including grey literature was to identify narratives and arguments used by non-academic policy actors, such as health campaigners and alcohol industry representatives. It also allowed for analysis of government policy position papers and strategy documents. Texts returned from these searches were screened for relevance via titles and abstracts and then texts identified as most relevant were downloaded and read in full. Key debates and authors were identified, and reference lists were used as a basis for snowballing and forward searching, to identify further sources and gather further information relevant to emerging themes. Key emerging themes arising from the literature identified are presented below.

### 1.2.1. Defining the Alcohol Industry

The narrative review identified an emerging body of literature that makes reference to alcohol industry engagement in public policy. However, a clear definition of the 'alcohol industry' was not apparent, with one study noting that "there has been little consideration of exactly what constitutes the industry".[39] A number of definitions were identified ranging in scope from alcohol producers and retailers,[11] to commercial operators involved in the full supply chain of agricultural, packaging, marketing and distribution activities.[40] The WHO defines alcohol 'economic operators' as 'developers, producers, distributors, marketers and sellers of alcoholic beverages'.[4] The emergence of social aspects public relations organisations (SAPROs) and increased visibility of alcohol industry trade associations was cited as an important mechanism for industry engagement in public policy by several authors who identified these groups as 'alcohol industry' bodies.[35, 41, 42] This additional category of actors is not included in the WHO definition above and in the context of policy engagement warrants consideration based on the existing literature.

The impact of globalization and the emergence of a relatively small number of multinational alcohol producers, formed through a series of mergers and acquisitions, was frequently cited and the term 'global alcohol producers' was often used interchangeably with 'alcohol industry', implying that these industry actors are considered dominant, more powerful and influential in public policy settings.[43] The alcohol industry is more transnational compared to other Fast-Moving Consumer Goods (FMCG) industries, and its political economy has been compared to that of the tobacco industry in terms of industry structures, market and political strategies.[44] The differences in strategic objectives amongst and between alcohol industry actors with regards public policy has been explored,[39] implying that the alcohol industry is not a monolithic policy actor. The lack of a coherent definition of the 'alcohol industry' and the evidence of different levels of power, influence and strategic objectives amongst the diverse range of alcohol industry groups warrants further investigation into the understanding about the identity and purpose of alcohol industry groups, ranging from alcohol producers, retailers, trade associations and SAPROs, amongst policy actors.

### 1.2.2. Alcohol industry engagement with public policy

This review found evidence to indicate that alcohol industry bodies are active stakeholders in public policy processes in the UK, European and global settings. It also found evidence to indicate that alcohol industry involvement in policy initiatives was met with opposition from public health stakeholders and in some instances was linked to policy obstruction and/or inertia. A 2018 systematic review by McCambridge and colleagues summarized the available evidence on alcohol industry involvement in policymaking and concluded that 'alcohol industry actors are highly strategic, rhetorically sophisticated and well organised in influencing national policymaking'.[14] In the UK, alcohol industry actors were invited by the

government to engage in a Public Health Responsibility Deal Alcohol Network (RDAN), which was launched as a flagship policy in 2011 to improve public health outcomes.[45] At the EU level, alcohol industry representatives were invited to become members of the EU Alcohol and Health Forum (EUAHF) in 2006, a mechanism chaired by the European Commission that required industry and NGOs to pledge voluntary commitments to help reduce alcohol harm.[46] Both of these policy initiatives were halted following objections and/or boycott actions from public health stakeholders: Six public health bodies declined to participate in RDAN when it was launched, citing COI related to alcohol industry involvement as a barrier to the initiative's potential success and their endorsement.[47] In 2013, four high profile public health NGOs resigned from RDAN, accusing the alcohol industry of pressurizing the UK government to scrap plans to introduce MUP.[47] Similarly, 20 NGO members of EUAHF resigned from the Forum in 2015, citing COI between the alcohol industry members' economic objectives and public health goals as the principal reason why the European Commission had failed to develop a new EU alcohol strategy to reduce harm.[48]

At the global level, in 2013 more than 500 public health professionals, health scientists and NGO representatives from 60 countries signed a joint statement of concern about the activities of the global alcohol producers, which was sent to the WHO Director General.[9] This statement called on WHO to "clarify the roles and responsibilities of economic operators in the implementation of the WHO Global Strategy; implement stronger COI policies and continue to avoid partnerships with the commercial alcohol industry, its social aspects organisations and other groups funded by the commercial alcohol industry".[9] To date no such guidelines have been developed and WHO officials continue to hold regular meetings with alcohol industry representatives.[49]

This review found documented evidence describing alcohol industry activities that seek to undermine public health goals and there is evidence of such activities conducted by producers, retailers, trade associations and SAPROs.[50] Tactics include: information and messaging to frame alcohol as an ordinary part of a healthy lifestyle that is consumed responsibly by the majority of drinkers and misused only by a small minority;[51] discrediting scientific evidence to support effective alcohol control policies and promoting 'junk science' reports based on unreliable data that promote ineffective measures;[11] corporate social responsibility initiatives and sponsorship of sporting and cultural events to enhance the image of companies as socially responsible;[52] promoting ineffective solutions and voluntary partnership agreements that focus on individual behaviour change with no environmental changes to support that;[23] and legal challenges to government actions to reduce alcohol harm that are deemed contrary to trade.[23] Such industry activity has been compared to tactics used by tobacco companies to obstruct health policy.[52]

A systematic review of alcohol industry tactics to influence marketing regulations was published by Savell and colleagues in 2015.[23] This review adopted the same protocol as a

previous systematic review of tobacco industry strategies,[53] and was based on Hillman and Hitt's taxonomy on corporate political strategy.[20] Hillman and Hitt's taxonomy identified three main strategies employed by corporations to influence public policy to achieve outcomes favourable to their financial objectives. These three strategies were 1) provision of information to decision makers (both directly and indirectly), 2) provision of financial incentives (such as political donations and honoraria for speaking at events) and 3) constituency building (including grassroots mobilisation and targeting of decision makers indirectly through constituents).[20] Savell et al. followed scholars that had applied this framework analysis of tobacco industry corporate political activity and identified further strategies adopted by the alcohol industry: constituency fragmentation (neutralising or weakening opponents), policy substitution (promotion of self-regulation) and legal action (the use of litigation or threat of legal challenge to policy interventions).[23] See Figure 3 for an overview of the strategies and tactics adopted by alcohol industry bodies as identified by Savell et al, based on Hillman and Hitt's taxonomy.

| Strategy | Tactics |
|---|---|
| Information and messaging | Developing evidence: Funding and shaping original research<br>Disseminating evidence: collating and interpreting existing evidence, for the public and policymakers<br>Lobbying: making direct proposals and representations to policymakers |
| Constituency building | Forming industry groups and associations to assist coordination and collaboration<br>Forming alliances with sympathetic non-trade bodies e.g. think tanks |
| Policy substitution | Corporate Social Responsibility (CSR) programmes, apparently promoting the social good independently of the government<br>Developing self-regulation as an alternative to government restrictions |
| Financial | Using economic incentives to influence policymakers, particularly employment opportunities and connections |
| Legal actions | Shaping trade policy to secure favourable terms and access to new markets o Using legal challenges to undermine unfavourable policies and regulation (typically on the basis of trade law) |

*Figure 3: Alcohol industry corporate political activity*

Alcohol industry involvement in science (a tactic termed 'shaping the evidence base') was identified as a key debate, with concerns from the alcohol research community identified by a second systematic review led by McCambridge in 2018.[54] This analysis assessed views of academic researchers expressed in peer-reviewed journals in the form of research studies, commentaries, opinion pieces, editorials and letters and identified 'serious concerns' about alcohol industry involvement in three areas related to science: 1) evidence-informed policy making and the instrumental use of research by industry actors, 2) the content of scientific evidence and industry funding as a source of bias and 3) the processes of undertaking

research and transgressions from basic scientific norms.[54] The authors identify that the concerns held by members of the alcohol research community are extensive, longstanding and unresolved, and they call for high quality investigations to address this issue.

### 1.2.3. Impact of alcohol industry activities

As highlighted by McCambridge et al, it is challenging to measure impact and influence in policymaking, a complex process involving multiple factors and actors.[14] The existing evidence to date on the impact of alcohol industry activities largely focusses on the undermining of health policy goals by obstructing, delaying or diverting attention away from evidence-based public health policies. Greater evidence was identified on indirect impacts, such as information and messaging tactics that helped to shape support for less effective policy interventions, although there is evidence to show direct impacts of industry activities such as the SWA legal challenge to the Scottish Government that obstructed the introduction of MUP,[6] and SAB Miller's authorship of national alcohol strategies in four sub-Saharan African countries.[55]

There was little evidence identified in the literature to demonstrate that alcohol industry activities have a positive impact on public health, in terms of reducing rates of alcohol related health and social harms. Despite numerous alcohol industry partnerships and voluntary schemes, no formal evaluations were identified that provided evidence of effectiveness: In the UK, a series of evaluations of the public-private partnership RDAN found little evidence that the range of voluntary pledges performed by industry actors, including producers, retailers and trade associations, had affected rates of alcohol harm.[12] At the EU level, an evaluation of the EUAHF found that commitments from alcohol industry members had no impact on public health outcomes.[56] A systematic analysis of more than 3,000 alcohol industry corporate social responsibility initiatives globally found the majority of industry actions were based on minimal evidence of effectiveness, were rarely subject to evaluation and that more than half of all industry actions performed in low-income countries had some risk of generating harm.[57]

### 1.2.4. Gaps in the literature and study rationale

The literature reviewed above indicates that alcohol causes significant harm and places a burden on health services, communities and economies in the UK and worldwide. Evidence indicates effective policies which exist to reduce alcohol related harms are opposed by alcohol industry bodies. It is argued that a fundamental COI exists between alcohol companies' fiduciary responsibility to shareholders and public health goals, and health bodies have raised concerns about alcohol industry involvement in public health policy settings. Despite this, alcohol industry actors occupy a prominent position in alcohol policymaking, and this has led to the breakdown of a number of policy initiatives. Researchers have questioned the contrast between involvement of the alcohol industry in public health policy to the treatment of

tobacco industry actors who are largely excluded from the policy process.[44] Guidelines exist in other public health fields for tobacco control and obesity prevention to manage and protect against COI from economic operators, however little guidance exists with relation to alcohol, which is among the greatest risk factors for non-communicable diseases (alongside tobacco consumption, unhealthy diet and physical inactivity). No rationale was identified in this review for the current treatment of the alcohol industry.

McCambridge and colleagues noted in their recent systematic reviews the paucity of studies exploring the role and impact of alcohol industry actors in public policy making and science. Drawing comparisons with other areas of public policy, tobacco control and environmental protection, the authors described the issue of alcohol industry involvement as 'grossly understudied,' leading to a recommendation for further research that investigates alcohol industry involvement in public policy.[14]

The lack of research into the potential COI raised by the involvement of alcohol industry actors in public health policy, and the absence of alcohol-specific guidelines to manage COI in alcohol policy contexts suggests an investigation into alcohol policy actors' understanding of COI and perceptions of alcohol industry engagement in public policy is urgently needed. The literature identified in this review shows clear tensions between a desire by government agencies to involve the alcohol industry, as well as other non-state actors, in making and implementing public policies to reduce alcohol harm, and public health actors' requests to exclude them from policy processes. No clear rationale or recommendations for practice were identified in this review for either perspective. This indicates the importance of the present study in investigating alcohol policy actors' perceptions of these issues, which could provide important knowledge to inform the development of future guidelines to inform public health policy making.

## 1.3. Thesis overview

### 1.3.1. Aims and Objectives

This thesis investigates the understandings of COI among UK alcohol policy actors relating to industry involvement in policy-making processes. More specifically, it explores how different policy actors perceive risks and benefits associated with alcohol industry involvement in the development and implementation of public health policy designed to reduce alcohol harm, and how they value public health goals compared to economic objectives. In doing so, it seeks to answer the following research questions:

1) How do UK alcohol policy actors understand the concept of COI in public health policy making?

2) How do UK alcohol policy actors perceive the actual and potential involvement of alcohol industry bodies in public health policy making?

3) How does policy actors' understanding of COI influence their ideas about the legitimacy of industry involvement in public health policy making and implementation related to alcohol?

4) How do UK alcohol policy actors' understanding and perceptions of COI and alcohol industry involvement in public health policy converge and diverge across different stakeholder groups?

## 1.3.2. Scope of the Thesis

This thesis explores how UK alcohol policy actors understand and perceive COI in relation to alcohol industry involvement in public health policy settings. It begins from the premise that, to address problems associated with industry involvement in policy identified in the literature and/or to develop guidelines for identifying and managing COI related to alcohol industry involvement, a clearer understanding is required about the nature of COI as well as policy actors' perceptions of and beliefs about this in light of their experiences of public health policy processes and alcohol industry involvement in this.

This thesis seeks to understand how policy actor beliefs converge and diverge across different stakeholder groups to gain a better understanding of the lived experience of policy actors. Whilst it does not aim to develop specific or ideal-type guidelines for alcohol industry engagement in policymaking, it does explore policy actors' views on how best to manage COI. These insights may provide valuable knowledge and subsequently help to inform the development of future guidelines on alcohol industry involvement in policy.

## 1.3.3. Structure of the Thesis

This thesis is submitted for examination within the Doctor of Public Health (DrPH) programme. Requirements for DrPH theses differ from those of the PhD programme at LSHTM, which mirror those of similar programmes widely offered at other UK universities. As with the PhD programme, an original contribution to knowledge is the key requirement for the award of the DrPH. However, DrPH theses are around half the length of a PhD, meaning that their scope is more limited in terms of the breadth, if not the depth, of the analysis presented. The overarching structure of this thesis is a 'book style', whereby a single narrative is presented throughout all chapters, versus the 'publication' style thesis in which the results and discussion chapters are structured as a series of discrete articles written and formatted for direct submission to scholarly journals.

The following chapter outlines the theoretical approaches and conceptual lens adopted. This chapter describes the epistemological position that informs the study and outlines the theoretical approach termed Interpretive Policy Analysis, which this thesis adopts. It also

describes the main theoretical frameworks chosen to guide and analyse the data generated; the Policy Stages framework and the Advocacy Coalition Framework.

Chapter 3 describes the mixed methods employed to generate data; key informant interviews and document analysis. A total of twenty-six semi-structured interviews with a range of policy actors including medical professionals, parliamentarians, civil servants, academic researchers, health campaigners and alcohol industry representatives were conducted between January-September 2018. Interviews were transcribed verbatim and data were subjected to detailed thematic analysis. A document analysis of alcohol industry responses to a key public consultation was conducted to supplement interview data, due to a low participation rate of alcohol industry representatives.

Chapter 4 presents the results of the study. This is divided into four sections. The first describes how policy beliefs of participants were analysed in order to identify the existence of advocacy coalitions within the alcohol policy subsystem. Two competing coalitions were identified, a "public health coalition" and an "industry partnership coalition". The remaining sections describe how beliefs shared by members of the two coalitions compared and contrasted in relation to understanding of COI as a concept, COI related to alcohol industry involvement in public policy and suggestions for how to manage risks associated with COI in alcohol policy settings.

Chapter 5 comprises the discussion of the results and presents the conclusions of this thesis. It reflects on the findings and how they interact with existing literature. The discussion is similarly presented in four sections: identifying advocacy coalitions; participants' understanding and definitions of COI; participant beliefs relating to COI and alcohol industry involvement in policy settings and suggestions for how to manage COI. It describes the strengths and limitations of the study and the originality of this research and its contribution to knowledge. The conclusion reflects on the implications of this research for policy with reference to the development of guidelines to identify and manage COI in alcohol policy settings.

A 1,500-word integrating statement is presented at the end of this thesis as is required under the regulations of the DrPH programme. This section outlines my learning during the DrPH and how the three components of the degree, the taught component, Organisational Policy Analysis (OPA) and thesis, are linked.

## 2. Theoretical approaches and conceptual lenses

### 2.1. Epistemological perspective

This project is informed by a constructivist ontology and epistemology, according to which knowledge is constructed through the interaction of the researcher and the research environment[58]. It draws on interpretative theories of the policy process in which the objective of research is to *understand* rather than *explain* actions and processes.[59] The study aims and the research design acknowledge that science is not 'value-free' and positionality of the researcher is a key component of the research process. That is to say, the researcher is unable to transcend the social context in which they are embedded and evaluate society from a position of objective neutrality. Instead, the research process proceeds through a process of interpretation which is necessarily historical and positional, reflecting the specific viewpoint of that researcher informed by their unique experiences and beliefs.[60] This is not to say, however, that no methodological standards and norms apply, or that researchers can simply 'cherry pick' findings which suit their values and hypotheses. Through processes of reflexivity and triangulation researchers become consciously aware of their own positionality and produce plausible accounts of social realities on the basis of multiple data sources analysed.[61] The accounts of social objects, and the supporting evidence produced by researchers, made open to scrutiny by the relevant community of scholars to evaluate, are in line with the established norms of peer review. In keeping with this approach, this study does not aim to discover *the* (unique, optimum) definition of COI or the 'truth' about how COI shapes and impacts on health policy. Instead, this thesis will explore actors' perceptions and interpretations of the issue to build a greater understanding about what factors influence their perceptions and thus the decisions taken in alcohol policy.

### 2.1.2. Interpretive Policy Analysis

This study draws on, and takes its theoretical and methodological lead from, the field of Interpretive Policy Analysis (IPA), and the wider ontological and epistemological presuppositions of interpretive social science.[58] IPA, like many qualitative approaches to research, rejects the positivist objective of discovering generalizable and universal causal laws of the social world.[59] IPA acknowledges that each policy setting is unique and that universal laws cannot be applied to policy decisions and processes. In the current thesis, the policy context in question is complex and subject to influence by a range of actors with varying levels of power. Alcohol policy in the UK is a highly contested area and the involvement of alcohol industry groups has been the subject of much criticism from public health actors.[11]

Central to the methodological presuppositions of IPA is the concept of 'meaning-making' through which human agents generate and attach context-specific meaning to social objects, actors and processes inter-subjectively.[62] Given the bounded rationality, and values-based

nature, of public policy decision-making,[61] it is appropriate to explore the situation-specific meanings that are created and interpreted by policy actors working in this space, and how such meanings influence policy decisions. Within this tradition, a plurality of different meanings may be attributed to key policy concepts, and conflict over meaning is at the heart of policy debate. According to Edelman: 'if there is no conflict over meaning, the issue is not political by definition.'[17] An acknowledgement that multiple, concurrent meanings exist amongst different policy actors, is essential to understanding the development of policy processes and the emergence of policy decisions. In this regard, framing theory played an important role in this study in seeking to understand how policy actors deliberately seek to frame issues in order to generate meanings favourable to their position.[63] The use of framing was identified in the systematic review by McCambridge and colleagues as a key aspect of alcohol industry strategy to influence policy decisions.[14]

IPA is an approach that considers the role of the researcher as interpretive and integral to the research generation. [64] Researchers are unable to remove themselves from the context of the policy they are investigating and therefore must constantly reflect on their own positionality and how their values, experience and beliefs may impact the generation of data.[58] Indeed, Yanow argues that the researcher may herself be seen as a study participant, co-constructing or co-generating evidence.[62] My positionality as the researcher – as a well-known policy advocate working in the field – was both a strength and limitation for this study. I have worked in alcohol policy networks as an NGO leader for several years and work closely with many of the interview participants. My organisation, the Institute of Alcohol Studies, works to advance the use of the best available evidence in public policy decisions on alcohol and has publicly supported policies such as MUP and alcohol duty increases.[65] This experience gives me extensive tacit knowledge of the policy context under investigation and a comprehensive understanding of the policy processes within which policy actors operate. However, it also means that I may be perceived as having a vested interest in the outcomes of this research project. I address these issues below.

My personal knowledge of, and membership of networks in the UK alcohol policy arena placed me in a strong position to recruit elite interviewees to whom researchers with no such prior knowledge or networks may not be able to gain access. My insider status meant that the use of semi-structured interviews was an appropriate method of data generation, since I was able to gain insights from senior civil servants and politicians, who may have been less likely to provide candid interviews to unknown and thus less trusted researchers. Participants who were embedded in the same policy community are aware of my track record and reputation for integrity. Furthermore, the long-standing and ongoing relationships with many of the study participants means that I could be trusted to ensure anonymity of findings. In addition, my extensive knowledge of the chosen topic placed me in a strong position to extract rich data from interviews, as I was able to identify key questions and probe the

subtleties and nuances in responses that a researcher less familiar with the field may have missed.

However, my perceived position as an 'insider' among peers and colleagues may have been a disadvantage in other respects, and may have influenced data generated from certain stakeholder groups in different ways.[66] Participants from public health, policy and parliamentary backgrounds may have felt a sense of obligation to offer statements that correspond with public positions on particular issues, as opposed to their own private beliefs (which may differ or be more nuanced). Industry participants may have expected interviews with me to have been more challenging than with an unknown researcher as my prior knowledge of the subject area would lead to a more detailed, forensic approach to questions if their answers were vague or did not address specific questions. It is also possible that industry participants would have approached interviews strategically and used the opportunity to communicate pre-agreed messages on issues, or even to try and persuade me to shift allegiances from my own (public health) position. Such challenges have been faced by researchers when interviewing corporate actors.[67]

I was very conscious from the outset that my professional position as an alcohol policy actor working within a public health environment meant that I would be collecting and analysing data through a particular lens that may be less sympathetic to the positions adopted by alcohol industry actors. The potential for this to be perceived as a vested interest was identified as a likely reason that interviews with alcohol industry respondents proved challenging to recruit. My position as an NGO representative who has publicly voiced concerns about COI and industry engagement in health policy meant it is likely I was viewed both as an 'outsider' and a possible opponent to many industry representatives, reducing the likelihood of trust in the process.[68] Furthermore, public health researchers have faced criticism from industry bodies for taking advocacy positions which has led to accusations of bias.[69, 70] However, the poor response rate from industry may also be an indicator that industry bodies are reluctant to engage in research about the nature of their involvement in public policy processes, in ways similar to the tobacco industry. Indeed, Hawkins and McCambridge, who conducted interviews with alcohol industry representatives to inform a previous study of alcohol industry,[34, 39, 51] decided not to interview alcohol industry representatives for a subsequent research project in 2018-19. They argued that because increasing research attention to the industry in the intervening period – including their previous findings which had exposed industry actors in ways they would prefer not to be represented – access to industry participants was unlikely.[47] Furthermore, where access to industry was possible, the authors argued the data generated would have to be treated with caution given the awareness of industry actors of the potential reputational risks associated with this type of study and their subsequent efforts to manage the situation through strategic provision of information.[47]

However, my position as the researcher may also have facilitated the involvement of some alcohol industry representatives, who may have felt a sense of obligation to participate in the study in order to be perceived as cooperative and supportive of a multi-stakeholder approach to alcohol policy.[67] The fact I was able to interview two industry participants, and other policy actors that worked closely with industry (mainly civil servants and parliamentarians), can therefore be seen as a strength compared to similar alcohol policy studies. A researcher external to the alcohol policy subsystem may or may not have had greater success with recruiting industry participants.

I took a number of steps to mitigate the risk that alcohol industry perspectives would be underrepresented in this study. I conducted a document analysis that provided valuable data to supplement the data generated during interviews with two industry representatives, to help identify secondary beliefs held by alcohol industry bodies. However, the documents were limited in the scope of information they presented and did not provide insights into all aspects of industry perceptions of COI, as this was not an objective of the public consultation. During all interviews, including with participants who expressed views that supported alcohol industry involvement in health policy, I constantly reflected on my position and was mindful not to ask potentially leading questions or express my own opinions that may affect the direction that interviews took. I made written notes at the end of each interview about my reflections on how my position, values and previous experience may have influenced the data generated and used these notes to guide future interviews.

I was able to build rapport with participants during interviews and create a safe environment where all beliefs and opinions were valued. This approach proved valuable when interviewing public health stakeholders who felt confident in expressing beliefs that diverged from established public positions, for example the comparison in treatment of the alcohol and tobacco industries. The diversity of beliefs within the public health community which were shared during interviews is a strength of this study which provides a much deeper understanding of an issue than is present in published literature. Similarly, I was pleased that my interview technique facilitated two interviews with alcohol industry participants that were conducted in a measured and respectful tone and generated useful data and insights. I enjoyed the opportunity to understand and explore different perspectives about the policy context within which I work.

By stating explicitly at the start of each interview that there were no 'right or wrong answers' to questions I was able to reassure participants who were supportive of alcohol industry involvement in certain policy contexts that I wanted to learn more about their beliefs and my role was not to agree or disagree with them. My personal views on this subject also evolved during the course of the study and I became more sympathetic to positions of policy brokers (civil servants and parliamentarians) who are faced with multiple pressures from 'hurtful stalemates' due to stakeholder conflict. I have also reflected on the value of democratic

norms and principles of good governance which require that stakeholders are actively involved in making decisions which affect them. Establishing terms of engagement for the alcohol industry's role in public health policy will mark an important step forward towards policy progress.

### 2.1.3. Theoretical frameworks

This study is informed by and uses two theories of the policy process (the Advocacy Coalition Framework and Policy Stages Model),[19, 71] a taxonomy relating to corporate political power (Hillman and Hitt)[20] and an alcohol policy framework (WHO Global Alcohol Strategy)[4] to structure and make sense of the data generated. See Table 2 for an overview of all frameworks and analytical devices that informed the approach to data analysis. The use of multiple theoretical approaches to inform a study design can be both beneficial and challenging. An evident benefit is that applying perspectives and learnings from different sources can serve to enhance and enrich our view of the world. However, on a practical level, the use of more than one theory can lead to tensions between ontological and epistemological approaches (if theories are grounded in contrary positions) and can be highly resource intensive if they require different methodological approaches.[72] The aim of this study is not theory generation through the combination of multiple theoretical perspectives into a new single approach. Rather, the aim is to pragmatically use different approaches to study the same phenomena through multiple theoretical lenses. An overview of the chosen frameworks, including their relevance for this study, alongside their strengths and limitations, is given below. This is followed by a critical reflection on the utility of the chosen frameworks and how they relate to my research design.

### *2.1.3a Policy stages model*

The policy stages model was developed in the 1950s by Harold Lasswell, considered by many to be the founder of policy sciences, as an attempt to amalgamate a diverse range of theories and multidisciplinary approaches to policy analysis.[61] This framework described the policy process as evolving through a set of discreet stages.[19] Several iterations of the framework have refined the identify of each of the policy stages, which are today commonly referred to as 1) agenda setting, 2) policy formulation, 3) legitimation, 4) implementation and 5) evaluation.[61] See Figure 4 for a diagrammatical representation of the policy stages model.
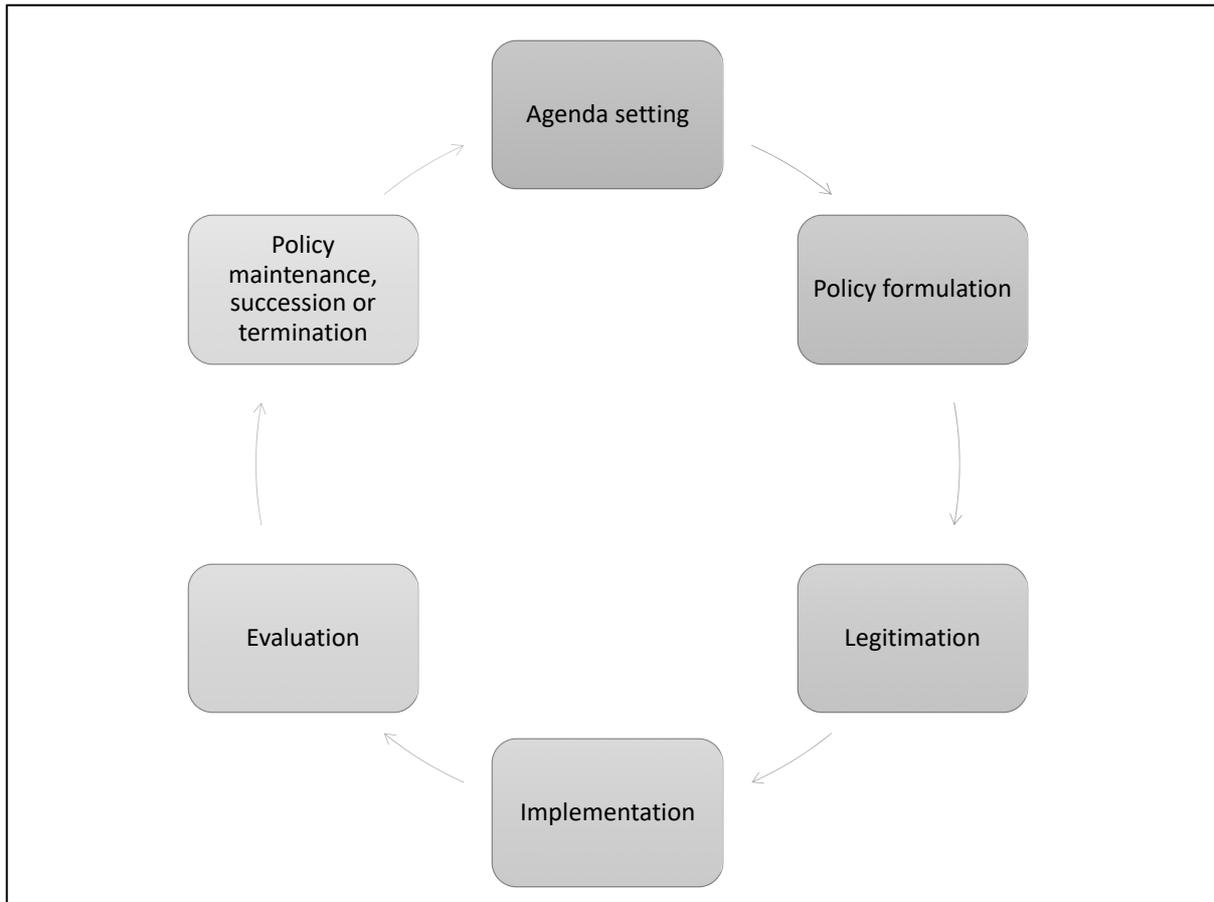
*Figure 4: Policy Stages Model*

The 'agenda setting' stage refers to problem recognition and issue selection within a crowded policy subsystem full of competing priorities. This stage is highly politicised and results in certain issues, defined as 'problems', receiving priority over other issues for government attention.[19] Agenda setting activities include the production of research reports, media relations, lobbying, and public opinion polling.

The policy formulation stage comprises activities which review policy solutions and compare alternative options in order to develop government proposals for action. This stage has been identified as a means of basing policy decisions on evidence and rational planning that aspires towards specific measurable goals.[19] However, numerous scholars have highlighted the tension between evidence-based policy and competing influences on the policy process, including competing political priorities and the availability of resources which affect policy decisions.[73-75] During this stage, the competing interests of different policy actors continue to shape policy outcomes. Public consultations, evidence reviews, and impact assessments would constitute activities conducted within this stage as decision makers develop policy programmes. The legitimation stage includes activities related to the legitimation of proposals. Drafting policy guidance, drafting and passing legislation, including through parliamentary processes, would take place during this stage.

The implementation stage refers to activities which take place after a policy has been adopted. This stage was introduced to the policy stages model as a new concept in the 1970s as scholars became increasingly interested in analysis of the post-adoption phases of the policy process.[61] It was observed that the success of any policy will depend on how it is implemented and this in turn will depend on how well designed, resourced and, if appropriate, effectively enforced it is.

The evaluation stage was originally conceived as a stage in which evidence was reviewed on the outcomes of any policy and whether pre-agreed objectives had been met, as demonstrated by measurable indicators. This stage described how policy decision makers could determine whether or not a policy had been 'successful' at achieving the desired effect and would inform whether to continue, amend or terminate a programme.[19] Evaluation studies have evolved over time and evaluation is widely regarded as an important aspect to incorporate into all stages of the policy process, with resources for effective monitoring and evaluation of policies included in initial policy design.[76]

The policy stages model can be seen as an example of an 'ideal-type' model, quasi-rational, linear, uni-directional decision-making process involving a circumscribed range of policy actors, whereby elected politicians take decisions on the advice of civil service who then implement political decisions.[61] However, there have been many criticisms of this framework as an unrealistic representation of how 'real world' policy decisions are taken.[73, 75] The main criticisms include the fact that policy making does not take place in distinct stages, with many activities identified within these stages overlapping or being inseparable in the often chaotic and messy policy process. Furthermore, the sequential order of the cycle stages does not reflect real-world policy timescales, with decisions often taken in response external events. Related to this concept is the criticism that the government is often not in control of its policy agenda and is required to respond to events and shifts in public opinion. It has been argued that this model may assume an overly technocratic and rationalist conception of the policy process which under-emphasises the fundamentally political nature of policy actors and policy-making processes.[77]

Despite these criticisms, the policy stages mode can be seen as a useful heuristic device to analyse policy processes and the actions of different policy actors. In the UK alcohol policy context, the concept of discreet stages within the policy cycle will be familiar to most policy actors. The Institute for Government describes the 'policy cycle' model as dominant within the UK civil service, which can be found in current policy guidance for HM Treasury, Department of Environment, Food and Rural Affairs, Department for Education and the Home Office.[75] Whilst scholars have expressed criticisms of the cycle for neglecting 'real world policymaking',[78] many government recommendations for good practice in policy development continue to address actions for discreet stages. For example, the use of impact assessments and scrutiny of evidence before taking decisions about policy design.[76]

Furthermore, the concept of policy processes being broken down into discreet stages is present in the literature relating to alcohol industry engagement in policy processes: The WHO Global Alcohol Strategy referred to engagement of economic operators in implementing policy,[4] which has been interpreted by researchers as an indicator that industry involvement in policy formulation is not appropriate; that their activities must be focussed on implementing policies once key decisions have been taken.[41]

The stages framework can be seen as a simplified 'ideal-type' representation of the policy process. While it underplays the complexity and nuance of actual policy-making practices, it can be seen as a useful heuristic device to facilitate analysis of the policy process.[79] While acknowledging the limitations of this framework as a means of describing how 'real world' policy change occurs, the policy cycle offers an important analytical lens for the present study, which seeks to explore how different policy actors view alcohol industry engagement at different stages of the policy process. For the purposes of this study it is used as a functional requirement to guide discussion as opposed to a framework for describing how policy is made.

### 2.1.3b Advocacy Coalition Framework

The Advocacy Coalition Framework (ACF) conceptualises the policy process as a complex system involving a broad range of actors and influencers.[71] The first iterations of the ACF were identified as a synthesis of top-down and bottom-up approaches to policy implementation, and as an approach to better understand regulatory decision-making.[71] The ACF has evolved over time, with new theoretical insights added and concepts clarified by scholars who have applied the framework to policy studies.

The ACF is based on a set of key assumptions, principal to which is that the primary unit of analysis is a policy subsystem. According to Jenkins-Smith et al, policy subsystems are defined by a policy topic, territorial scope, and the actors directly or indirectly influencing policy subsystem affairs.[71] ACF, therefore, lends itself to analysis of the UK alcohol policy subsystem, which for the purposes of this study is defined as public policy relating to reducing harm from alcohol in the UK, which incorporates a variety of actors. The ACF defines relevant subsystem actors as any person regularly attempting to influence subsystem affairs, which can include a range of governmental, non-profit, academic and commercial actors. This definition aligns with key UK alcohol policy stakeholders identified for this study, that span multiple sectors across varying levels of governance. Major alcohol policy advisory groups consist of parliamentarians, civil servants, non-governmental organisations (NGOs), alcohol industry representatives, academics and medical professionals.[28]

At the heart of the ACF is the concept that policy actors are boundedly rational with limited ability to process stimuli, largely because they are motivated by belief systems. Three levels

of beliefs are described: 'Deep core beliefs', which are based on fundamentally normative values (such as religious beliefs or views on human nature); 'policy core beliefs', which are broad beliefs which relate to the policy subsystem (such as the correct balance between state intervention and individual responsibility); and 'secondary beliefs' related to policy implementation and preferences for specific policy solutions[80]. Deep core beliefs and policy core beliefs are described as relatively fixed, however secondary beliefs may be subject to change as a result of policy learning. The description that all policy actors are boundedly rational and motivated by beliefs makes the ACF an appropriate framework for this IPA, which acknowledges that all individuals are influenced by core values, past experiences and both personal and professional lenses. Policy actors which may be (traditionally) perceived as impartial or independent such as civil servants and academic researchers, are included in the ACF as belonging to coalitions based on their beliefs. This is an important approach to assessing the role such actors play in alcohol policy processes as these two groups have been identified as key stakeholders to participate in this study.

Sabatier and Jenkins-Smith describe how policy actors form coalitions based on shared beliefs and coordinate their actions in a 'non trivial manner'.[78] By grouping actors together into coalitions, the ACF can be used to analyse and make sense of policy subsystem affairs, identifying areas of conflict, competition and contestation, but also assessing opportunities for policy learning amongst actors which may influence beliefs and instigate change and/or progress. The acknowledgement within the ACF that policy subsystems are often subject to conflict and contestation between actors who share competing beliefs makes this framework particularly relevant to the UK alcohol policy subsystem. The ACF describes how conflicting beliefs between coalitions can lead to a 'hurting stalemate' whereby policy processes are paralysed. It also describes how competing coalitions may be vulnerable to the 'devil shift', whereby they overstate the power and success of 'demonised' opponents due to a propensity to remember losses more than gains.[80] A number of key UK alcohol policy events have been subject to paralysis during the period under investigation, most notably the delayed introduction of minimum unit pricing in Scotland and the collapsed Public Health Responsibility Deal for Alcohol Network (as described above). Media reports and commentaries have laid responsibility for these failings on both the alcohol industry and public health groups' unwillingness to cooperate.[10, 24, 29] Using the ACF to explore policy actors' perceptions of these events will provide a useful tool for analysis of the role and influence of different policy coalitions.

Using the ACF as an analytical tool can also help to ensure the findings of this research study have relevance to future alcohol policy debates. The ACF describes how secondary beliefs held by advocacy coalitions can shift over time (normally over long periods of around ten years or more that encompasses a full policy cycle) as a result of policy learning[81]. Such learning occurs as coalition members monitor and evaluate policy positions and respond to emerging evidence. Policy learning can also be facilitated by policy brokers, who are often

government officials with decision making responsibilities, that can identify weak links in belief systems and work to influence secondary beliefs to mediate conflicts and address 'hurtful stalemates' to achieve policy progress[82]. By identifying and developing a better understanding of alcohol policy coalitions and their associated beliefs, including how beliefs converge and diverge between advocacy coalitions, this study may help inform alcohol policy actors and facilitate policy learning that could address hurtful stalemates and lead to future policy progress.

The ACF has a number of limitations which were considered when choosing this framework for application to this study. Firstly, the three tiers of belief system can be difficult to assess or analyse. Fundamental core beliefs may be both conscious and unconscious and due to their very nature will be extremely difficult to identify and describe using interpretive research methods[82]. Information pertaining to the secondary beliefs is most likely to be elicited from interviews and documentary analysis. This study therefore focusses on identifying secondary policy beliefs relating to the topic under investigation.

Secondly, the ACF rejects the concept of cycles and stages within the policy process. Indeed, the first iteration of the ACF was described as providing an alternative causal theory to the policy stages model.[71] This rejection limits the ability of analysts to explore how different policy actors can interact and influence decisions before, during or after key policy events in the UK such as public consultations, passing of legislation through parliament, enforcement of legislation and evaluation of policy. However, this limitation was addressed through the use of the policy stages model to guide the data analysis, as outlined above.

### 2.1.3c Combining theoretical frameworks

The choice of frameworks to guide the data analysis for this study is somewhat unusual, in that they emerge from different ontological and epistemological starting points. The ACF is based on positivist approaches to research, whereas I have adopted an interpretivist perspective to generating and analysing the data from this study. As stated above, combining multiple perspectives and frameworks can prove challenging, especially if the theoretical grounding requires different methodological approaches. The methods commonly adopted by scholars conducting ACF studies include surveys of policy actors, seeking to identify generalisable results relating to competing coalitions within policy sub-systems[83]. This approach advises that the researcher remains objective and distanced from the research. However, the field of IPA assumes that researchers are active participants in studies, generating explanatory narratives and interpretive accounts of the specific processes and phenomena they examine, which necessarily draw on their own values, judgements and experiences.

Given my position as an insider in the UK alcohol policy subsystem under investigation and the unique access this affords me to rich data, in applying the principles of IPA I am situated myself within the research to generate data and interpret beliefs and meanings in relation to one specific policy context. My chosen research design therefore employs the conceptual architecture of the ACF but does not share the traditional methodological approach. The ACF framework was an accessible, useful and appropriate framework to apply to this research. Its insights relating to competing advocacy coalitions and associated foci, such as the contribution that divergent beliefs can make to hurting stalemates, are relevant to current issues evident in the literature on UK alcohol policy. However, I have chosen to employ methods more closely associated with IPA, analysis of data generated through interviews and policy relevant documents, to gain insights and interpret how policy actors make sense of the issue of COI and alcohol industry involvement in public policy.

I could have chosen to conduct an interpretive discourse coalition analysis to explore how different groups of actors coalesce around ideas, an approach which interpretive scholars argue is more valuable in explaining policy change than the positivist ACF.[84, 85] However, whilst my analysis focussed on how participants make sense of key issues – in accordance with a discourse coalition approach – the conceptual vocabulary provided the ACF, with an emphasis on ideas, beliefs and values was identified as more relevant to this study than an analysis of shared language and narratives. An overview of the methods adopted, and their strengths and limitations, is provided below.

# 3. Methods

As outlined previously in section 2, this study is informed by IPA and its underlying ontological and epistemological presuppositions,[58] and rejects positivist attempts to discover universally generalizable causal laws of the social world.[59] This study acknowledges that each policy setting is unique and must be understood in its own historical context. Policy processes are complex and subject to influence by a range of actors of varying levels of power. Alcohol policy in the UK is a highly-contested area and the involvement of alcohol industry groups has been the subject of much criticism from public health actors.[11]

A qualitative approach, informed by IPA, is appropriate for this study, which seeks to understand participants' views and perspectives within the social, cultural and professional contexts of their lives at the time of interview. Typical methods employed in IPA research are (participatory) observation, interviews and document analysis.[58] Participant observation was not feasible given the time constraints however, my position as an active policy actor in the alcohol field meant that I had several years' experience of observing and participating in key policy networks. Given my prior knowledge and tacit understanding of the alcohol policy subsystem, key informant interviews and document analysis were therefore considered the most beneficial methods of data generation.

The time-period chosen to inform this study is the years 2000 to 2018. This period was identified because it incorporated a number of different UK Government administrations (Labour-led 1997-2010, Conservative-Liberal Democrat Coalition 2010-2015 and Conservative-led 2015- present) and saw the development of several UK alcohol policy milestones: Three UK government alcohol strategies were developed and published during this period (*Alcohol Harm Reduction Strategy for England*, 2004,[86] *Safe. Sensible. Social*. 2007,[87] *Government's Alcohol Strategy,* (2012)[88] and legislation was passed in devolved nations to introduce restrictions on the sale of alcohol including MUP in Scotland and Wales. This time period therefore is likely to offer the potential for rich accounts of policy actors' experiences engaging with highly contested policy issues in which a range of different actors were extensively involved.

## 3.1 Key informant interviews

Semi-structured interviews with policy actors was the principal form of data generation to inform this study. This method of data generation is appropriate because I was able to identify key topics for discussion during the interview, according to the chosen data analysis framework (see below), however the interview participants were able to determine the scope of the information produced in each interview, and the level of importance awarded to each chosen topic.[59] This allowed for exploration of themes and topics that had not emerged as part of the literature review or been considered by me beforehand. The data analysis

framework was able to evolve as a result of the style of interviews, which allowed for the emergence of additional themes based on lived experience and beliefs of key informants.

### 3.1.2 Sampling of interviewees

A total of twenty-six interviews were conducted for this study, which took place between January and September 2018. Participants were purposively sampled based on their current or past involvement in UK alcohol policy processes during the period under investigation (2000-2018). Purposive sampling is a method which allows for the recruitment of study participants based on their level of expertise and interest in the chosen subject area.[59] A stakeholder analysis was conducted, identifying key alcohol policy networks and fora that were active between the years 2000-2018 inclusive. Stakeholder analysis is a method of action research used to explore the various interests that different stakeholders may have on potential outcomes and their relative influence.[89] In this instance, an 'active' network or group was defined as a collection of individuals or organisations that held regular meetings with government policy officials to discuss alcohol harm during the period of study. Online searches of the main government web portal, www.gov.uk, identified such networks. A combination of expert and snowballing sampling was used to recruit participants: expert sampling allows for participants to be chosen in a non-random manner based on their expertise in the phenomenon being studied, and snowball sampling allows experts to identify individuals with relevant insights and knowledge who can help answer chosen research questions.[90] One of the benefits of snowball sampling includes the identification of hard-to-reach individuals, which proved valuable in this study when recruiting alcohol industry representatives. This is discussed in more detail below.

The categories of respondents that were invited to participate were derived from the actor groups identified within the ACF who participate in and influence policy subsystems.[71] Six stakeholder groups were identified as fulfilling the role of policy actor within the UK alcohol policy subsystem: health campaigning groups, researchers, medical professionals, civil servants, Westminster politicians and alcohol industry representatives. The sampling 'target' for this study was to recruit five participants from each of the six stakeholder categories (n=30), to give a broad range of views and perspectives from across the alcohol policy subsystem. The purposive sampling technique was not employed with the aim of achieving 'representativeness' amongst alcohol policy stakeholders, as this would not have been an appropriate aim for this inductive, interpretive study. Rather, numerical guides were used with the ambition of achieving balance in reporting of experiences by different policy actors. A maximum of thirty interviews was considered a manageable number for the sole researcher to transcribe and analyse. However, if data saturation was achieved before the interview 'target' had been met, further interviews with a particular stakeholder group were not conducted.

Membership of the Public Health England (PHE) Alcohol Leadership Board was the primary sample used to invite participants from civil service, health campaigning groups, medical and research backgrounds to interview.[28] This Board was established in 2014 and, during the period of data generation, was co-chaired by PHE and the Chair of the Alcohol Health Alliance UK[1]. Its membership includes civil servants from all government departments with an alcohol policy remit (Department of Health, Home Office, Defra, Department for Transport, HM Treasury), academic researchers, medical professionals and health campaigning groups (including non-governmental organisations, regional NHS partnerships and professional membership bodies).

The All-Party Parliamentary Group (APPG) on Alcohol Harm provided a sample of relevant Westminster parliamentarians to approach for interview. This cross-party parliamentary group exists to promote the discussion of alcohol-related issues, raise matters of concern and to make recommendations to UK Government and other policy makers.[91] Whilst other alcohol related APPGs exist, such as the All-Party Parliamentary Beer Group[92] and the All-Party Parliamentary Wine and Spirit Group,[93] the Alcohol Harm APPG was considered the most appropriate group to recruit parliamentarians to participate in this study because of its focus on government policies to reduce harm (as opposed to the commercial focus of the alternative groups). MPs and Peers from the three main UK political parties (Conservative, Labour and Liberal Democrat) who are members of the APPG on Alcohol Harm were invited to interview, with the aim of investigating cross-party understanding and opinion on alcohol policy issues.

Alcohol industry representatives who are members of the Portman Group Local Alcohol Partnership Network were invited to interview. This is a network of industry bodies that facilitate and lead local partnerships to tackle alcohol related crime, anti-social behaviour and underage drinking. Members of this network include the British Beer and Pub Association, British Institute of Innkeepers, Association of Licensed Multiple Retailers, Drinkaware, Wine and Spirits Trade Association and the Scotch Whisky Association.[94] The Portman Group convene this network.

### 3.1.3. Recruitment of interviewees

Several of the key informants were known to me prior to interview and can be considered as colleagues and peers. Interviewing colleagues and peers presents methodological implications in qualitative research, when the researcher and informant occupy a similar role or status, possess a similar body of knowledge and share an ongoing professional relationship.[95] Shared knowledge of a subject and common language increases the

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[1]The Co-Chair on the PHE ALB resigned in September 2018 after PHE entered into a partnership arrangement with Drinkaware. See above.

likelihood that the interviewer can elicit rich data and achieve in-depth discussion without the need to pause for explanations on terminology and basic concepts.[95] Furthermore, the researcher being viewed by the informant as an 'insider' can result in increased levels of trust and subsequent openness to discuss sensitive or delicate issues.[66] However, the complexities of generating data through interviews with people who have pre-existing relationships require specific consideration for the 'who', 'where' and 'how' of any interview[96] and such consideration was taken when recruiting and arranging key informant interviews for this study.

Steps taken to identify the 'who' to invite to interview are described above. More details on my reflexivity as the researcher when approaching and interviewing the various key informants is given in chapter 5, discussion and conclusions. Consideration was given to 'how' I would approach and interview informants, to increase the likelihood of successful recruitment. All participants were formally invited to interview by email, although many participants were approached informally at face-to-face meetings before being formally invited. The informal approaches allowed me to take advantage of my existing relationships with peers and colleagues, adopting the method of communication they were accustomed to, whereas the formal written invitation allowed me to explain my position as a researcher for the purposes of the interview, along with the study aims which were separate from my day job. A copy of the template email and information sheet sent to participants can be found at Appendix A and Appendix B.

Recruitment of participants who were members of the PHE Alcohol Leadership Board and APPG on Alcohol Harm was notably more successful and straightforward than recruiting alcohol industry representatives. A total of twenty-four participants were successfully recruited to represent civil servants, medical professionals, health campaigners, academic researchers and parliamentarians, out of twenty-nine who were invited. Conversely, just two alcohol industry representatives agreed to conduct an interview, out of a total of thirteen individuals invited to participate. One civil servant declined to participate, and seven alcohol industry representatives declined the invitation to interview. The remaining individuals who were approached either accepted the offer but couldn't find the time to interview or accepted the offer but did not respond to further correspondence regarding logistical arrangements. An overview of the recruitment of participants is provided in Table 1.

| Policy actor category | No. invited to interview | Accepted | No response/unable to arrange interview | Declined | Interview conducted |
|---|---|---|---|---|---|
| **Civil servants** | 7 | 6 | 1 | 1 | 5 |
| **Health Campaigners** | 6 | 5 | 1 | 0 | 5 |
| **Medical Professionals** | 5 | 5 | 0 | 0 | 5 |
| **Academic Researchers** | 5 | 5 | 0 | 0 | 5 |
| **Parliamentarians** | 6 | 6 | 2 | 0 | 4 |
| **Alcohol Industry** | 13 | 6 | 4 | 7 | 2 |
| **TOTAL** | 43 | 35 | | 8 | 26 |

*Table 1: Recruitment of Interview Participants*

Research design in the context of qualitative studies is an iterative process and requires the researcher to refine methods and approaches in light of emerging data and other developments within the research process. This may mean adapting and expanding methods in response to the availability and the access to proposed interviewees.[59] The paucity of alcohol industry representatives who were willing to participate in this study by conducting an interview led to a development in the study design: To ensure alcohol industry positions were represented when assessing the existence of advocacy coalitions, a document analysis of alcohol industry submissions to a government consultation was performed. More details on how this was performed are provided below.

As outlined above, the location of an interview (the 'where') plays an important role in determining the richness of data generated, especially when interviewing peers and colleagues.[96] Interviews were largely conducted face-to-face and, where possible, in participants' place of work, both for convenience for participants but also to ensure they were situated in a familiar environment where they held power and status. The exception for this approach was interviews with two medical professionals, which took place at my place of work, at the participants' requests. This environment may have helped informants to reflect on the policy aspects of their roles, as opposed to their medical duties which may have appeared more prominent in a hospital setting.[95] Three interviews were conducted remotely by video conference using Skype, also at the participants' requests. Interviews lasted approximately between half an hour (30 minutes) to one hour and a half (90 minutes). All participants were presented with the study information sheet (Appendix B) and study consent form (Appendix C) directly before the interview began. All participants provided consent for the interview to be recorded. Participants were given four options for providing consent to the use of their interview data and level of anonymity. Nearly all participants provided consent for interview quotations to be used in the final research report, with the exception of one civil servant who wished to inform the study by conducting an interview but did not wish for any of the transcript to be quoted. Three participants were happy to be

named as individuals however the majority chose to remain anonymous and therefore when presenting quotes from interviews in results sections, participants are categorised by their stakeholder group and not identifiable as individuals.

Participants were presented with the list of six policy actor categories devised for this study and invited to self-identify with one of the groups for the purposes of reporting any material from their interview. Only once an agreed category definition had been established between each interview participant and me, and all consent forms had been signed, did interviews commence.

### 3.1.4.  Data Generation and Analysis

All interviews were recorded on a digital recording device (subject to consent from participants, as detailed above) and transcribed by me. Transcriptions were word processed using Microsoft Word for Mac 2016. I chose to transcribe all interviews myself as opposed to outsource this task to an agency, to ensure the process of familiarisation with the data began at the earliest possible stage of the analysis. A combination of verbatim and intelligent verbatim transcription was adopted as the method of creating a text record of each interview. Intelligent verbatim transcription is used to capture the essence of recorded speech whilst omitting repetition, pauses and 'fillers' (such as coughs, "ums" and "ahs") used in verbal communication.[97] It is designed as a time-saving method to produce "clean transcripts" that have been lightly edited to remove text that could act as a distraction to the reader.[98] Verbatim transcription on the other hand records all verbal communication, including throat clearing, coughs, stutters and stammers etc and is therefore more time-consuming. A combination of these two techniques was adopted for the following reasons: Firstly, I chose to transcribe all interviews myself to enhance familiarity with the data. Time constraints meant that intelligent verbatim was the preferred style of transcription. Secondly, the interpretive nature of this study required an understanding of *how* participants responded to interview questions, not just *what* their responses were. This meant that pauses, laughter and stutters could provide valuable context to verbal responses when written down. I therefore adopted an approach which would capture what I perceived as significant verbal cues within written transcription, whilst recording interview text in an intelligent verbatim manner which was easy to read and interpret. This approach proved valuable when analysing interview data, for example responses to questions on personal definitions of COI: illustrating how participants struggled to articulate COI as a concept proved to be an interesting finding of the study, as outlined in the results section below.

A data analysis framework was developed and refined over four stages during the study: Prior to the interviews, a data analysis framework was developed based on the findings from the narrative review used to inform the study's scope and design. This framework included several theoretical frameworks and alcohol policy taxonomies as heuristic devices to organise

and provide structure to the data generated during interviews.  An overview of the framework used to guide interview questions is presented in table 2 below.

| Main Code | Sub-category |
| --- | --- |
| Interview participant characteristic | 1. NGO<br>2. Academic researcher<br>3. Civil servant<br>4. Parliamentarian<br>5. Industry representative |
| Understanding and perceptions of COI | 1. Financial<br>2. Non-financial<br>3. Perceived<br>4. Actual |
| Perceptions of AI involvement in health policymaking | 1. Type of AI actor<br>2. Stage of policy process<br>3. Type of industry engagement<br>4. Type of alcohol policy |
| Position on/support for WHO Global Strategy policy recommendations | 1. Pricing<br>2. Availability<br>3. Marketing<br>4. Health service response<br>5. Drink driving<br>6. Education<br>7. Industry partnerships |

*Table 2: Stage 1 Data Analysis Framework (draft)*

The second stage of developing the data analysis framework took place both during and after interviews. Handwritten notes were made during interviews to record emerging themes from data generated. Similarly, during the transcription process handwritten notes were made to inform the initial data analysis and record additional themes. Transcription was usually completed within one month of each interview to ensure data was fresh in my mind.

Upon completion of transcription, all interview transcripts were read collectively for familiarity and to identify any additional emerging themes. This stage was conducted manually, using printed hard copies of transcripts. Identified themes to be considered for adding to the framework were highlighted in allocated colours and reviewed in total at the end of this stage. Themes that appeared frequently or were considered to add significant value were subsequently added to the framework. See Table 3 for the final framework which was used to analyse interview data.

| Main Code | Sub-category | Theoretical framework/analytical device |
|-----------|--------------|------------------------------------------|
| **Participant characteristic** | Health campaigner<br>Medical professional<br>Academic researcher<br>Civil Servant<br>Parliamentarian<br>Alcohol industry representative | Advocacy Coalition Framework |
| **Understanding of alcohol harm** | Harm increasing<br>Harm decreasing<br>Harm stabilising<br>Drivers of harm | Advocacy Coalition Framework |
| **Alcohol Policy support** | Pricing<br>Availability<br>Marketing<br>Health service response<br>Drink driving<br>Education<br>Industry partnerships | WHO Global Alcohol Strategy |
| **Understanding of COI** | Financial<br>Non-financial<br>Actual<br>Perceived | OECD/WHO guidelines |
| **COI in alcohol policy settings** | Existence of COI<br>Evidence as a source of conflict<br>Examples of industry obstructing policy | |
| **Alcohol Industry COI in policy settings** | Type of actor<br>Type of policy<br>Stage of policy process<br>Type of engagement | WHO Global Alcohol Strategy<br>Policy stages model<br>Hillman and Hitt corporate political activity |
| **Suggestions for managing COI** | Government motivations for working with industry<br>Comparison to tobacco and food policy<br>Experience of managing COI in professional setting | |

*Table 3: Final Data Analysis Framework*

The fourth stage of developing the data analysis framework involved uploading all transcripts to specialist software. NVivo for Mac version 11.4.3 was used as a tool to analyse the interview data according to the chosen data analysis framework. Codes (termed 'nodes' in NVivo) were set up corresponding with the 'main code' and 'subcategory' headings identified. All transcripts were then read again in NVivo, with relevant text labelled under each code. Once all transcripts had been labelled, queries could be run in the software, extracting all text from interviews identified as relevant to each code. Key arguments and emerging themes within each code were then identified and described by me.

Interpretive methodologies pay particular attention to language used by research participants,[58] and policy studies lend themselves to certain types of analysis such as frame- or value-critical analysis based on their (general) degree of contention.[62] The thematic

analysis of data generated in this study aimed to identify common and competing frames used by policy actors, and understand the underlying meanings, beliefs and values that such frames are based on. These arguments are outlined in section 4, 'results'

## 3.2. Documentary analysis

Due to the limited number of alcohol industry representatives that agreed to participate in this study, an analysis of public documents was performed to explore key findings from the interview data relating to beliefs about alcohol harm and policy support. This analysis was performed after all interviews had been transcribed and coded. Triangulation between data generated during interviews and the document review helped to either corroborate findings or identify cleavages between what interview participants said and what is stated in organisational policy documents.[59]

Industry responses to the UK Health Select Committee inquiry into the UK Government's 2012 Alcohol Strategy were analysed according to the framework emerging from the secondary policy beliefs described by participants. This policy event was chosen to assess industry positions because it was the most recent opportunity for industry stakeholders to publicly express positions relating to the broad range of policy options to reduce harm.

Three alcohol industry organisations were identified from the list of participants who declined the invitation to conduct an interview. This number was chosen to ensure that five industry positions were assessed to inform the study, the same 'target' number as other actor groups. The organisations were prioritised based on the frequency of referrals made to them by interview participants throughout the data generation. The chosen organisations were the industry-funded charity Drinkaware,[99] the industry self-regulatory body the Portman Group[100] and multinational alcohol producer Diageo.[101]

A number of indicators were identified to inform the analysis of these industry organisations' policy positions and perceived secondary policy beliefs about alcohol harm in the UK. Each document was coded using the data analysis framework outlined in Table 3. Information was available in each document for the codes 'participant characteristic', 'understanding of alcohol harm' and 'alcohol policy support'. Little information was found in document text relating to COI, as this was not a focus of the chosen public consultation. The analysis therefore did not seek to code information pertaining to COI.

As with interview transcripts, statements that described alcohol harm were analysed to identify secondary policy beliefs, with statements about increasing, stabilising or decreasing rates of harm recorded. Likewise, descriptions in the document text that related to patterns of alcohol consumption were coded, including statements about harmful drinking patterns and 'responsible' consumption, and/or consumption linked to healthy lifestyle. Statements

that described support for and opposition to policy interventions were coded according to the sub-categories in the data analysis framework. Any reference to additional policy interventions, not listed in the data analysis framework, was also recorded. These data from industry documents were used to triangulate interview data to identify alcohol industry secondary policy beliefs and to assess how beliefs converged and diverged between stakeholders.

## 3.3.  Data management

Interviews were recorded on a digital audio recording device and the audio files saved in a password protected file on my computer. Written transcripts were also stored in a password protected file. I kept a hand-written data record whilst conducting the interviews to record key points and emerging themes and this was kept in a locked drawer when I was absent.

All printed hard copies of transcripts were anonymised and stored in a locked desk drawer when unattended by me. After the second stage of the data analysis framework development was completed, and all transcripts had been uploaded into NVivo, printed copies were shredded. All documents obtained were publicly available. Collectively they were stored in the password protected file with interview transcripts.

## 3.4.  Presentation of data

Presenting the depth and richness of qualitative data is a challenge as they cannot be set-out in a neat series of graphs as would be typically found within quantitative research reports. Nevertheless, the imaginative use of diagrams and other schematics to illustrate the analytical process and findings can be a very useful way of simplifying the complexity of the iterative process of the gradual refinement of analytical categories.[102] The iterative process of analysing the data from interviews and documents led to the identification of a number of themes relating to consensus and opposition of beliefs from members of competing advocacy coalitions. No analytical distinction was made between data generated from interviews and document analysis, both of which are presented together. In order to present these beliefs, I chose to include quotations from interview transcripts and documents to demonstrate the richness of data. The steps I took to identify themes within interview transcripts (as outlined in 3.1.4) ensured that multiple quotes were grouped together for analysis. By coding text according to sub-headings using NVivo software, I was able to assess common views held by multiple members of each coalition and the quotations I chose to present are intended to help illustrate these views. The quotations chosen to include in the text are not intended to be 'representative' of the views of *all* members of the coalition and/or stakeholder group they belong to. Rather, quotations were selected on the basis they illustrated beliefs that were expressed by multiple participants within a coalition.

Recognising the challenge of presenting such rich and extensive data in summary form via text only, I developed tables to be used as an illustrative guide that outlined key arguments and beliefs. For presentational purposes only, beliefs relating to risk posed by COI are categorised in these tables as 'low', 'medium' and 'high'. These descriptors are not intended to be quantifiable, rather, they are used to illustrate similarities and differences between the beliefs identified amongst the two competing coalitions. A 'low risk' of COI is used to describe beliefs which did not reference any negative associations with industry engagement. A 'medium risk' describes beliefs whereby risks associated with industry engagement were identified by participants, however they were described as either manageable under certain conditions or acceptable when balanced against potential benefits associated with industry engagement. A 'high risk' of COI was used to describe scenarios whereby participants stated that industry engagement would present a strong threat to public policy goals and therefore where engagement should be avoided.

# 4. Results

## 4.1. Identifying advocacy coalitions

### 4.1.1. Overview

The data generated through interviews and triangulated by document analysis provides evidence of advocacy coalitions within the alcohol policy subsystem. By identifying subsystem members' secondary policy beliefs, this study was able to explore the existence of advocacy coalitions. Jenkins-Smith et al describe how empirically, policy core and secondary beliefs include overall assessments of the seriousness of the problem, its basic causes, and preferred solutions for addressing it.[71] Interview participants were therefore invited to share their views on alcohol harm levels in the UK and to suggest appropriate policy responses to any harms or problems identified. These positions were also assessed by the document analysis of alcohol industry responses to a public consultation.

Two competing coalitions were identified; the "public health coalition" and the "industry partnership coalition". The secondary policy beliefs of members belonging to each coalition diverged in relation to the description of alcohol harm as a problem and the appropriate policy responses. Divisions between the coalitions were clear and there was coherence and consistency of shared beliefs. Two stakeholder groups, parliamentarians and civil servants, were split across the two coalitions. This chapter describes how membership of each coalition was assessed and how policy actors were categorised on the basis of their beliefs.

Each participant was confident in describing the key issues related to alcohol policy in the UK, and worldwide in some cases, often drawing on data sets to support their position. This indicates that their participation in this study was relevant to their own knowledge and experience. A summary of the competing beliefs and membership of these two advocacy coalitions, as identified by the data generated, is presented in Table 4.

| Advocacy Coalition: | Public Health | Industry Partnership |
|---|---|---|
| **Membership** | Health Campaigners<br>Academic Researchers<br>Medical Professionals<br>Parliamentarians<br>Civil Servants | Alcohol Industry<br>Civil Servants<br>Parliamentarians |
| **Secondary Policy Beliefs** | Alcohol harm trends worsening<br>Alcohol causes population-wide harms, beyond individual drinkers<br>Evidence-based policies required to tackle harm at population level<br>Restrictions on price, availability and marketing most effective policy solutions | Alcohol harm trends stabilising/improving<br>Alcohol harms concentrated in small minority of irresponsible drinkers<br>Targeted measures required that don't affect majority of responsible drinkers<br>Industry voluntary partnerships and self-regulatory measures are the most appropriate policy response |

*Table 4: Advocacy Coalition Membership among Interview Participants*

## 4.1.2. "Public health coalition" beliefs

### 4.1.2a Understanding the nature of alcohol harm

There was a general understanding from interview participants that alcohol is linked to health and social harms. The variation in the description of these harms related to their estimated scale and impact, and also the balance between described health impacts of individual drinkers versus harm to people beyond drinkers (such as crime and social disorder problems). Health campaigners, researchers and medical professionals frequently described alcohol harms as relatively broad, with (largely health) impacts seen at the population level:

> So the alcohol harms fall into a number of categories, so the first is obviously the health harms, and so my main area of interest there is the link between alcohol and cancer […] And then alcohol has an impact on a whole range of other conditions from mental health issues to liver disease, etc. then there's another category which is directly attributable accidents, that's happened to people that harms health, and thirdly there's the significant harm to others. So, the social harms of alcohol – crime, domestic violence, violence full stop, and also issues around parenting and family issues that are affected by alcohol. So I guess those are the three categories of harms.
>
> Academic researcher

The relationship between alcohol consumption and health harm was cited by health campaigners, researchers and medical professionals. Population consumption rates were described as both a cause and indicator of levels of harm, with participants citing that the UK

is experiencing increasing rates of harm, especially related to chronic disease, most notably cancer.

Tensions in the portrayal of alcohol harm were identified and described by several participants. Different types of alcohol harm were described as drawing different levels of attention from policymakers. More 'visible' harms, such as crime, violence and anti-social behaviour were identified as receiving greater attention than chronic harms. However, civil servants and parliamentarians did report that alcohol harm was rising in the UK and these harms extended beyond individual drinkers. It was evident that these participants shared many policy beliefs with those that self-identified as belonging to a 'public health' coalition, mainly health campaigners, academic researchers and medical professionals: They cited broader concerns about health and social inequalities linked to alcohol and harms to people other than the drinker, as demonstrated by one civil servant's response:

> I think a key component in that is the fact that the lower socioeconomic communities are bearing the brunt, so take hospital admissions, nearly half of them are occurring in the three lowest deciles, so I think there's a real issue in this country in terms of harm. I think the knock-on effect though, that's in terms of the individual, to families, to wider society and the cost to society, that is often under-recognised.
>
> Civil servant

Participants that identified themselves as belonging to the 'public health' community described tensions between the way alcohol industry and public health representatives communicated key issues relating to alcohol harm. This indicated that participants recognised the concept of competing agendas between the two stakeholder groups. The alcohol industry was described as 'disputing the evidence' linking alcohol to chronic disease, especially cancer:

> So alcohol harms are legion, it's often stated that there are 200 health conditions that are affected by alcohol. The evidence is fairly clear, although it is disputed by industry, the evidence is clear, particularly in terms of the impact on cardiovascular disease, cancers and mental health.
>
> Academic researcher

Health campaigners and some parliamentarians described the rates of alcohol harm as a result of increasing consumption driven by what was viewed as a flawed marketplace whereby alcohol as a product was too easy to access. Particular policy issues were also seen as contributing to increased rates of harm. The introduction of 24-hour licensing in England and Wales was cited as increasing access to cheap alcohol, particularly in the off-license trade (shops and supermarkets) and thus driving harm. Similarly, the delay to the introduction of MUP in Scotland was described as a driver of continued harmful trends which could have been reversed or abated. It was also argued that the legal challenge to MUP may threaten

future policy progress in Scotland, with the Scottish Government reluctant to proceed with future measures which may open them up to risk of litigation:

> I think the biggest problem that we've had in Scotland is that we haven't had minimum unit pricing implemented, when it should have been implemented in 2012 and it hasn't been. And that's going to be a key driver in reducing consumption amongst the people who are disproportionately harmed by alcohol but also in reducing overall population consumption […] The current biggest issue at the moment is because there's been this court case for so long there's this regulatory chill effect is setting in. I think that it's possible that the Scottish Government may not want to take forward anything else that will get them stuck in court.
>
> <div align="right">Health campaigner</div>

Whilst health campaigners and medical professionals described a range of negative impacts related to alcohol, researchers, parliamentarians and civil servants described the existence of a balance between the positive and negative impacts. However, it was recognised by these participants that a public health consensus had arisen that the harms outweighed the benefits and therefore any benefits demanded less attention in public debate, as demonstrated by this response from an academic researcher:

> I'm not sure that all public health discussions of the harms take account of the benefits – there will be benefits, you know there are potentially social benefits, but I guess within a wider public health framework one should consider those benefits, but I think both the expert consensus and more importantly, the evidence would seem to be fairly clear and consistent, and has been for a long time, that the harms are significant and that the benefits there, if you look at particular conditions such as cancer and cardiovascular disease, the harms outweigh the benefits.
>
> <div align="right">Academic researcher</div>

### 4.1.2b Support for policies to reduce harm

A number of participants explicitly self-identified with what they viewed as a 'public health approach' to alcohol policy, and subsequently reported support for population-level interventions which restricted the availability and promotion of alcohol. Several participants aligned their views with international evidence and guidelines on alcohol policy, most notably the WHO 'best buy' policies (that support regulation on price, availability and marketing of alcohol). The uniformity of responses from participants identifying with a public health approach to reducing alcohol harm was remarkable. The perceived consensus on the evidence to support a policy framework to reduce alcohol harm was noted by participants, who described alcohol policy as an unusual field of research where contestation was uncommon:

So I think the evidence there is particularly clear about what works and what doesn't work [...] it's not one of these issues where there's much debate or controversy. We know that restrictions on availability are effective and cost effective, restrictions on advertising and marketing, which the industry disputes, you know the balance of evidence suggests that it is likely to be effective. So I think, what I think is really interesting is that it's not an area where the evidence pulls in different directions, particularly in relation to availability and pricing."

<div align="right"><em>Academic researcher</em></div>

Researchers, health campaigners and medical professionals more frequently identified with the public health approach, led by evidence to indicate population-level policies were the most effective interventions to reduce rates of alcohol harm. Several participants explained the rationale for their views on the basis of a hierarchy of evidence. A number of policies were cited as lacking evidence of effectiveness, such as education and information campaigns. However, some participants articulated they did not necessarily disregard these measures; rather, they were seen to be ineffective in the absence of population-based controls that tackled the supply of alcohol:

OK, so I would kind of take the main public health line that the effective ones tend to be increasing alcohol prices, reducing alcohol's availability and restricting marketing practices. But part of the reason they are highlighted as effective is because they are needed to create an environment which makes other policies effective, so it's not that I would think that information and education campaigns are ineffective per se, it's that they are ineffective in an environment where you have a regulatory system that doesn't allow them to be effective.

<div align="right"><em>Academic researcher</em></div>

The relatively limited number of policy priorities was identified by one participant as being a result of limited resources and scope to influence government decisions. The view that policy support must be ordered and prioritised reflects the advocacy and campaigning approach many participants identified with, in particular non-governmental and medical professional participants from the "public health coalition":

In terms of policy levers, as you know we have looked very carefully at that and everyone who has looked at it has come out with some variation of manipulation of price, marketing and access as being the key drivers… I don't think that means we should disregard other areas like education and looking at behaviour change from other areas… But we still, given that resources are finite and our asks to government are likely to be limited, I think we should stick to the ones where the evidence is strongest of the biggest impact.

<div align="right"><em>Medical professional</em></div>

This shows an awareness amongst participants of the political nature of the use of evidence to inform decisions on policy and practice, which are not only based on scientific data but also on values, judgement and opportunities to influence.

### 4.1.3. "Industry partnership coalition" beliefs

#### 4.1.3a Understanding the nature of alcohol harm

Industry representatives described adverse impacts from alcohol as experienced by a small minority as opposed to a large proportion of the population. When describing trends in alcohol harm, industry representatives and some civil servants described problems as improving in the UK, quoting population-level data from industry and government sources about the overall reduction in consumption and/or rates of crime. One industry representative described the decline in underage drinking as evidence that alcohol harm was falling:

> In terms of our relationship with alcohol in the UK, I think the amount people drink is without doubt decreasing, and if you look at all the statistics, and I would only quote from what the Portman Group statistics would be in terms of the amount of alcohol we're drinking has fallen, I think by 20% or whatever it is, since 2004. If you look up my children – I have three grown up children – their generation, they drink far, far less, even from a university perspective than they did, and they are much more health conscious in that sort of sense. And if you looked at all the indices that we get from ONS, they are decreasing.

> Alcohol Industry representative

Industry responses to the Health Select Committee Inquiry of the Government's Alcohol Strategy presented data to indicate the majority of UK public enjoyed alcohol without adverse consequence and that rates of alcohol harm were in decline. For example, the Portman Group's submission included the following statements to describe 'alcohol trends in context':

- *Alcohol is commonplace in society*—in 2010, 84% of the working-age population in England drank alcohol.
- *UK per capita consumption has fallen* from 9.5 to 8.3 litres per head between 2004 and 2011. Consumption in the UK is equal to the European average and lower than many of our European neighbours, including Spain, Ireland and France.
- *Majority drink within weekly guidelines*—in 2010, 74% of men drank less than 21 units p/w (2005: 69%) and 83% of women drank less than 14 units p/w (2005: 79%).

- *Drinking at harmful levels falling*—in 2010, 6% of men drank more than 50 units p/w (2005: 9%) with the equivalent for women down to 3% from 5%).
- *Binge drinking down*—in 2010, 19% of men drank more than 8 units on their heaviest drinking day (2005: 23%) and 13% of women drank over 6 units (down from 15% in 2005).
- *Young people binge-drinking at lowest recorded levels*—in 2010, only 17% of 16–24-year-old women drank more than 6 units on their highest drinking day (2005: 27%) and 24% of young men drank more than 8 units (2005: 32%).
- *Fewer 11–15-year olds trying alcohol*—in 2010, 55% had never had an alcoholic drink (2001: 39%) with the percentage reporting past week drinking falling by over half from 26% to 13%.

Portman Group, 2012[100]

Contrary to "public health coalition" members, alcohol industry representatives described more clearly the benefits linked to alcohol consumption. Such benefits included the description that alcohol acted as a social lubricant, aiding mental wellbeing. Some parliamentarians and civil servants also described positive aspects linked to alcohol consumption, however balanced their arguments with a reference to harmful effects. However, unlike parliamentarians and civil servants belonging to the "public health coalition", "industry partnership coalition" members did not acknowledge that the harms outweighed the benefits:

> So clearly there are health difficulties created by, potentially by any level of alcohol consumption, but multiplied and magnified if there's considerable levels of consumption but also in terms of its impact on behaviour, because it's a loosener, and where sometimes its positive things that get loosened, like humour and garrulousness, you enjoy a party if you've had a drink more than if you were sober. But it's also that sometimes you hit your partner, you're more likely to take part in risky behaviours if you've lost that sense of judgement.
>
> Civil servant

### 4.1.3b Support for policies to reduce harm

Alcohol industry representatives, civil servants and parliamentarians that reported stagnating levels of alcohol harm or gave greater focus on positive trends (such as declines in population consumption in the UK) reported favouring policies that included voluntary partnerships with alcohol industry groups. A representative from the alcohol industry was explicit in their opposition to all government-led policy interventions:

I wouldn't support policy interventions, I'm really nervous about blanket bans, blanket interventions […] So minimum pricing is probably the best example of a policy intervention. The beer duty escalator was a policy intervention […] I'm on the whole against anything that is legislative intervention actually, I think that there's much more that you can do through behavioural change than I think you can do through policy interventions at the legislative level.

<div align="right">Alcohol industry representative</div>

All participants made reference to pricing policies, specifically MUP, indicating the salience of this policy issue at the time of study. Whilst participants from the "public health coalition" spoke favourably about pricing measures as an effective means to reduce harm, "industry partnership coalition" members either described opposition to MUP or were ambivalent about the policy. Civil servants in this coalition were keen to point out that the empirical evidence to indicate MUP is an effective measure was yet to be collected, and the policy remained 'under review' by the Westminster government. Similarly, parliamentarians identified as belonging to the "industry partnership coalition" articulated a reluctance to see pricing mechanisms prioritised over and above other interventions, for example education:

So I think as a society we don't take alcohol seriously, so education – and we have to be educated in a very clever way, not just told the facts, we have to understand. I do think there's a role for putting up barriers, particularly for younger people drinking, so I think the price, and I don't know whether that means selective price increases or more generally a minimum unit price. I'm actually open to how to use economics; I'm not closed to the idea that MUP is the only solution. And we need to enforce current laws as well.

<div align="right">Parliamentarian</div>

Of the three alcohol industry submissions which were coded according to whether they reported support or opposition to the WHO 'best buy' policies of regulating price, availability and marketing of alcohol, no support was identified for such controls. Both Portman Group and Diageo reported explicit opposition to MUP in their submissions:

However, whilst we agree with the Government that a rebalanced relationship with alcohol is needed for some groups and individuals in Great Britain, we do not agree that minimum unit pricing is the way to achieve this. Diageo believes such a policy would: disproportionately penalise the majority of the population who drink responsibly, particularly affecting those on modest incomes; be ineffective in tackling alcohol misuse among the minority; jeopardise the competitiveness of the alcohol industry based in Great Britain; have the unintended consequence of increasing the prevalence of counterfeit, and potentially be in breach of UK and EU Competition Law.

<div align="right">Diageo, 2012[101]</div>

All three industry organisations did however express support for voluntary partnerships with government within their submissions to the Health Select Committee. The analysis of these documents supports the findings from interview data which indicated alcohol industry frame voluntary pledges and partnership approaches as policy substitutes to address alcohol problems. For example, the Portman Group's submission welcomes the Alcohol Strategy's recognition of "the need for effective self-regulation and the Portman Group's role in achieving this". It also praises RDAN:

> The Responsibility Deal is the right approach. It enables industry to deliver practical measures quickly to effect positive behaviour change. It encourages local partnerships to reduce anti-social activity and uses innovative consumer marketing and education programmes (e.g. the industry funded Drinkaware) to communicate the Government's sensible drinking guidelines and promote responsible behaviour.
>
> Portman Group, 2012[100]

Alcohol industry bodies cited education programmes as effective interventions to reduce alcohol harm, particularly amongst young people. Responding to the specific Health Committee Inquiry question about what evidence exists to support the most effective interventions, Drinkaware cited the merits of its own school-based alcohol education programme, 'In:tuition', which was described as "a life-skills resource aimed at providing teachers with the tools required to equip learners with the knowledge and skills to make lifelong healthy decisions, develop greater self-esteem and self- confidence and enhance cognitive and behavioural competency to reduce and prevent a variety of health risk behaviours".

### 4.1.4. Chapter summary

The data generated through interviews and triangulated by document analysis provides evidence of advocacy coalitions within the alcohol policy subsystem. Two competing coalitions were identified; the "public health coalition" and the "industry partnership coalition". The secondary policy beliefs of each group of actors diverged in relation to the description of alcohol harm as a problem and the appropriate policy response: "public health coalition" members share a belief that alcohol harm is at unacceptable levels in the UK, is a problem that is increasing and requires population-wide regulatory measures restricting the alcohol supply chain. Conversely, "industry partnership coalition" members believe that alcohol harm is a problem that has stabilised or declined in recent years, affects a minority of the population and should be addressed by industry partnership initiatives with government and NGO stakeholders and education programmes.

The divergence between beliefs of the two competing coalition members was very clear. It was relatively straightforward to code each participant as belonging to either the "public health" or "industry partnership" coalition. Shared language and framing of the problems linked to alcohol harm and appropriate policy solutions was apparent. The issue of how consensus may be used strategically to frame policy problems is explored in more detail in the discussion section 5.1. Participants from two stakeholder groups (parliamentarians and civil servants) had members who were identified as belonging to both competing coalitions. Two civil servants and two parliamentarians were identified as belonging to the "industry partnership coalition", whereas the remaining participants from these groups expressed beliefs that identified with "public health coalition" membership. This finding supported the use of the ACF as an analytical tool, as it identifies that policy actors who are traditionally viewed as 'neutral' or 'impartial' (such as civil servants) also hold shared values and beliefs that align themselves with advocacy coalitions.[18] The divergence of beliefs held by civil servants also indicates that these actors may be more likely to fulfil the role of "policy brokers" in mediating conflict and working towards consensus on policy issues where contestation is high.[103] This issue is discussed in more detail in the discussion section 5.4.

## 4.2. Participants' understanding of conflicts of interest

### 4.2.1. Overview

This chapter presents findings from the data on how different actors within the alcohol policy subsystem understand the concept of COI and their perceptions on how COI is manifest in alcohol policy settings. Particular attention was paid to COI presented by alcohol industry involvement in policy; however participants were also invited to share their beliefs and experience of how other actors seek to influence the policy process, which may constitute a manifestation of COI. Secondary beliefs about alcohol industry involvement in policy and COI were identified amongst members of the two advocacy coalitions; "public health" and "alcohol industry partnership" and analysed according to what extent they represented competing or shared beliefs.

Four main themes emerged from the data, which are outlined below: 1) how participants define COI as a concept, 2) participant views on the existence of COI in alcohol policy settings, 3) evidence as a key site of conflict and 4) participants' own experience on how alcohol industry COI has impacted on policy goals.

### 4.2.2. Definition of conflicts of interest

Study participants were invited to describe their own definition of what the term 'conflict of interest' means. Particular attention was awarded to how different types of COI were described and whether descriptions varied by type of policy actor. There were no notable trends or differences in description of COI as a concept between members of the two

identified advocacy coalitions, however medical professionals and academic researchers (members of the "public health coalition") reported being more confident in their professional knowledge of COI and its application in their working lives.

All participants were able to offer a definition of what their understanding of a conflict of interest was. However, a number of participants struggled to articulate a clear description. For example, one academic researcher was not able to provide a concise definition and had to repeatedly pause and reflect on his thoughts:

> So, I think it might be something where [pauses] the goals… I suppose I need to think of it in terms of a particular context, I suppose in relation to this issue, I suppose a meeting or a decision or participation in this process. So I guess it would be where the goals of that process, or the goals of what you are doing, or whatever it is, are not [pauses], I was going to say aligned but I suppose it's not about having an alignment but where you're goals or the influences on your goals are not in alignment with the goals of that process. So if we think about it as a public health policy process or a public health intervention or whatever; there are influences on your behaviour or there could be apparent influences to do with, they could be financial conflicts or personal conflicts through your own families or so on, but where there is a clear misalignment between those two sets of goals.
>
> Academic researcher

Several participants demonstrated both amusement and embarrassment at the fact they were unable to describe something about which they held such strong beliefs. Many participants described a lack of confidence in articulating a definition in the absence of an academic reference point:

> I couldn't give you an academic definition, but I think that at its very basic level, I would describe it as involvement in some kind of [pauses] Someone has a conflict of interest if they are involved in some kind of decision making process or regulatory process, when actually they have a financial or other benefit which might influence how they would view that policy and what advice they would give in terms of what direction that policy should be taking. So they have something to benefit from the outcome of this change, or this policy or this recommendation, or whatever it happens to be.
>
> Health campaigner

Participants that were more confident in offering a clear definition of COI often described how dealing with COI was part of their professional role. For example, academic researchers and medical professionals described how they have to declare COI in published journal articles:

> Conflicts of interest is something I deal with all the time as a researcher, so for example, the declarations now are almost draconian in terms of what we have to do even just to submit papers.
>
> Medical professional

The concept of COI was described in terms of forces, interests or goals that were often divergent and therefore in opposition. The definitions articulated by participants were frequently oriented around the concept of conflict which precluded collaboration as opposed to compromise or conciliation. This understanding was expressed by one alcohol industry representative:

> I guess its two people that have got an opposing view on something which will allow or force either of them to not meet whatever their objectives are, I'm sure there's a much better definition that I've no doubt you have studied endlessly, but for me it's you know, if somebody is forcing you to do something that is bad for your corporate or your personal objectives and therefore you can't find a middle ground.
>
> Alcohol industry representative

The language used to describe the concept of COI was often active and, in some cases, combative, presented as a threat to the public interest or public good. In some instances, COI was described in terms of negative or immoral behaviour such as deception and abuse of power:

> The most immediate and obvious conflict of interest is if someone is financially remunerated to argue a case in a hidden or non-transparent way and perhaps against their beliefs, certainly against public interest, and it itself that can be an abuse of the system if someone is in a... well, non-transparent is quite important in a – what's the phrase you began with? Conflict of interest. For it to be a conflict of interest, it's non-transparent.
>
> Parliamentarian

By far the clearest and most common form of COI described was financial. This was cited by all participants as a tangible example of where vested interests may conflict with a common goal:

> So there's financial conflicts of interest, which would be in relation to salaries, income or profits that agencies or actors benefit from, and so that would be alcohol producers, manufacturers, distributors and retailers. It also would be people who've taken money from funders or companies around research or alcohol full stop and had benefitted financially from that relationship.
>
> Academic researcher

However, several participants acknowledged that COI was not restricted to financial transactions. Non-financial COI described included relationships and networks, and unpaid affiliations with organisations such as membership of a Board. Personal relationships were also cited as a potential source of COI, for example having family members or friends employed by or affiliated with organisations or causes with goals that differ from an individual's professional objectives:

> There're also other categories of conflicts of interest – from an academic perspective they tend to fall into relationships or networks that people are engaged in. So they might be a trustee of a committee members or sat on a guidelines group that means they have a particular opinion or perspective towards alcohol related issues. And then there's relational conflicts of interest, which are going from family members through to people they have collaborated with that are either relevant to alcohol policy or the manufacture or distribution of alcohol.
>
> Academic researcher

"Public health coalition" members described COI in relation to both individuals and institutions. However, alcohol industry representatives described COI among individuals only. Indeed, one participant was explicit in their argument that COI can only be generated by individuals, because organisations do not hold values, judgements and beliefs:

> I think that in order for a conflict to exist, people need to have different points of view. But organisations don't have points of view, people in organisations do, and so it takes a… there's not a Diageo thought process, there is a chief executive of Diageo… So it comes down to those individuals, as to whether they want to have a conflict or whether they want to work together. And it becomes kind of psychological I suppose, but you know, policies in themselves, don't create conflicts, it's people's reaction to them. That's my view.
>
> Alcohol industry representative

In addition to material examples of COI presented by individuals, several participants described individual biases, values and judgements as potential sources of COI. In this guise, COI was seen as a concept inherent in all walks of life, that all decisions and processes could be influenced by individual bias, both conscious and unconscious. This was described by one medical professional:

> In a way your own professional background is a conflict of interest. I mean me being a medical doctor I tend to be much more interested in death than in anything else. I mean a sociologist would probably have a different perspective and a social scientist would probably have a different perspective […] The other conflict of interest is your cultural background and country of origin. I mean if you're an American you have a

different perspective on things than if you're a Spaniard, so I think that brings in conflicts of interests too because how you have come up in a cultural background influences the way you think about things.

<div align="right">Medical professional</div>

### 4.2.3. Conflicts of interest in alcohol policy settings

All study participants acknowledged that COI exists in alcohol policy settings, however beliefs relating to how COI manifests in alcohol policy were divergent between the two competing coalitions. "Public health coalition" members described alcohol industry economic goals as in direct conflict with public health policy objectives to reduce harm. Members of both coalitions described how other non-industry actors may present COI in alcohol policy settings, however the perceived risks associated with these actors varied between the two coalitions.

Participants belonging to the "public health coalition" referenced alcohol industry goals and public health objectives as being in direct conflict. This was often explained in terms of alcohol industry's legal obligation to maximise profit for shareholders and therefore a commitment to increase sales, conflicting with the reduction in alcohol consumption necessary to reduce rates of health and social problems:

> Yes, there's an inherent danger around conflict of interest, we have an alcohol industry who are very keen to be part of the policymaking process and yet they are in a position to directly benefit from any policy decisions which are taken [...]They have a legal duty to maximise return to their shareholders, which overrides, in my view, anything else [...] The problem with reducing alcohol harm is that you have to reduce how much we drink and that has the possibility, a strong possibility that is going to affect their profits and returns to shareholders so there's a direct conflict of interest there.

<div align="right">Health campaigner</div>

Participants that reported direct experience of working with alcohol industry representatives described confidently that public health and industry goals were irreconcilable. One civil servant who had worked on alcohol policy issues for more than a decade described how their experience of working with industry led to the conclusion that very little agreement could be reached:

> In the early days I might have been a bit naive and think maybe we should agree on some things with the alcohol industry, but it is really surprising over time, that there was extremely little that could be agreed between industry people in terms of measures that would improve public health.

<div align="right">Civil servant</div>

The most commonly cited example of COI in alcohol policy settings was the Public Health Responsibility Deal Alcohol Network (RDAN). Participants referred to this policy network as a specific case study whereby industry involvement undermined public health goals. One academic researcher described how the process of involving industry in developing the RDAN policy goals and its monitoring and evaluation threatened its credibility and potential success:

> The clearest conflict of interest was allowing alcohol industry representatives to be involved in developing a public health policy, in setting the goals of that policy and in assessing their own success in delivering that policy, which in effect is what happened. So they were not only marking their own homework, they were writing the exam paper […] It basically contravened any level of independence or any perception of independence.
>
> Academic researcher

The extensive financial resources at the disposal of alcohol industry bodies were cited as exacerbating the COI related to their involvement in alcohol policy settings. Participants referred to tensions between industry and public health actors as a 'David and Goliath' contest, whereby a more powerful industry was able to secure greater influence in pursuit of its economic goals. One parliamentarian belonging to the "public health coalition" described how they viewed the alcohol industry's involvement in public health policy with 'enormous scepticism' because of its motive to maximise profits and the high level of resources at its disposal:

> Oh it's massive, massive, massive conflict of interest. It's an overwhelming conflict of interest. And clearly it's an enormously well-resourced, loads of money and the alcohol industry wants to maximise its profits, and it hires very well-intentioned people often, with a lot of knowledge, but the primary objective of the industry is to get us to consume more alcohol or consume alcohol in a way that maximises profit. I'm extremely clear about that and I view any intervention by the alcohol industry with enormous scepticism.
>
> Parliamentarian

Participants' descriptions of COI in alcohol policy settings was not limited to alcohol industry involvement. The majority of participants acknowledged that other policy actors had interests in policy outcomes which could be described as COI. These included NGOs, researchers, medical professionals, police and public health institutes. One civil servant belonging to the "industry partnership coalition" described how they viewed all stakeholders as being conflicted in some way:

> Let me be frank with you – it's as true of all of the stakeholders we engage with as a policy official that they all have a conflict of interest so the alcohol industry is interested in seeing as few regulatory burdens placed on its business as possible, local government is keen on making sure that as much money flows into its coffers, as government is prepared to tolerate, the public health community is interested in seeing quite sharp restrictions on the ability for the alcohol industry to operate on the high street, and the police are interested in making sure that alcohol related violent crime causes them as little trouble as possible. So everybody has their own particular thing that they are interested in and, to an extent all of that can be badged as a vested interest. The challenge is about the extent to which that permeates the policy space and what officials and ministers then do about it.
>
> Civil servant

Academic researchers were described by several participants as open to bias due their vested interest in policy outcomes. One researcher belonging to the "public health coalition" described the obligations that researchers were under to produce 'high impact' policy relevant studies, which encouraged academics to engage in activities which generate impact for research and demonstrate how they have informed or influenced policy. Furthermore, the involvement of medical professionals and academics in advocacy activities was seen as increasing the risk of bias in research as they became committed to fixed positions:

> There are also, in alcohol policy a large number of academics who wear multiple hats, so there are academics who are also health professionals and therefore have a strong commitment towards improving the health of the public, in a professional sense rather than in the general academic sense of making a better society. There are also a number of academics who act as advocates, and thus in some sense commit themselves to a position, and as a result you could argue that position may influence the way they go about their research in a whole range of ways, from the questions they ask to what they promote from their findings.
>
> Academic researcher

Politicians were also described as committing to fixed positions that may not evolve if evidence changes. One participant described how it would be extremely challenging for a politician to admit that they had been wrong when taking a policy decision, if evaluation evidence proved that policy to be ineffective. Using the introduction of MUP in Scotland as an example, this civil servant described how the alcohol industry had a vested interest in the outcome of the MUP evaluation, but the politicians also had a vested interest in the results. They argued it was the job of civil servants to navigate these vested interests and remain objective:

First of all there's an industry group who generates product and profit, but also politicians who create vested interests for themselves by the nature of the political climate and culture that we have. So how easy would it be for a Scottish Government minister as part of an SNP administration to stand up in Parliament in 2024 and say we were wrong […] Not easy at all. So they have a vested interest, the industry has a vested interest, one of the things that I think the civil service should provide is that we do not.

<div align="right">Civil servant</div>

NGOs and advocacy groups were cited by participants as having vested interests in alcohol policy debates. Third sector organisations in receipt of government funding to provide treatment and support services to people adversely affected by alcohol were described as at risk of seeking policy outcomes favourable to their own financial status. In addition, some participants described how NGOs could be driven by ideological values, most notably temperance values, which could result in a COI between those organisations and alcohol policy outcomes. The Institute of Alcohol Studies was cited as an example NGO which could be perceived as conflicted due to its core funding from the Alliance House Foundation which promotes total abstinence:

There is a debate in the alcohol policy landscape about whether the Institute of Alcohol Studies have a conflict of interest because of its history with the Alliance House Foundation. My view on that has always been that if there is a conflict, it doesn't manifest itself, and it comes across very much like any other public health organisation – it argues from a public health perspective, but within the definition of the conflict of interest I gave[2], you could definitely say there is one.

<div align="right">Academic researcher</div>

Research funded by NGOs designed to inform policy debates was cited by participants as an example where fixed values and positions may permeate policy decisions. Participants described how findings of studies funded by public health organisations would be unlikely to draw conclusions which contradicted funders' objectives and public positions on policy. One alcohol industry representative acknowledged that research was used by both sides of the alcohol policy debate (commercial and public health) in order to further their respective aims and objectives:

I would have said they would have used their data and statistics in a different way than I would use their data and statistics and everyone in a sense would have a bit of a conflict of interest in what they put forward – you put forward your views because

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[2] Participant's definition of COI was "anything that essentially leaves people either consciously or to some degree, unconsciously beholden to someone else".

you firmly believe in those views and because they come from your professional experience. I don't think – and to be honest – the health lobby does exactly the same thing but from a different perspective, and, in some cases, they might be right in some of what they say and in other cases, we might be right in what we say.

<div align="right">Alcohol industry representative</div>

A number of participants referred to the ubiquity of COI across all walks of life, whereby complete objectivity was a false notion. Individuals were described as bringing their own values, judgements and experiences to their professional roles which could be considered as introducing unconscious bias or subjectivity into decision making. This was described as a necessary part of the policy process which should be acknowledged but did not necessarily represent a barrier to engagement. However, several participants were keen to differentiate between interests in policy outcomes, which could be arguably in the public interest, versus COI associated with industry financial goals. For example, medical professionals were identified as having an interest in improving health, which did not undermine public policy goals to reduce rates of alcohol related deaths and hospitalisations. In this line of argument, alcohol industry financial COI was identified as warranting 'special status':

> If you're an NHS doctor pushing for the expansion of your treatment field then yes you have your patients in mind but it's also pretty good for your career, you know, getting investment and getting a bigger clinical team, you get a bigger research unit and so on […] But my own view is that I think it's appropriate that the financial and corporate conflict of interest is seen as having a particular importance and a particular relevance here, so there are those conflicts right through advocacy work that there will be various bits of self-interest, but I think in the actual real world of alcohol policy and you look at the history of that, financial and corporate conflicts of interest I think have a particular status and a particular importance.

<div align="right">Medical professional</div>

Caution was expressed by participants with regards exploring how non-industry actors could introduce conflicts into the policy process. This was described as a risky exercise which might result in diminished attention awarded to commercial COI, which was described as qualitatively different to other values-based interests which could be interpreted as for the public benefit:

> There is a sort of overlap of problem there which perhaps isn't well enough explored in public health and its implications are well enough explored, but there is a risk in exploring it, that you kind of end up equating these really serious commercial conflicts of interest, with qualitatively different and often quantitatively different conflicts of interest among public health actors. And I guess that it the point, that while they are

both present, they are certainly not the same and they are certainly not the same seriousness.

<div align="right">Academic researcher</div>

### 4.2.4. Evidence as a key site of conflict

As discussed above, there was a strong consensus among "public health coalition" members about the evidence of effectiveness of alcohol policy interventions to reduce harm, which largely referred to population-level measures that restricted the affordability, availability and promotion of alcohol. However, alcohol industry opposition to the evidence which supports these policy measures was frequently cited by interviewees as a demonstration of industry COI with public health goals. Moreover, alcohol industry-funded public health research was cited as a clear example of COI in policy processes. Participants described examples of how the alcohol industry had funded academics or research groups specifically to undermine public health evidence to support policy interventions. It was also implied that industry funding of research undermined its legitimacy in alcohol policy debates:

> Someone like [XXX] who has taken money directly from the Scotch Whisky Association, to criticise in a very aggressive and unscientific way, a piece of policy research. Clearly that kind of thing should be seen as a conflict of interest and we should […] see that as beyond the pale, conflicts of interest, that's not how academics should behave in my view. Moving down the scale, someone who has taken funding from Diageo, perhaps for a piece of policy research which wasn't overtly hostile, again we should be very careful about that and I would be sceptical for instance about whether a leading scientific journal should publish it, and how it should be treated in the policy debate.

<div align="right">Academic researcher</div>

The described value of and risks associated with industry-funded research varied between policy actor. Parliamentarians from both coalitions reported being extremely sceptical of industry-funded reports, which were often dismissed altogether for lacking legitimacy. One parliamentarian stated industry-funding of research completely undermined the concept of evidence-based policy:

> The more time I've spent on alcohol issues […] the more I've discovered that we insist that public policy must be based on evidence, evidence based public policy. And then when I start delving into where the evidence emanates from […] I've then found that on occasions there has been a direct link into the drinks industry, and they have been funding the research. And this is a very clever way of influencing policy, it's a sophisticated way, particularly as everybody argues it must be evidence based, yet

very few people sit down and examine where the evidence comes from – the motivation and where the money in particular has been found.

<div align="right">Parliamentarian</div>

Health campaigners described how they placed value on independent, peer-reviewed academic research but discounted industry-funded reports or data published by organisations associated with industry. Civil servants from both coalitions also reported an awareness that industry-funded evidence was often subject to bias. Policy officials described taking industry arguments 'with a pinch of salt', demonstrating an awareness that the evidence presented to them lacked independence. One civil servant, categorised as belonging to the "industry partnership coalition", explained they would never advise a minister to make a statement based on alcohol industry unsubstantiated claims:

I'm more likely to take what the alcohol industry give me with a pinch of salt – and how big that pinch is depends on what it is […] We're quite happy to get involved in things like Best Bar None, and Pubwatch[3], because we think that it's a sensible thing for people to do […] But I'd never ever stand a minister up and say, as the alcohol industry might like me to say, that one of the reasons why violent crime has fallen is because of these schemes. I'd never say that because there's no evidence for it. And I know that they present evidence on that basis, but that's not something I'm going to get the minister to say.

<div align="right">Civil servant</div>

Civil servants acknowledged that alcohol industry representatives often challenged the evidence-base to support alcohol policy interventions. Several officials described their role as defending independent evidence, which was value- and judgement-free:

Engaging with the industry, I always will be concerned to bring things back to the evidence and that price, availability and marketing – it's not something we've just made up, there's a body of evidence around all these things. So that's important that you don't forget the interests of health as a health official.

<div align="right">Civil servant</div>

Similarly, parliamentarians described an aspiration to develop evidence-based policy, which was free from values, judgements or conflicts which may be detrimental to the public good. Defending policy positions based on their evidence of effectiveness was seen as an important anchor for decision makers:

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[3] Best Bar None and Pubwatch are industry voluntary schemes with the stated aim of improving safety and preventing alcohol related crime and disorder in the night-time economy. More information is available at https://bbnuk.com/ and https://www.nationalpubwatch.org.uk/

I think you need to start with the position that we're not just changing things for the sake of it […] The reason why you would be doing it is because there is evidence – and I think evidence-led policy is really important in all of this – that there is evidence that the easy access to alcohol is contributing to more people having alcohol problems and whatever form they may be taking. And I think you always have to come back to the evidence to answer these questions and I do think that's important because you've got to have something that anchors you in what you're trying to do.

<div align="right">Parliamentarian</div>

Concerns about bias in evidence production and representation were raised by alcohol industry representatives. One interviewee described how academic research was awarded a low value in industry circles, as it was seen to be driven by vested interests of public health professionals:

I think there's a suspicion in most parts of the alcohol industry that the kind of academics who write about alcohol misuse are out to get them and there are a few figureheads as you know that the alcohol industry generally have taken a dislike to and regard a lot of their work as biased and you know, fulfilling a different objective. And I think that unfortunately, that's becoming quite entrenched.

<div align="right">Alcohol industry representative</div>

### 4.2.5. COI and industry obstruction of policy

Participants that reported the existence of COI relating to alcohol industry involvement in public policy were asked to describe examples of how alcohol industry activity had impacted on policy outcomes. A range of examples were described, the most common of which was the legal challenge brought against the Scottish Government by the SWA objecting to the introduction of MUP for alcohol in Scotland. One participant described how this action by SWA represented a COI with the Association's corporate social responsibility activities designed to tackle alcohol harm:

Yes I think for me the clearest example was the Scottish Whisky Association's challenge to the implementation of minimum unit pricing in Scotland, where the policy was delayed for five years, by a series of legal challenges with I think were driven by the corporate interests of the alcohol producers who were leading that challenge […] But at the same time as doing that, various organisations, like the Scotch Whisky Association […] were setting up charitable funds publicly saying how concerned they are about alcohol misuse and how much they want to be part of the solutions. And so you can see a clear conflict between the left hand and the right hand of those organisations

<div align="right">Medical professional</div>

The SWA legal challenge was described by one civil servant, identified as belonging to the "industry partnership coalition", as unacceptable corporate behaviour. Denying governments' ability to act on a democratic mandate was cited as beyond the realms of legitimate policy influencing:

> Where I think there's a problem, is where people are actively preventing governments from taking decisions […] Ministers are perfectly entitled not to do minimum unit pricing if they don't want to, that's why they're paid as ministers, but I think taking away policy options from them, I think is a bit of another matter.
>
> Civil servant

The Scottish MUP legal challenge was described by one participant as detrimental to policy development beyond MUP. The threat of future legal action by alcohol industry groups was seen as introducing a regulatory chill effect in Scotland:

> MUP in Scotland is one of the most obvious things, where we've had the legislation in place for six years, but we don't have the policy in place yet. And I think what's now happening is that because they've obstructed it to that extent, I think that politicians are going cold on doing anything more that's going to tie them up in court for years.
>
> Health campaigner

The second most commonly cited example of industry activity obstructing public policy was the RDAN, which was criticised by participants for providing an inferior substitute to evidence-led alcohol policy interventions. Industry members of RDAN were described as delaying and obstructing the implementation of the UK Government's 2012 Alcohol Strategy, which included a commitment to MUP:

> The alcohol strategy of 2012 was excellent, and that was then side-lined as a direct result of industry pressure. So you've got industry sitting round the table on one hand, and then on the other hand, briefing ministers and effectively putting a stop to the alcohol strategy […] So the danger of these talking shops is when they delay effective policy, and that's what the purpose of them is as far as the drinks industry is concerned.
>
> Medical professional

RDAN was also cited as an example of venue shifting by industry groups. Industry lobbying activity which contravened health objectives at a local level was described by participants as conflicting with the stated industry aims of the national RDAN process. One health

campaigner described how legal challenges to local licensing initiatives in England were led by industry members of RDAN:

> The alcohol industry, at the time they were sat on the Responsibility Deal, were doing everything they could to undermine a couple of interventions the government had brought in, and they still do everything to undermine them, which was the Early Morning Restriction orders and the Late-Night Levy. And they were doing it quite brazenly, they were raising funds to challenge local authorities in the courts. So that might be of interest that on the one hand you've got very high profile work going on at the national level with the Responsibility Deal, with them working hand in glove with government supposedly to reduce alcohol harm, and then on the other at a local level, not as visible to national policy makers at all, they are undermining some of those national policies that government has introduced which gives localities tools to try to help them to do something to help their communities.
>
> Health campaigner

The Westminster-based RDAN was also described as delaying alcohol policy progress in devolved nations. One participant described how Scottish Ministers who had voiced intentions to introduce alcohol labelling regulation in Scotland paused plans as a result of RDAN voluntary commitments on labelling:

> I think the most obvious example in terms of the UK context is the responsibility deal and just seeking to try and avoid any regulatory interventions by offering a few crumbs of voluntary progress. And Scotland didn't get involved too much, but in terms of the labelling stuff we could have potentially done something separate for Scotland [...] But the minister took the decision to go along with the voluntary arrangement under the responsibility deal under a temporary basis and to keep it under review, but they never have reviewed it or taken the stance that actually this isn't working, even though the evidence is clear it isn't.
>
> Health Campaigner

Another example of industry activity obstructing policy progress with regards alcohol product labelling was cited by several participants. They described how the alcohol industry body the Portman Group had entered into a partnership with the Royal Society of Public Health (RSPH) to conduct a research report on consumer preferences for alcohol labels. It was reported that Portman Group were unwilling to present the findings of the research, which indicated high levels of consumer support for calorie, unit content and health information on alcohol labels. As a result of this conflict, the partnership ended and RSPH published a report independently. An international example of alcohol industry obstructing provision of health information on alcohol labels was cited by one participant. A pilot study in a Canadian city that was designed

to assess consumer response to cancer warning labels on alcohol products was reportedly halted due to industry opposition:

> To give you an international example of alcohol labelling we know that the pilot in the Yukon in Canada, where they introduced health warning labels in one Yukon city, Whitehorse I think it was, the alcohol industry managed to directly stop that pilot by requesting that those labels be removed because it was deterring purchases and undermining their sales.
>
> Academic researcher

Indirect action by the alcohol industry was also described by participants as influencing policy debates. Industry funding of NGOs was cited as creating fractions in the health campaigning community, preventing a united and coherent voice on health policy relating to alcohol. One health campaigner described how a representative from an NGO in receipt of alcohol industry funding had publicly disagreed with criticisms levelled at the SWA regarding the legal challenge to the Scottish Government on MUP:

> I think there are a whole load of problems with that both in terms of it's very easy to see why they would fund you to do this if you're going to be a mouthpiece for them against one of their main opponents in public, and I guess also I feel quite strongly in relation to the voluntary sector in that we are small and we are limited in some ways – not that we are amateurish but that we have far less resources than the private sector - so even if I disagree with my NGO colleagues but I can hardly imagine a situation where I would be calling them out publicly.
>
> Health campaigner

Industry influence on public debate about alcohol harm was cited by several participants. A COI was described in relation to alcohol industry-funded or produced health advice and information. Industry representatives were described as misrepresenting evidence on alcohol's impact on health and industry-funded information sources were described as untrustworthy by participants. In particular, the example of the industry funded Drinkaware charity was frequently referenced as providing inaccurate or misleading health advice to the public:

> Now one of the problems of an organisation that is pushed as an independent organisation but is actually funded by the alcohol industry, is that how can you trust what they say […] there's a level of trust that can never be there in my view if the money is coming from a source which has a vested interested in the decision falling on one side or the other.
>
> Health campaigner

Participants also described direct experience of how alcohol industry bodies have misrepresented evidence relating to policies to reduce harm. One parliamentarian spoke of how they had been invited to contribute to the production of a policy report which was funded and written by alcohol industry representatives and did not reflect the contributions from public health stakeholders:

> And of course then we discovered they were paying the person to write up the report, they were funding the report, and the report was drafted and came out and was quite unacceptable. It didn't reflect it accurately; it was weighted towards the drinks industry's view - It came out in opposition of MUP [laughs]. But it was run very cleverly because they had police, doctors, clinicians, a wide range and if one had looked at the report you would have thought it was a very well-balanced report from a well-balanced group, but the report was not well balanced. And that would have found its way into a minister's brief and into other places of influence afterwards.
>
> Parliamentarian

The final impact of alcohol industry actions to obstruct public health policy goals experienced by participants was a general delay to progress. Obfuscation was identified as a key strategy of the alcohol industry by one civil servant participant. Another participant, a former civil servant, described how alcohol industry representatives' disingenuous engagement worked to slow down even the smallest of activities:

> It felt like they were pouring sand into the machines, so it was all about slowing things down, creating objections, saying 'oh well why don't we have a look at this'. And everything from the high policy stuff to delivering an alcohol awareness week… dissecting every message and trying to change the language, was driving my team absolutely demented.
>
> Health campaigner

### 4.2.6. Chapter Summary

All participants, from both advocacy coalitions, expressed a belief that COI exists in alcohol policy settings. Members of the "public health coalition" described a strong belief that the alcohol industry presented a clear COI, largely because their economic goals conflicted with health objectives of reduced alcohol consumption and associated harms.

An interesting finding from the results is that, whilst all participants expressed confidence in their belief that COI exists in alcohol policy settings, many struggled to articulate a clear definition of COI. As a result, the descriptions of COI offered by participants were extremely varied and many respondents appeared to question their own understanding of the concept when attempting to articulate a definition.

The concept that most participants were comfortable in describing was financial COI: being in receipt of funds from organisations whose objectives were contrary to the goals of a particular programme or activity was described as representing a clear example of COI. The alcohol industry funding public health information campaigns or research into public health issues was cited as an example of financial COI and understood by participants from both the "public health coalition" and "industry partnership coalition".

Participants described a range of non-financial forms of COI, displaying an understanding that COI is not limited to financial transactions. Such examples tended to focus on individual as opposed to institutional level conflicts and included relationships, personal obligations, professional experience and membership of organisational boards or networks. When describing these non-financial, individual examples, participants expressed a belief that COI extends to other actors within the alcohol policy subsystem beyond the alcohol industry. The descriptions of alleged 'conflicts' of interest amongst non-industry actors included personal attributes beyond an individual's control; for example, unconscious bias, ethnic and cultural background, professional experience and education. Such attributes can be seen as aligning with the ACF definition of 'deep core' and 'policy core' beliefs. However, concerns were raised about equating alcohol industry financial objectives with the public-interest goals advanced by members of the "public health coalition". A number of participants described how commercial financial COI should be awarded 'special status' compared to other actors' interests in alcohol policy settings.

## 4.3. Conflicts of Interest and Alcohol Industry engagement in policy

### 4.3.1. Overview

This chapter presents findings on participants' views on alcohol industry engagement in public health policy processes. Specifically, it seeks to situate the contestation regarding COI in the context of broader debates about alcohol industry engagement in the public policy process. As outlined in the data analysis framework, four themes were explored relating to conflict of interest and 1) type of alcohol industry actor, 2) type of alcohol policy, 3) different stages of the policy process and 4) type of industry engagement activity. Members of the two competing coalitions ("public health" and "industry partnership") expressed varied beliefs relating to each of these themes. Whilst there were several examples of conflicting beliefs, some potential areas of consensus were identified. These are outlined in full below.

### 4.3.2. Type of industry actor

Participants were asked to comment on whether they believed the level of COI, or any associated risks to public health outcomes, varied according to the type of alcohol industry actor that was engaged in the policy process. Participants were encouraged to describe their

own definition of which actors they believed belonged to the alcohol industry. Several participants agreed that the risks of conflict did vary with different types of alcohol industry organisations, and a number of key cleavages were identified. A summary of the alcohol industry actors identified by participants and the level of COI associated with their engagement in public health policy processes is outlined in Table 5.

The most commonly cited difference was the conflict associated with on-trade versus off-trade retailers of alcohol. Pubs and bars were described as having a greater interest in the wellbeing and safety of their customers than shops and supermarkets, and so were more inclined to engage positively with policies designed to prevent violence and antisocial behaviour on premises. This difference was described by members of both advocacy coalitions. One alcohol industry representative spoke about the popularity of pubs with policymakers, and how they had worked hard to frame pubs as closer to the hospitality and tourism industry and more distant from the rest of the alcohol industry:

> I have spent a lot of time […] for pubs in particular to be seen as part of the hospitality and tourism industry, which I believe they are. And it's actually quite interesting because people care passionately about pubs, from politicians to local people, and to be quite honest, quite a lot in the medical profession.
>
> Alcohol industry representative

However, participants identified as belonging to the "public health coalition" did not perceive pubs as completely immune from the risks associated with alcohol industry COI. Participants accepted that pubs were viewed differently to the rest of the alcohol industry, however ultimately, they still shared the same economic goals which conflict with public health objectives. The proximal interests of on- and off-trade retailers of alcohol were cited as varying. One respondent explained that the difference between on- and off- trade retailers was less about risks associated with COI and more about different levels of responsibility:

> I mean, if you are a pub landlord, you are there to sell alcohol and that's your job, you are only going to be paid if you're successful. But you have a direct responsibility not to let anyone in your pub get to a level of intoxication where they are not safe, where they are not safe within or without of your premises. So, you have a responsibility at a level which is tangible.
>
> Medical professional

|  | Public health beliefs on risk of COI | | | Industry partnership beliefs on risk of COI | | |
|---|---|---|---|---|---|---|
| **Type of industry actor** | LOW | MED | HIGH | LOW | MED | HIGH |
| **On-trade retailer** |  | X |  | X |  |  |
| **Off-trade retailer** |  |  | X |  |  | X |
| **Beer producer** |  |  | X | X |  |  |
| **Spirits producer** |  |  | X |  |  | X |
| **Wine producer** |  |  | X |  |  | X |
| **Cider producer** |  |  | X |  |  | X |
| **Domestic/artisan producer** | X |  |  | X |  |  |
| **Multinational producer** |  |  | X |  |  | X |
| **Trade associations** |  |  | X |  |  | X |
| **SAPROs** |  |  | X |  | X |  |
| **NGOs funded by industry** | X |  |  | X |  |  |
| **Think tanks funded by industry** |  |  | X |  | X |  |
| **Individual experts funded by industry** | X |  |  | X |  |  |

*Table 5: Perceived Risk of COI by Type of Alcohol Industry Actor*

Industry actors associated with different alcohol product categories were cited as having varying levels of COI in alcohol policy by some members of the "industry partnership coalition". Beer was viewed as less harmful than spirits by one alcohol industry representative, who claimed the majority of other products such as wine and spirits were stronger in alcohol by volume (ABV) and therefore more likely to be associated with harm.

"Public health coalition" members reported an awareness that industry representatives associated with different beverage categories adopted different levels of cooperation with and support for public policy processes. However, this was not described as demonstrating varying levels of risk associated with COI for different types of beverage. Rather, this was viewed as a reflection of different levels of economic interest and with varying relevance across specific policy issues. For example, one health campaigner described how the beer and wine industry bodies responded differently to labelling policy proposals, driven by beliefs about how their consumers would respond:

> So, the beer people, it turns out, quite like calories, really like them because they can see that the wine drinkers didn't know how many calories were in wine because they assumed it was less than beer because beer has more volume […] Meanwhile the wine people were less happy because they thought that people didn't quite know how many calories were in their wine so they were quite anti it.
>
> Health campaigner

Members of both advocacy coalitions reported that alcohol producers presented varying risk of COI depending on their size, wealth and perceived power. Small, domestic and artisan producers were described as more socially responsible and connected with their consumers compared to large, multinational producers:

> There's been a lot of growth of small craft brewers. And those guys have got a very close relationship with their nearby consumer groups, they probably know by name their best customers and they are sourcing products from the farm next door and selling it down the road. So they've clearly got a very different perspective to the big multinational companies, the AB InBev, the Heinekens and Diageos and so on, who have board meetings in cities around the world, in fact on different continents, and will have a different perspective.
>
> Alcohol industry representative

The power and influence of multinational alcohol producers was cited by participants from both advocacy coalitions as presenting an escalated risk of COI obstructing health policy goals. The level of resource and influence available to global corporations was described as creating a large imbalance of power between both smaller domestic alcohol companies, but also public health representatives working to influence alcohol policy. In addition to having significant resource to lobby policy makers, participants cited the ability of large multinational producers to spend time deflecting policy discussions away from evidence-based public health measures and using the process of engagement to slow down policy progress:

> I think we need to be really mindful of where the power lies and where the level of sophistication and resource that these organisations have and how that dwarves what we have available, so anything that we do, any time spent engaging with them is an opportunity cost and any engagement with them has risk around it in terms of what are they getting out of it, not just in terms of the content of the conversations, but even the fact they've had a conversation.
>
> Health campaigner

Multinational alcohol producers were described by participants as dominating alcohol trade associations and therefore wielding greater influence over UK alcohol policy than smaller domestic producers and retailers. A lack of progress in promoting the UK Chief Medical Officers' low risk drinking guidelines was attributed to the influence of multinational producers within trade bodies who had rejected calls to place the updated guidelines on alcohol product labels. Similarly, participants described how support for MUP amongst on-trade retailers, who would be largely unaffected by the measure, was reportedly hampered by representations from multinational brewers within pub trade associations:

The pubs have a very good case for being given support, they are social hubs and community centres and I personally regret that they are disappearing at the pace that they are. The drinks they sell are all way above the minimum unit price and we seek to try and persuade their representatives that they have an interest in pushing for MUP but they then turn back to the BBPA, their trade association, which is strongly against MUP […] But the reality is, they also represent the brewers, who produce the beer that is then canned and sold in the supermarkets, so there is a conflict of interest within that organization.

Parliamentarian

Trade associations in general were cited by participants as presenting a greater risk associated with COI than other alcohol industry actors. They were described as being the most obstructive to alcohol policy change, acting as strong defenders of their members' economic interests and less useful to engage with as part of the policy process:

I do see that the trade associations as being more defensive of the industry interests than some of the individual companies have. And I suppose that's why people join trade associations, it's why individuals join trade unions because the union fights on your behalf and perhaps does things that you wouldn't be willing to do things yourself […] Trade associations are a bit of a buffer and not very useful to the policy process.

Medical professional

Whilst trade associations were described as presenting overt risk of COI, social aspect and public relations organisations (SAPROs), such as the Portman Group and Drinkaware Trust, were described as presenting covert COI. Participants described these groups as exhibiting COI due to their efforts to distance themselves from the economic goals of their funders or members, when they were firmly perceived by participants as representing the alcohol industry:

Whether they like it or not, they are part of the industry. They are not arm's length bodies. If there was any evidence that they had any transparency or any independence, that would be great, but they are all part of the industry. They use the same tactics, they use the same language, they use the same arguments and strategies time and again. So again, the level of risk I think is the same right across the board. They clearly understand what a conflict of interest is but in their daily practice it means nothing, these are industry bodies.

Academic researcher

Industry-funded SAPROs that claim to share goals linked to health promotion or education about alcohol harm were described by participants as presenting more insidious risk that

alcohol companies and/or trade associations. Their operations were described as covert and more deceptive because of their claims to legitimate engagement in public health policy development and implementation:

> I think the approach to something like Drinkaware is more insidious, it's in many ways more dangerous because actually its whole remit of operations, no matter how well you think it is organised in how it carries out that remit, is designed to focus on an area of activity in alcohol harm which is one of the least effective areas […] and I say insidious because it describes itself as an independent charity. Well to me it cannot possibly be independent if 90 per cent of its funding comes from the alcohol industry.
>
> Health campaigner

Conflicting beliefs between the two advocacy coalitions was identified in relation to alcohol industry involvement in the governance of SAPROs. Members of the "public health coalition" described this as presenting an inherent COI if the organisation's objectives were stated to be related to health improvement. Drinkaware was referenced by many participants as an example of an organisation which claimed to work independently of its alcohol industry funders, yet several members of its governing Board had formal links to alcohol companies. However, members of the alcohol "industry partnership coalition" described how industry involvement in the governance of SAPROs provided valuable expertise: one alcohol industry representative described how having industry expertise within organisations such as Drinkaware was beneficial to ensuring programmes were delivered effectively:

> Their trustees are appointed totally independently. That does not mean that I believe that you shouldn't have trustees who have knowledge. Because they need to work with industry at a local level and they need help with outlets […] So, you've got to have some knowledge of the industry, well you haven't got to have some knowledge, but having some knowledge of the industry should not de-bar you from being a trustee.
>
> Alcohol industry representative

NGOs such as charities and think tanks in receipt of funding from alcohol industry bodies were identified by "public health coalition" members as belonging to the wider network of the alcohol industry. Alcohol industry funding was described as a source of COI for these groups, however the level of COI was described as variable, depending on both the level of funding and the purpose of the organisation. Participants described charities that received small amounts of funding, and whose organisational objectives aligned with public health goals, as presenting less of a conflict than industry funded SAPROs. For example, one participant described the difference between Drinkaware, which is an organisation that receives more than 90% of its funding from alcohol companies, and the national alcohol treatment charity Addaction, who had reportedly received funding from a major brewer for projects which were regarded as relatively small in comparison to their overall operations:

> Clearly Drinkaware exist to act, to essentially ensure that the government is not leading the campaign against alcohol in terms of social marketing – it's there to provide a kind of shield for the industry. Addaction don't exist for that reason, they exist for their own reasons and they have their own motivations, and while they may have a conflict of interest because of their industry funding, that doesn't necessarily mean you should not touch them with a barge pole as a result.
>
> <div align="right">Academic researcher</div>

Whilst some participants from the "public health coalition" reported they would be happy to consider working with charities in receipt of small amounts of alcohol industry funding, there was a consensus that receipt of alcohol industry funds prohibited an organisation's involvement in public policymaking:

> I think it's legitimate for a voluntary organisation say that 'we will work with the alcohol industry and we will receive their funding because we believe that the benefits outweigh the problems with it.' But I think that by doing that you have to accept yourself that you won't have any policy influence. It still might be a reasonable decision, but you should have no role in the policy process after that, because you're conflicted.
>
> <div align="right">Health campaigner</div>

Transparency with regards alcohol industry funding was cited as crucial for NGOs to identify and mitigate risks associated with perceived COI. Participants stated that a lack of transparency about industry funding organisations such as think tanks created a high degree of perceived COI and undermined trust and credibility in such organisations' information and/or reports. The Institute for Economic Affairs (IEA) was cited by participants from both coalitions as an example of an organisation which was not transparent about its alcohol industry funding and therefore engagement with this organisation was viewed as hazardous.

Expert individuals funded by industry, such as medical professionals and researchers, were also perceived by "public health coalition" members as belonging to the wider alcohol industry network and were therefore seen as having a COI in health policy processes. Participants described how alcohol industry SAPROs often appoint medical experts to provide 'independent' advice and information about alcohol's health impacts. However, despite a claim to independence, participants stated that any financial payment or formal ties with alcohol industry bodies represented a COI for these individuals:

> You might think you're being independent, you might think you're keeping your independence even though you're being paid thirty thousand a year or whatever, that you've managed to squirrel that off and avoid any conflict of interest, but the fact is

you're part of a process in which the conflicts, no matter how you see yourself, the whole process is conflicted and not independent.

<div align="right">*Academic researcher*</div>

Academics and researchers in receipt of alcohol industry funding were described by "public health coalition" members as lacking credibility due to their COI. Participants argued that alcohol industry funding should preclude publication in peer reviewed journals and should not be awarded the same attention in policy debates as independently produced, peer reviewed research. Some participants spoke of how certain academics had been paid by the alcohol industry to criticise existing evidence or researchers that supported regulatory measures such as price, availability and marketing controls. This behaviour was likened to tobacco industry corruption of science:

> This is not just alcohol, the history of the tobacco industry is the same […] The history of tobacco industry corruption of science is such that they would draw people in and use them as a front, so you can keep your hands clean, and maybe you haven't taken any money, but the minute you have engaged in the process you are part of the process you are part of that conflict, because you have been used – you're name, your credibility, your clinical credibility, your medical credibility has been used as part of that process.

<div align="right">*Academic researcher*</div>

Whilst many participants described different alcohol industry actors as posing varying levels of risk associated with COI and public health policy, "public health coalition" members expressed caution regarding separating actors and awarding greater degrees of legitimacy to some than others. Several interviewees stressed that, despite some actors presenting greater conflicts than others, all alcohol industry actors were conflicted and should be treated with scepticism within policy processes. Creating different categories of actor, it was argued, may allow industry more favourable terms on which to engage and influence health policy according to their own (conflicted) interests:

> I think the risk of conflict of interest is just the manifestation of wider risk, but I think it does vary across producers and between retailers and so on. But I'm not sure that it's helpful to try and separate that too much because I think it lets them off the hook in a way. Basically, what industry does too often is try to separate things out, separate problems out and cut them into small slices and to talk about culture and context […] so in a way I'd be concerned that, if they are in that space, and you start to differentiate in terms of conflict of interest between different producers, I think the game's lost.

<div align="right">*Academic researcher*</div>

### 4.3.3. Type of alcohol policy

Interview participants referred to risks associated with alcohol industry engagement as varying according to the type of alcohol policy. The policy framework outlined in the WHO Global Alcohol Strategy was used as a prompt to guide participants in their descriptions, although interviewees were encouraged to describe their own interpretations of alcohol policy scenarios. An overview of the risks associated with COI and alcohol industry engagement in different types of alcohol policy described by participants is presented in table 6 below.

| Type of alcohol policy | Public health beliefs on risk of COI | | | Industry partnership beliefs on risk of COI | | |
|---|---|---|---|---|---|---|
| | LOW | MED | HIGH | LOW | MED | HIGH |
| Education & provision of health information | | | X | X | | |
| Server training programmes | X | | | X | | |
| Product reformulation | X | | | X | | |
| Voluntary partnerships to reduce crime & disorder in NTE | | | X | X | | |
| Pricing policies | | | X | | | X |
| Marketing regulation/monitoring | | | X | X | | |

*Table 6: Perceived Risk of COI by Type of Alcohol Policy*

It was largely accepted by members of both advocacy coalitions that different industry actors would have different levels of interest in policy areas most relevant to their economic success. One alcohol industry representative acknowledged that policies which had the largest impact on the bottom line of an industry sector would face the most opposition:

> I think there can be different types of conflict, let's take drink driving in Scotland, the lower drink driver limit probably hit golf clubs or bowling clubs in Scotland way more than its hit Heineken's global sales. So there's probably something there where, I don't know, golf club owners of Central Scotland are thinking 'that drink driving limit is a nightmare' but the people in Amsterdam probably couldn't care less about it.
>
> Alcohol industry representative

Overall, members of the "public health coalition" perceived industry to have some level of COI in all types of alcohol health policy. However, certain policy areas were awarded more attention, either because they were seen as opportunities to legitimately engage with

industry on some level, or because they were deemed far too divergent from industry economic goals to consider any engagement at all. Education and provision of health information was referenced by a number of participants as being outside the remit of the alcohol industry and with high levels of COI. Risks associated with school-based industry education schemes included brand promotion to children and young people. Providing education materials to health care professionals was also cited as posing a major COI by alcohol industry bodies. One example referenced by "public health coalition" members was a major alcohol producer funding midwifery training programmes linked to foetal alcohol spectrum disorder. This was perceived as not only beyond the remit of the alcohol producer, but a contradictory CSR initiative that sought to prevent a problem created by its own product sales:

> I do think there is a problem where there is a direct funding of activities, where the industry… for example funding midwife training around alcohol and teaching about FASD with funding of Diageo is really problematic. And I have spoken out against that many times.
>
> Health campaigner

Provision of accurate information about health risks associated with alcohol was also described by "public health coalition" participants as a policy area where industry actors are highly conflicted. It was stated that the alcohol industry could not be permitted to assist in the development of government communications campaigns designed to increase knowledge and awareness of alcohol and health harms:

> When it comes to public facing campaigns, given we know the industry is not keen on certain messages being promoted which are evidence based, such as alcohol causes cancer, even things like public facing campaigns which are more downstream, you couldn't involve the alcohol industry in the development of those messages, because there are certain messages, even though they are true, they wouldn't want to see.
>
> Health campaigner

However, there was a consensus amongst participants from both coalitions that alcohol industry bodies would be able to assist with policies that were directly relevant to their core business. It was acknowledged that in certain policy areas the alcohol industry had insight and expertise that meant they were ideally positioned to either inform or implement initiatives. Training for bar staff and servers of alcohol was one policy that several interviewees described as legitimately designed and implemented by on-trade industry representatives. Supporting policies relevant to alcohol industry core business areas was identified by participants as in line with WHO guidance on engaging economic operators. One "public health coalition" member described how industry held relevant and valuable information and expertise on

policy areas directly linked to their core roles as producer, distributers, marketers and retailers of alcohol:

> I like the paragraph in the WHO Global Strategy about the industry's role as producers, retailers and marketers. And I think there could be an enormous amount to be gained for the enormous amount of expertise they have in those roles being used for public health gains. To give an example, beer duty in the UK is lowered on beers under 2.8% in order to reduce the price of those products, increase the popularity and reduce the overall consumption of alcohol is the idea. We consistently hear from the trade organisations that that 2.8 level should be moved up to 3.5 because technically it's difficult to make desirable product under 3.5. Now that might be true that might not be true, and who would you go and ask, whether it's a lobbying position or whether it is actually true.
>
> <div align="right">Medical professional</div>

Product reformulation was cited as a policy area by participants from both coalitions where engagement with industry experts may prove beneficial. At the heart of this belief was a desire for industry to share their technical expertise and sales data to inform policy development and evaluation. One interviewee expressed frustration that alcohol industry bodies concealed many data sources as commercial in confidence, and called for greater transparency in data sharing across the sector to assist public policymakers:

> So I think we need to have a step change, in the same way that we expect an aircraft company to share the data after an accident, an air accident [...] So I think that should be the industry's involvement in evaluation, it should primarily be in their role as experts in the sale of alcohol and their knowledge of that.
>
> <div align="right">Medical professional</div>

Perhaps unsurprisingly, members of the "industry partnership coalition" were more likely to identify policy areas where positive engagement with industry was possible. One civil servant described how a wide range of industry voluntary initiatives relevant to their own policy portfolio offered opportunities to engage, whereas industry actors who did not operate in their policy space were less relevant:

> The reason why we speak to the five that we do is that they're all responsible for a variety of things that we have an interest in. So Wine and Spirits does CAP, Community Alcohol Partnerships, Beer and Pub – they're interested in Best Bar None and Pubwatch, as are the ALMR. The Portman Group has its Local Alcohol Partnerships, so kind of taxi marshals, street pastors, Purple Flag, all that sort of stuff [...] So the reason why we have engagement with them is that we know what they say, but they do things

that we're interested in. And so we're trying to try and influence them, and we try and have conversations about what we can do.

<div align="right">Civil servant</div>

The one policy area identified by participants from both coalitions where alcohol industry had too great a conflict of interest to be engaged was pricing. Setting the level for MUP and developing alcohol duty structures was referenced by the majority of interviewees as a 'red line' where industry must not be involved:

Where tax is involved, again, they can lobby but you've got to be careful about having anyone from the industry sat on any groups in the Treasury or elsewhere that has an undue influence on the setting of that tax or anything like that.

<div align="right">Parliamentarian</div>

Overall, participants reported that whilst the level of interest may vary for different policies by industry actors, it was challenging to assess COI by policy topic. It was acknowledged that context for each policy scenario was important, however greater value was placed by the majority of interviewees on risks linked to different stages of the policy process as opposed to policy topics:

For me it's more of a principal in that – instead of slicing it vertically by taking each policy one at a time, there is an element of actually when it comes to the top of each of those policies, shaping those policies, in the best interest of the public at large, they don't have a role to play. They may further down the line have a role to play in terms of the implementation of those policies'

<div align="right">Health campaigner</div>

The following section describes participant views on alcohol industry engagement at different stages of the policy process.

### 4.3.4. Stage of policy process

Participants were invited to reflect on whether or not alcohol industry COI varied between different stages of the public policy process. Interviewees were presented with an overview of the 'policy stages' model as a heuristic to outline in brief and simple terms how alcohol policy was developed, starting with the problem identification, policy development, legitimation, implementation and evaluation. Whilst the majority of participants agreed that risks associated with COI and alcohol industry engagement varied across different stages of the policy process, divisions in opinion were identified between members of the two coalitions. An overview of participants' beliefs about the risks associated with COI and alcohol industry engagement at different stages of the policy process is presented in table 7 below.

| | Public health beliefs on risk of COI | | | Industry partnership beliefs on risk of COI | | |
|---|---|---|---|---|---|---|
| Stage of policy process | LOW | MED | HIGH | LOW | MED | HIGH |
| Agenda setting/problem identification | | | X | X | | |
| Policy formulation | | | X | | | X |
| Legitimation/policy adoption | X | | | X | | |
| Implementation | X | | | X | | |
| Evaluation | | | X | | | X |

*Table 7: Perceived risk of COI Associated with Alcohol Industry Engagement at Different Stages of the Policy Process*

Members of the "public health coalition" reported that the risks associated with COI were greatest when the alcohol industry was involved at the earlier stages of the policy process. It was reported that industry influence during the problem identification stage could frame the policy debate in terms which would narrow the scope for evidence-based policy solutions to emerge and promote substitute policies such as voluntary partnerships which have limited impact on health outcomes:

> I think the risk is highest at the start because at the start you have industry framing the problem in particular ways that they can be quite effective at […] So if you frame a problem in terms of individual responsibility and you misrepresent the evidence, and that has been your job for 20 years, it's very difficult for someone outside of that process or someone who's very new to that process, or even for someone for whom it isn't their day to day work, to see that it is a problem that is being framed in a certain way.
>
> Academic researcher

Involving the alcohol industry in problem identification was described by "public health coalition" members as offering an opportunity to shift focus away from areas of need and towards topics that aligned with the industry's commercial agenda. The mere presence of alcohol industry representatives in meetings to discuss alcohol harms was described as a potential distraction from 'in-need populations' towards policy topics that were considered favourable by the industry. One medical professional described how industry representatives worked to focus discussions on territory they felt comfortable with, such as drink driving and underage drinking, as opposed to alcohol consumption amongst middle-aged groups, which posed a greater burden on the health service.

I've seen often enough, a fairly tight and predictable list of acceptable territory for the industry groups. So I think if you're at an early stage of policy development and the agenda is being set, and the easy thing is to go with consensus on the agenda and steer away from the more contentious stuff then that's much more problematic than engagement at a later stage when you have a national strategy with some agreed goals and agreed actions.

<div align="right">Medical professional</div>

Alcohol industry framing at the problem identification stage was also described as a threat to effective evaluation of policies. Participants described how, if a problem linked to alcohol was framed by specific, narrow terms, policy solutions to address such problems would be evaluated using narrow criteria. This was seen as divergent from a long-term, systems-based public health approach to reducing alcohol harm at the population level, purported by "public health coalition" members. One academic researcher described how the evaluation of MUP in Scotland had been impacted by industry framing, because success was going to be measured against a set of narrow clinical outcomes:

So industry has a way of framing, it knows that it can frame these problems in such a way that their success can only be measured in gains against quite narrow outcomes, but the purpose of any public health interventions is to shape environments, to shape social norms, to impact on a range of other health and social outcomes as part of a bigger system.

<div align="right">Academic researcher</div>

Members of the "industry partnership coalition" stressed the importance of engaging all stakeholders at the early stages of scoping out problems and policy solutions. Such participants argued that the alcohol industry is a legitimate stakeholder, linked to a legal business operation, and that a rights-based, whole of society approach to democratic governance must be adopted in the UK:

I think whenever there is any legislative change, whatever area it is, health, education whatever, I mean everybody's got a right to have their say. And I don't think we should be afraid of that quite frankly. And to therefore suggest that the alcohol industry shouldn't have their voices heard, I think is wrong. I mean, look, alcohol is not illegal, and to be fair, to say they can't have a voice […] it's somewhat different than some drug dealer selling heroine.

<div align="right">Parliamentarian</div>

"Industry partnership coalition" members acknowledged that involving the alcohol industry at the early stages of the policy process could limit policy selection. A civil servant described how, when presented with all stakeholder views on policy options, ministers might be less

inclined to pursue certain ideas if they were made aware of industry opposition. However, this was seen as vital to policy progress, because ministers needed to be made aware of all arguments in order to judge whether or not a policy would survive the parliamentary process:

> Within the general ebb and flow of policy, it's the policy official's job to be able to talk ministers through 'well if you do this, then this is likely to happen and these people will say this', and so in a way, you've kind of got to have some of those discussions, because otherwise you're not going to be able to prepare your minister for what happens. And in a way, then it kind of tempers their realism, or tempers their ambitions.
>
> Civil servant

Striking a balance in policy debates at the early stages of problem identification and solution development was described by several "industry partnership coalition" members. However, it was acknowledged by some participants that alcohol industry representatives do have objectives which may conflict with health policy goals, and that decision makers need to be made aware of this and consider industry motives when making choices:

> What is important I think is that there is an understanding, that whilst you have your say, you are selling a product, and we all have to be a bit mindful of the fact that turkeys don't vote for Christmas […] So I think it's just about the nuancing in all this, which is really important, but everybody can have a say and it would be really daft to leave out the people who produce or sell alcohol in whatever place that is. But I think we also obviously have to be mindful that they are coming from a different place in all of this.
>
> Parliamentarian

Participants from both coalitions described how it was the responsibility of decision makers to account for all policy actors' views and potential COI. However, the importance of transparency with regards COI was stressed, to ensure that parliamentarians and civil servants were equipped to make fully informed decisions on policy options:

> I think it's fine for them to make proposals, but I don't think politicians should place much weight on those proposals. If the proposal can be good for the public's health – there are possible win-wins, and politics is often about the art of compromise and if you can find win wins that help the industry and protect the public then that's acceptable. So they are entitled to put forward policy proposals, but I think it's largely up to people like me to have a really clear understanding of the conflicts behind those proposals.
>
> Parliamentarian

Moving forward along the policy cycle, there was a degree of consensus amongst participants from the competing coalitions about the role of industry in the policy legitimation phase. This stage was described as the responsibility of government and engagement with external actors, including the alcohol industry, was described as inappropriate. However, a number of participants described how industry did still seek to influence this stage of the process:

> I don't think they should be directly involved in anything that is – they can have their view, but I don't think they should be directly involved in writing up what the policy should be. So in that sense you can't have them sponsoring documents […] You couldn't set up, what seems to me, a sort of bill committee group that had someone like them on it. I think that would be ridiculous.
>
> Parliamentarian

Participants from the "public health coalition" described greater support for alcohol industry engagement after major policy decisions have been taken. Industry involvement in the legitimation and implementation of policy was described as more appropriate than in the earlier stages of the cycle where policy was developed. At the legitimation stage, industry could add expertise and insights as part of the public consultation process which may aid the objectives or smooth running of policy programmes:

> I don't think it's completely 'no we shouldn't engage at all' but where in that process you engage them is probably the area in the debate. For me it's after the policy decisions has been made. You may want to gather evidence from them and understand their position and their objections, because I think that's important, but whether they have a role in the actual policy decision, I don't think they do.
>
> Health campaigner

One "industry partnership coalition" member described the balance of engagement between industry and government as an inverse relationship, whereby government took greater authority at the beginning of the policy process and industry picked up the majority of responsibility towards the end of the cycle:

> As a rule of thumb I would see, if you put the cycle of policy implementation in a sort of graph of a triangle going from 100% government involvement one end and 10% the other end, and flip the industry line to be the opposite way round, so they sort of crossed over, that would roughly work for me I think.
>
> Alcohol industry representative

However, engaging with industry at the implementation stage of the policy cycle was described by "public health coalition" members as carrying risk related to COI. Participants

described how alcohol industry bodies were able to thwart the effective implementation of policies:

> My broader understanding is that implementation is really important, that essentially you can create a great policy but if it's not implemented it becomes meaningless. So I think again there is plenty of scope there for alcohol industry to have a problematic impact and for other conflicts of interest to have a problematic impact as well.
>
> Health campaigner

It was argued that once government had taken decisions and legislation had been passed, alcohol industry efforts to derail or obstruct that legislation was not appropriate. This scenario was implied to refer to the legal case launched by industry groups against the Scottish Government regarding MUP:

> So I don't think there are conflicts of interest in terms of rights to make the case, but when something becomes the law of the land I think that's when… so in public fora and in public debate, that's when the industry had their right to make arguments when legislation was going through parliament, and we would have poorer policymaking if people didn't have that right – but where it comes to once it is the law of the land, then the question has changed.
>
> Civil servant

The final stage of the policy process, evaluation, was a topic which the participants from both coalitions demonstrated a degree of consensus. It was argued that evaluation and monitoring of policy outcomes must be conducted independently, and therefore the alcohol industry must not be engaged in this stage as they were conflicted:

> I don't think that they should be involved in evaluation, I think evaluation has to be independent. It has to be independent of people who implemented the policy, whether they are government or industry. If it's a government policy then it needs to be evaluated not by government either, it needs to be by an independent researcher or whatever.
>
> Medical professional

A number of participants described how the alcohol industry could inform evaluation of policies, especially policies that they were responsible for implementing, by sharing data. However, despite the acceptance of this role as information providers, "public health coalition" members were keen to stress that the industry should have no role in the development of evaluation plans or in the evaluation process itself:

I think they have a role in helping to provide intelligence or information about what data sources or how you might measure things in terms of evaluation, but they absolutely shouldn't have anything to do with how the evaluation is conducted, because they have no expertise in evaluation methodology for example, and equally in how it is written up, and findings, they haven't got a role in that.

<div align="right">Health campaigner</div>

A number of risks associated with allowing industry to engage in the evaluation of policies were described. These included narrowing the scope of evaluation criteria to limit the definition of what success looked like and misinterpreting evidence to imply a lack of impact. Participants described how interfering with evaluation programmes could deter decision makers from choosing certain policy options in future, and possibly prevent the adoption of effective policies in other jurisdictions:

I would suggest that evaluation is a particularly risky point, probably coming at that from an academic perspective, but certainly, because so much weight can be placed on evaluation, particularly whether policies can be adopted in other jurisdictions, obvious example being that everyone's waiting for results on minimum pricing, then conflicts of interest become particularly high risk there, because there is an opportunity to fundamentally change future decisions on quite a wide scale as well.

<div align="right">Academic researcher</div>

### 4.3.5. Type of engagement activity

Interview participants were invited to describe their thoughts about how different types of engagement between alcohol industry actors and the public policy process may represent COI. The framework for alcohol industry corporate political activity devised by Hillman and Hitt was used as a guide to discussions to prompt participants into describing their beliefs about different scenarios. Interviewees were encouraged to describe engagement activities that they had experienced in their professional careers as well as activities that they were aware of more generally. An overview of participant perceptions of COI associated with alcohol industry engagement in policy settings according to different types of engagement activity is presented in table 8 below.

| Type of engagement activity | Public health beliefs on risk of COI | | | Industry partnership beliefs on risk of COI | | |
|---|---|---|---|---|---|---|
| | LOW | MED | HIGH | LOW | MED | HIGH |
| **Responding to public consultations** | | X | | X | | |
| **Formal (recorded) meetings with Ministers & officials** | | X | | X | | |
| **Informal (unrecorded) meetings with decisionmakers** | | | X | | X | |
| **Industry funded research reports** | | | X | | X | |
| **Entertainment within parliament** | | X | | X | | |
| **Corporate hospitality outside parliament** | | | X | | | X |

*Table 8: Perceived Risk Associated with COI and Alcohol Industry by Type of Engagement Activity*

Participants described a number of engagement activities conducted by alcohol industry representatives with the alleged intention of influencing policy. These activities were discussed in terms of how much risk was associated with COI and their perceived legitimacy by interviewees. There was a general acknowledgement that some activities were conducted in a transparent way, which became part of public record. Such activities included responses to public consultations and meetings with ministers and officials that were recorded. These activities were perceived as more legitimate by participants from both coalitions. However, there remained a perception that many meetings took place between industry and officials which were not publicised, and this lack of transparency was described as presenting greater risk of industry COI influencing policy to the detriment of the public good:

> One of the things that I object to, which I think comes out in freedom of information, is how much ministerial time companies get versus public health […] I would like to see a much more open system so we would know exactly how many times Diageo had visited this administration, how many, so I think there needs to be transparency. But we know that doesn't happen, we know there are loads of meetings that we don't know about, and that bit should be transparent.
>
> Health campaigner

A lack of transparency around industry funding of third-party organisations such as think tanks was also described as introducing risk linked to covert COI into the public policy process. Not declaring that industry had funded research reports which were used to influence decision makers' views on policy issues was labelled corrupt by one "public health coalition" member:

What I think is corrupt is not too strong a word is to say 'we will go to a supposed independent think tank or academic and actually because we're giving them money, they will help produce things that are favourable to our case which they will then publicise. And they will be used by supposedly independent, reputable organisations like the BBC as experts in the area.

Parliamentarian

Industry funded entertainment and corporate hospitality was cited by a number of participants as a common engagement activity intended to influence policy makers. Formal entertainment such as parliamentary drinks receptions was described as commonplace. The transparency of these events, which were seen as overtly aligned with the sponsoring organisation's objectives, led participants from both coalitions to describe them as less of a threat to the pursuit of open decision making. One participant from the "industry partnership coalition" described such receptions as an essential part of the parliamentary process that all lobbying groups should have the right to access:

On entertainment its entirely legitimate for any business or organisation to want to be able to access parliamentarians and brief them on their issues and do so with reasonable entertainment for example providing canapés and wine at a reception and allowing the organisation to make its case.

Parliamentarian

Corporate hospitality outside of parliament, such as invitations to sporting events or drinks parties, was viewed differently, with members of both coalitions identifying risk of COI with such activities. Civil servants described how they often received such invitations, however they reported declining due to a view that attending social events was not appropriate. Similarly, one civil servant from the "industry partnership coalition" described how it should be unacceptable for parliamentarians to receive corporate hospitality:

I think extending hospitality to, tickets to Wimbledon or whatever, to MPs, that is a direct conflict of interest. That should be on the register of interest and declared, and it should be culturally unacceptable for members of parliament or policymakers to accept that kind of hospitality. That's direct, it's indirect in that it's hospitality, but they are accepting a gift in kind from alcohol producers and I think that is a very significant conflict of interest.

Academic researcher

Whilst participants described how it was relatively straightforward to ensure transparency around formal engagement activities such as recording attendance at meetings and events, several interviewees described how informal networks and relationships were more difficult

to regulate. Opportunities for personal contact between corporate leaders and senior public officials was described as potentially more influential than formal lobbying activities:

> You have to look at the industry involvement across all the spheres of influence that it is engaged in, and they all have their roles to play. As we know, one-on-one conversations are often the most influential, so if the CEO can meet Theresa May at such and such […] that would have a much more greater impact than all the other lobbying, because it's those little private words in the ear that sway things more.
>
> Academic researcher

There was a perception among "public health coalition" members that alcohol industry bodies belonged to a powerful international business network which provided many opportunities for representatives to have informal discussions with decision makers. This level of access and influence was perceived as an example of how the alcohol industry occupied a far more powerful position than public health stakeholders, because they were able to focus on economic interests of government which were believed to take greater priority over health interests:

> I think there are networks that I don't even know exists – where decision makers and opinion shapers meet, whether in hallowed halls or clubs or – I don't even pretend to know the first thing about those. Although again that's sort of the keepers of the Quaich thing has been mentioned to me as something that's international and enables the industry to make connections with very senior business people […] Because even though on the health agenda governments may be in a particular place, all of them are thinking about the economy and inward investments and all of that […] I think we're just innocents abroad in all of that.
>
> Health campaigner

### 4.3.6. Chapter summary

Risks associated with COI and alcohol industry involvement in alcohol policy were described by members of both coalitions as variable and context specific, depending on the type of industry actor, the stage of policy process, the topic of alcohol policy and the type of engagement activity. With regards type of industry actor, on-trade retailers were seen as presenting less of a risk compared to off-trade retailers, and multinational producers were described as more highly conflicted than domestic or artisanal producers. "Industry partnership coalition" members were more likely to describe differences in risk of COI associated with different types of beverage however "public health coalition" members did not see any variance in level of COI by beverage type.

Support amongst both coalitions was identified for certain types of industry engagement on certain policy topics at specific stages of the policy process. Implementation of server training schemes for licensed retail staff and product reformulation to reduce ABV% strength of beverages are two examples. Both coalitions also shared beliefs regarding opposition to alcohol industry involvement in pricing policies, policy development and evaluation. Formal engagement in policy processes such as responding to public consultations and recorded meetings with ministers and officials were viewed as presenting lower risk of COI compared to informal engagement which does not become a matter of public record. Industry undeclared funding for research reports and corporate hospitality outside of parliament were described by participants from both coalitions as high-risk activities due to the industry COI.

## 4.4. Managing conflicts of interest

### 4.4.1. Overview

This chapter describes the views expressed by participants about how COI and the associated risks of alcohol industry engagement in alcohol policy subsystems could be managed and mitigated. It explores perceptions around the benefits of industry engagement and also compares the alcohol industry to other corporate actors involved in health policy. A number of themes were identified from the data: 1) The perceived government motivations for engaging with the alcohol industry, 2) The alcohol industry in comparison to other 'unhealthy commodity industries' such as tobacco and producers of foods high in fat, salt and sugar, and 3) suggestions for how to improve the management of COI to better protect public health policy goals. An overview of participant views relating to these themes is provided below.

### 4.4.2. Government motivations for working with industry

Given the existence of COI identified in alcohol policy settings, participants were invited to share their understanding of why governments choose to engage the alcohol industry. A number of motivations for government-industry partnerships were identified. Political motivations were frequently cited by participants: governments too weak to introduce controversial measures may look at alternative non-regulatory activities proposed by alcohol industry groups in order to appear active:

> If you were a health minister, and you thought well I can wave a magic wand and I can have all sorts of regulation in place and so forth, well you might think that's fine I'll do that with alcohol, you might take that view. But actually, whatever your personal view is, you're not going to get that through the rest of government, then you want to get stuff done and you want to see how far you can push the industry to help you.
>
> Civil servant

Public opinion was described as an important influencing factor in motivating government towards working with alcohol industry bodies as opposed to introducing regulatory controls on alcohol. Civil servants explained that alcohol occupied an important place in UK culture and any policy measures which may threaten to interfere with individuals' pleasures would likely attract negative publicity, something it was their duty to advise ministers about:

> So as a policy official, what we are essentially preparing for is the point at which the thing hits the press and it's launched [...] and once ministers stand up in parliament and say 'here are all the things I'm going to do', here are all the obvious points of attack and what people are going to say in response to this.
>
> Civil servant

In the absence of statutory regulation, industry voluntary partnerships were described by members of both advocacy coalitions as attractive to ministers. They were viewed as cheaper and easier to roll out than new legislation and also in line with recent UK Government priorities for streamlining regulation and minimising red tape to allow businesses to thrive. The Public Health Responsibility Deal was cited as an example of this approach favoured by the then Secretary of State for Health, Andrew Lansley:

> It's a cheap way of regulating, so I think it's attractive in that sense. I suppose this is one of the things that the Responsibility Deal came in on the back of the Better Regulation agenda, the bonfire of red tape etc and this was one of the views that Andrew Lansley sold the Responsibility Deal on, the view of less regulation.
>
> Academic researcher

Political ideology was a major factor identified by participants from both coalitions as influencing government motivations for engaging with the alcohol industry in voluntary partnership agreements. The current UK Government ideology was described as based on neoliberal, free market values which emphasised individual personal responsibility and steered away from regulatory interventions:

> So I think there has been a dominance of neoliberal ideology, emphasising individualism, emphasising free markets, and within that kind of context you will have far more access for companies, for business, for financial interest to influence policy.
>
> Health campaigner

The prioritisation of partnerships and involving all stakeholders in policy was also cited as a contemporary political ideology, adopting a 'good governance' approach to policymaking. Parliamentarians described the importance of achieving consensus from all sides of an argument in order to introduce a new measure. The value they placed on this consensus meant they were open to compromise on aspects of legislation:

As a politician, you have to make some decisions quite often about 'well, I might want to do this next year, but if I can get them on board and we do it in two years, would that be a better option and what we need to do?' and then also part of it might be are there any other factors that you as a government have to put into the pot so to speak, to make the policy become real.

Parliamentarian

The economic benefits associated with the alcohol industry in the UK were also described by interviewees as motivating government engagement in partnerships and making regulatory controls on the production and supply of alcohol less attractive. At a national level, the alcohol industry was cited as a major employer and contributor to the UK tourism industry. "public health coalition" members highlighted the important role alcohol industry played in local politics, where parliamentarians were likely to oppose any regulations which would have an adverse impact on their own constituencies:

You've got to bear in mind that the political pressures are such that there are certain areas where industry can be very influential in terms of the ability for MPs to get re-elected, you know the cider industry in the South West clearly has a lot of influence on MPs in that area, they're very good with their lobbying activities in terms of influencing political thoughts and decisions, they clearly have lots of access to politicians and their advisors.

Health campaigner

"Public health coalition" members described how a naivety and lack of understanding about COI amongst decision makers allowed for the pursuit of ineffective and sometimes damaging alcohol industry voluntary pledges. Participants described how policy officials who joined the alcohol policy field often had good intentions of creating positive partnerships with the alcohol industry. However, these intentions were often ill-informed:

So it's quite interesting to me, in terms of governments' engagement, is how much of it is down to a naivety, and, as a civil servant, government has to engage with all stakeholders so it's not possible for them to completely shut the door to people, but they have to be willing to have a conversation, but at the same time the practice and the understanding of how disingenuous that engagement is in practice.

Health campaigner

### 4.4.3. Comparisons to tobacco and food policy

Several participants drew parallels with COI in alcohol policy settings and in other health areas, most notably tobacco control and nutrition. A number of "public health coalition"

members described how similar tactics are used across what they described as 'unhealthy commodity industries', notably tobacco, alcohol and sugar-sweetened beverages/ultra-processed foods, to delay or obstruct evidence based public health regulations. Research was also cited which explored formal relationships between alcohol, tobacco and food companies and identified a number of interlocking directorates between and across industries:

> Definitely there are similarities between them and I think those similarities are very evident in the tactics they adopt to oppose the most effective evidence-based measures around restricting marketing, and taxing the unhealthy products […] Often they employ the same people to advise them on marketing and growth and profit, you know, their boards have people who sit on both types of industry. Or they are part of bigger conglomerates, where one arm will sell tobacco, one arm will sell alcohol and one arm will sell food.
>
> Academic researcher

However, despite the similarities described by some participants regards industry corporate political activities, the majority of interviewees, from both coalitions, did not agree that the alcohol industry should be subjected to the same restrictions as the tobacco industry, which is excluded from many aspects of the public policy process under article 5.3 of the WHO Framework Convention on Tobacco Control (FCTC). Among alcohol industry representatives, there was strong resistance to comparisons between tobacco and alcohol products:

> I think that tobacco is totally different from the brewing industry. Tobacco is bad for you, full stop. If you smoke, it will cause you problems. Whereas I believe that drinking in moderation can be absolutely fine, I think it can be good for your mental health and wellbeing, and in the social situation where you drink it, there is some evidence, and I certainly wouldn't want to go into some medical publication, but there is quite a lot of good evidence around cardiovascular and around various other things to do with drinking in moderation and that was never true of tobacco, so to me the two are really very different.
>
> Alcohol industry representative

"Public health coalition" members also acknowledged that tobacco and alcohol were different entities. Interviewees described how the tobacco industry had acted appallingly and had subsequently achieved pariah status, so the alcohol industry strived to take a different path in order to avoid the same end:

> I wouldn't equate them with the tobacco industry, I don't think they are the same. I worked in Washington DC and I saw those tobacco lobbyists in Congress, they were a scary group […] and I think if you were running Diageo you would have looked at what is happening and what has happened to the tobacco industry and you would not want

to be going in that direction [...] So the production of lesser ABV and some of these other things that we have been seeing which are perhaps quite good, I think we'll see more of that. Because they're quite mindful I think of some of these issues.

<div align="right">Health campaigner</div>

Civil servants and parliamentarians from the "industry partnership coalition" were very clear in their view that the alcohol industry should not be classified in the same way as the tobacco industry. Whilst there was acknowledgement that the alcohol industry had adopted a number of tactics to delay regulation which would harm their objectives, there was a consensus that no evidence existed to indicate these tactics were of the same scale and subversive extent as those adopted by Big Tobacco in the past:

I know that they challenge and they quibble at the detail of the CMO guidelines, and we get stories about how a glass of red wine is good for your blood pressure, and all that sort of stuff [...] But I just don't know if there's anything, if there's any information quite on the scale of the tobacco industry have [...] I can understand exactly why the tobacco industry is not engaged with from a public policy perspective, but I don't think that I'd consider the alcohol industry in quite the same light.

<div align="right">Civil servant</div>

The divergent long-term UK Government objectives for tobacco and alcohol were cited by respondents as a reason for treating the two industries differently. The legitimate place the alcohol industry occupies within the Government's long-term vision was contrasted with the aim to eradicate smoking. It was acknowledged by members of both coalitions that the majority of people in the UK enjoy alcohol, which is seen as a normal part of everyday life, therefore the alcohol industry should not be excluded from society in the same way the tobacco industry has been:

So what we haven't discussed is the right of the drinks industry to exist. And they do have a right to exist, you know, the majority of the people in this country like to have a drink. And also a majority of people gain a lot of enjoyment from having a drink. So I think it's very important just to sort of bear that in mind as well. It's difficult to make the same statements about the tobacco industry. But the drinks industry, they have a right to exist.

<div align="right">Medical professional</div>

### 4.4.4. Experience of, and suggestions of how to manage, COI in professional settings

Participants were asked how they address COI in their professional settings; whether they followed formal guidance and whether they had a view on how best to manage COI with regards engagement with the alcohol industry. Civil servants reported that no specific

guidance existed for them to follow regarding how to engage with the alcohol industry, which corroborated the findings from the literature review. Several participants referred to the Civil Service Code, which requires senior civil servants to declare any financial interests and keep a register of gifts and hospitality, however there was no knowledge of any guidance on how to manage COI when developing policy:

> If I have shareholdings in something, we've got declarations of interest for senior civil servants, which are updated annually […] So at that level there is a degree of recognition and a degree of structure around it, but in how one handles conflict of interest within the development of policy, where it's not about one's own conflict of interest, I don't know of any guidelines.
>
> <div align="right">Civil servant</div>

Parliamentarians described how they were required to declare all financial donations and corporate hospitality on a register of interests. However no guidance was cited in relation to engagement with the alcohol industry. One parliamentarian described how the sanctions for non-compliance with the existing regulations around declaring financial interests and corporate hospitality were insufficient.

Declaration of funding sources was the most frequently cited means of managing COI amongst researchers and medical professionals. Several participants described how they had received COI training as part of their professional development, including on unconscious bias. Whilst it was explained that published research reports were mandated to list funders and any COI declared by authors, one researcher identified a lack of ability to search who had been in receipt of alcohol industry funding. A central register or database listing this information was proposed to make it easier to identify experts who had links with the alcohol industry.

Improved accessibility to funding records was also called for regarding political donations. Interviewees described the current system of declaring funding on registers of interest as lacking transparency. In addition, the current UK system of recording meetings with industry and other lobbyists was described as lacking transparency. One participant suggested that adopting an approach to monitoring lobbying as per the Unites States of America would improve levels of transparency in the UK:

> I think what you need is something more like the American system, where there's much more transparency about lobbying activity and all of it. Basically, you need more transparency, and at the same time, you know, it's naive to pretend it's not going to happen, the industry are highly influential and their influence will be brought to bear and the government will listen to them and certain parts of the government will only

listen to them and not to anybody else, so that's the situation, that's the scenario we're in.

<div align="right">Medical professional</div>

Alcohol industry funding of research and NGO activities was described as a clear example of COI by the participants belonging to both coalitions. Several researchers and NGO representatives stated clearly they would never accept alcohol industry funding. However, there were some examples of industry funding that were suggested which may not be prohibitive to engagement in the policy process. The first example was the difference between receiving funds that were linked to current versus historical alcohol industry profits. This type of funding was raised in the context of charitable trusts and foundations that award grants to NGOs and researchers. One participant implied that if such funds were based on historical industry profits, it may be seen as less of a conflict than funds linked to the profit from current alcohol sales, which would be linked to current and future rates of harm.

The second form of alcohol industry funding suggested was linked to the evaluation of industry corporate social responsibility initiatives. The evaluation of schemes such as promotion of lower strength ABV% products was described as difficult by one participant due to a lack of public money available for such research projects. They argued it was the industry's responsibility to finance such evaluations, however due to their COI it would not be appropriate for industry to have any role in the design or conduct of such projects. Rather, a blind trust arrangement, whereby industry would award funding to a research council or institute, for evaluation to be conducted completely independently, was suggested:

> So all the rest of the research process, the methods, the data collection, the receipt of data or data analysis, is all done by the researcher, with no influence whatsoever by industry. So it's just as simple as that. I think it's clear enough. I mean if you have that full stop, everything else is fine, because the industry is no longer involved.

<div align="right">Academic researcher</div>

Whilst NGO members of the "public health coalition" declared they would not be willing to accept alcohol industry funding as a means of protecting against COI, several participants did describe how they would consider other non-financial forms of engagement if certain conditions were in place. Sharing a public platform, attending events and roundtable meetings where industry was present was described as a 'grey area' for health campaigners, who preferred to judge on a case-by-case basis whether the risk of COI was too great. One health campaigner described that they would not engage in bilateral discussions with the alcohol industry, however if meetings were convened by a government body, they would be willing to engage:

We only engage in mechanisms that are tripartite, where there is the NGOs, the academia and the government and those are the only fora where if we have to engage with industry, we will be there as well. And that's because we recognise that at some point the industry needs to speak formally with government.

Health campaigner

Civil servants similarly reported feeling more confident attending meetings or events where the alcohol industry was present if public health NGO representatives were also involved. The presence of health campaigning groups such as Action on Smoking and Health and the Alcohol Health Alliance UK was described by one civil servant as a 'decent yardstick' for assessing whether or not to attend, implying that NGO groups leant legitimacy to activities and reduced the perceived risk of COI.

### 4.4.5. Chapter summary

Participants from both coalitions were able to identify a number of government motivations for working with the alcohol industry in spite of the presence of COI. Such motivations included political power and ideology, public opinion and social pressures, economic concerns and a preference for a partnership approach to health governance. Naivety and a lack of understanding among decisions makers relating to the alcohol industry and COI was also cited by some "public health coalition" members as why partnerships with industry existed.

Similarities in tactics between the alcohol industry and other unhealthy commodity industries were identified, most notably tobacco and foods high in fat, salt and sugar. However, despite the similarities described by some participants regards industry corporate political activities, the majority of interviewees, from both coalitions, did not agree that the alcohol industry should be subjected to the same restrictions as the tobacco industry, which is excluded from many aspects of the public policy process under article 5.3 of the WHO Framework Convention on Tobacco Control (FCTC). The divergent long-term UK Government objectives for tobacco and alcohol were cited by respondents as a reason for treating the two industries differently. The legitimate place the alcohol industry occupies within the Government's long-term vision was contrasted with the aim to eradicate smoking. It was acknowledged by members of both coalitions that the majority of people in the UK enjoy alcohol, which is seen as a normal part of everyday life, therefore the alcohol industry should not be excluded from society in the same way the tobacco industry has been.

Financial COI was described as the simplest form of COI to manage for the purposes of protecting alcohol policy decisions from undue industry influence. Whilst participants from both advocacy coalitions identified examples of non-financial COI that could influence public policy, these were perceived as at risk of being nebulous and difficult to regulate. Participants described different levels of COI associated with industry funds linked historic sales of alcohol

(held for example by trusts and foundations) compared to those linked to current sales of alcohol (held by a producer or retailer). Participants also described how instances could be identified where use of industry funds could be beneficial to public health policy processes if decisions about the allocation of those funds were made entirely separately to the industry, for example in a blind trust arrangement.

Transparency was considered a key factor in managing COI and protecting public policies from undue influence. Participants from both advocacy coalitions described how unrecorded, informal engagements with decision makers were undesirable and could lead to deleterious outcomes. Formal engagements in the policy process that were a matter of public record such as meetings with officials and entertainment within parliament could be considered as acceptable forms of alcohol industry engagement by "public health coalition" members. However, whilst declarations of interest were described as important, they were not described as tools that would eliminate or reduce COI. Rather, they were described as instruments to manage COI and mitigate risks associated with covert influence.

# 5. Discussion and conclusion

## 5.1. Identifying advocacy coalitions

This study sought to identify the existence of advocacy coalitions within the alcohol policy subsystem to gain a better understanding of policy actors' perceptions of COI and alcohol industry engagement in public policy. Secondary policy beliefs relating to alcohol harm, policy solutions and alcohol industry engagement in policy processes were assessed to determine the nature of advocacy coalitions and how members coalesce around ideas and perceptions of COI. One of the reasons for using the ACF to organise the data generated in this study was to assess how secondary beliefs between coalition members diverged and converged. Identifying evidence of potential consensus on issues may be of use for policy brokers in future who, through policy learning, may be able to shift beliefs of coalition members to achieve common goals.[103] Similarly, identifying evidence of competing beliefs which may contribute to a 'hurtful stalemate' in alcohol policy, including signs of 'devil shift',[71] will further our understanding of how perceptions of COI and industry engagement may be obstructing policy progress.

Two competing coalitions were identified; the "public health coalition" and the "industry partnership coalition". The secondary policy beliefs of each group of actors diverged in relation to the description of alcohol harm as a problem and the appropriate policy response: "public health coalition" members share a belief that alcohol harm is at unacceptable levels in the UK, is a problem that is increasing and requires population-wide regulatory measures restricting the alcohol supply chain. Conversely, "industry partnership coalition" members believe that alcohol harm is a problem that has stabilised in recent years, affects a minority of the population and should be addressed by industry partnership initiatives with government and NGO stakeholders. As outlined in section 4.1 (Table 4), health campaigners, medical professionals and academic researchers were identified as belonging to the "public health coalition", whereas industry representatives were identified as belonging to the "industry partnership coalition". Civil servants and parliamentarians shared policy beliefs across both coalitions, however it was evident that these beliefs were described in more measured and balanced terms regardless of which coalition they belonged to. This supports the ACF hypothesis that within an advocacy coalition, administrative agencies will usually advocate for more moderate positions than their interest-group allies.[103] According to ACF, some actors can serve as policy brokers that seek to mitigate levels of conflict between coalitions and help opponents seek agreement.[18] Such agreement, ACF hypothesises, can be reached via policy-oriented learning whereby coalitions shift belief systems after re-evaluation of evidence or exposure to information and experience.[71] It could be argued that policymakers (parliamentarians and civil servants) can fulfil this role as policy brokers by providing opportunities for policy-oriented learning across competing coalitions, a concept which is discussed in more detail below in section 5.4, suggestions for how to manage COI.

The policy beliefs expressed by members of the two identified advocacy coalitions support the ACF premise that actors within a coalition will show substantial consensus on issues pertaining to the policy core.[103] The scientific consensus expressed by "public health coalition" members regarding the evidence supporting controls on alcohol price, availability and marketing was a notable example of this and was described by participants as an unusual area of research where contestation was rare. However, the contestation expressed by members of the competing "industry partnership coalition" in relation to such regulatory measures suggests that consensus on the evidence to support alcohol regulations does not span the entire policy subsystem. The rhetorical use of scientific consensus as a partisan framing device has been identified by scholars analysing public health stakeholder views on the use of e-cigarettes.[104] There are similarities with findings of this study, where "public health coalition" members argued that alcohol industry bodies who adopted opposing positions failed to follow the evidence base. The authors of the e-cigarette investigation concluded 'interpretive policy analysis suggests multiple legitimate framings of policy issues, supported by different bodies of evidence are possible, and policy differences are thus not due to bad faith but to policy actors framing the issue at stake in different terms and thus advocating different policy responses'.[104]  It is, therefore, important to consider how perceptions of COI and alcohol industry involvement in policy may be shaping how coalition members frame the evidence base for effective policy interventions. It is also important to consider whether the existence of core beliefs that oppose industry involvement may be obstructing policy progress through a reluctance to acknowledge the existence of or accept alternative frames.

As discussed in Section 2, the ACF acknowledges that competing coalition members can exaggerate the power and influence of their opponents,[81] and this can lead to demonization, described as the 'devil shift'.[71] According to Sabatier, one of the adverse consequences for policy progress of the devil shift is a 'hurtful stalemate', whereby advocacy coalitions experience periods of protracted conflict that prohibits policy-oriented learning and compromise agreements.[18] The UK alcohol policy context under investigation could be described as displaying symptoms of 'hurtful stalemate': as described above in the introductory section, a number of alcohol policy 'failures' in recent years have been accompanied by resignations from public health professionals from government programmes on the basis that alcohol industry interests have been prioritised over public health goals.[11] Several members of the "public health coalition" made reference to the alcohol industry as both a cause of the problems associated with alcohol and also a barrier to solutions being put in place. Attention was therefore awarded to the framing used by public health actors to describe the power and influence of the alcohol industry throughout the analysis in this study.

A key finding of this thesis is that, whilst two competing coalitions were identified, a number of shared beliefs were expressed by members of both coalitions, indicating that a degree of

consensus may be possible on specific alcohol policy issues. These shared beliefs are discussed in more detail below and relate to alcohol industry's involvement at different stages of the policy process, the type of industry actor involved, type of alcohol policy at stake and the form of engagement. An additional finding of this thesis is that that policy actors' perceptions of COI and alcohol industry involvement may be acting as a barrier to public health policy progress. This implies that further exploration of this issue, with the involvement of policy actors, is needed to foster policy learning and enable policy brokers to identify potential areas for consensus and advancement. Developing a more nuanced understanding of COI relating to alcohol industry engagement, that addresses both areas for potential agreement and also any 'hard-line' areas for disagreement between policy actors, is therefore an important exercise and this study will make a valuable contribution to this prominent debate. What follows is a detailed discussion outlining the implications of the findings from this analysis of perceptions and beliefs of advocacy coalition members about COI and alcohol industry engagement in public health policy.

## 5.2. Participant understanding and definitions of conflicts of interest

All participants, from both advocacy coalitions, expressed a belief that COI exists in alcohol policy settings. Members of the "public health coalition" described a strong belief that the alcohol industry presented a clear COI, largely because their economic goals conflicted with health objectives of reduced alcohol consumption and associated harms. However, members of this coalition also expressed a belief shared with the "industry partnership coalition", that alcohol policy settings are subject to COI from a wide range of actors and not limited to the alcohol industry. This is discussed in more detail below. An important finding from the results is that, whilst all participants expressed confidence in their belief that COI exists in alcohol policy settings, many struggled to articulate a clear definition of COI. This contrasts with the beliefs identified that relate to the understanding of alcohol harm and support for policy interventions: unlike these secondary beliefs, participants did not describe a shared definition of COI, did not use common language in their description of COI and did not collectively refer to any guidelines or established frameworks which they saw as providing a 'good example' to support their arguments. As a result, the descriptions of COI offered by participants were extremely varied and many respondents appeared to question their own understanding of the concept when attempting to articulate a definition.

This finding echo those from the narrative review, that the issue of COI in alcohol policy settings is currently ill-defined and under-researched. Participants' embarrassment at not being able to define a concept they have voiced concerns about was an interesting finding. This may not be a surprising finding, as difficulties can be expected in explaining complex phenomena in the abstract and under questioning from a well-known policy actor in the field. However, the embarrassment expressed can be seen as an indication that there is a recognition of the need for, and the willingness to develop, a definition of COI using common

language that participants can have confidence in using. This study's exploration of different components of COI, as perceived by participants, helps to unpack and build an understanding of the concept and may, therefore, inform future efforts to develop an agreed definition of COI in alcohol policy settings.

The concept that most participants were comfortable in describing was financial COI: being in receipt of funds from organisations whose objectives were contrary to the goals of a particular programme or activity was described as representing a clear example of COI. The alcohol industry funding public health information campaigns or research into public policy issues was cited as an example of financial COI and understood by participants from both the "public health coalition" and "industry partnership coalition" (although members of the latter were mainly civil servants and parliamentarians and not alcohol industry representatives). This belief is in line with the framework for assessing whether to receive funding support from unhealthy commodity industries developed by Peter Adams:[105] The 'PERIL' framework suggests that the purpose of any organisation offering funds to another organisation (or individual) must be assessed to determine whether the purposes of the funder and recipient diverge. Adams argues that, if a primary purpose of the recipient organisation or institution is the advancement of public good, particularly benefits related to social wellbeing, health and welfare, then industries receiving funds from dangerous consumption industries – particularly tobacco, alcohol and gambling - will conflict with this purpose.[105] There emerged a core belief from participants that alcohol industry funding of health-related activities represented a clear financial COI due to the divergent purposes.

Participants described a range of non-financial forms of COI, displaying an understanding that COI is not limited to financial transactions. Such examples tended to focus on individual as opposed to institutional level conflicts and included relationships, personal obligations, professional experience and membership of organisational boards or networks. This indicates an awareness among participants that COI can manifest and intersect across and between different levels of society. When describing these non-financial, individual examples, participants expressed a belief that COI extends to other actors within the alcohol policy subsystem beyond the alcohol industry. The descriptions of alleged 'conflicts' of interest amongst non-industry actors included personal attributes beyond an individual's control; for example, unconscious bias, ethnic and cultural background, professional experience and education. The attention awarded to such attributes in the context of COI can be seen as problematic for two reasons: Firstly, intangible and unquantifiable qualities inherent in individuals may prove difficult to manage or account for in any guidelines that seek to protect public policy against COI; and secondly, equating individual 'interests' in a particular policy outcome which may be in alignment with the general public interest risks downplaying the risk of commercial financial COI.

A number of participants described how commercial financial COI should be awarded 'special status' compared to other actors' interests in alcohol policy settings. Concerns were raised about equating alcohol industry financial objectives with the public-interest goals advanced by members of the "public health coalition". This theme is explored by Bero and Grundy (2016) who argue that conflation of "conflicts of interest" with "interests" in general serves to muddy the waters about how to manage COI in relation to research settings.[106] This argument conforms with the epistemological foundation of this study, that all policy actors, including scientists, view the world through a subjective lens based on their own beliefs, values and experiences. The approach taken in this study posits it is impossible for policy actors to be completely impartial, objective and value-free. Bero argues that whilst it is essential to systematically examine all of the social values shaping a research process, these cannot possibly be eliminated but must instead be made visible and open to critical interpretation.[106] This process could be applied to alcohol policy settings to ensure that all actors' interests in policy outcomes are transparent and assessed according to their conflict with public policy goals. However, the mixed reporting amongst participants in relation to non-financial COI implies that further refinement of the concept of COI is required to improve understanding of such nuances amongst alcohol policy actors.

Another indication that the definition of COI requires refinement for the purposes of protecting public health policies to reduce alcohol harm was the expression from a number of participants that COI as a concept precludes engagement. The existence of COI amongst alcohol policy actors, most notably alcohol industry representatives, was described as a barrier to involving them in alcohol policy processes and grounds for exclusion. Participants expressing this belief did not describe COI as a concept which could be managed in order to mitigate associated risks. This understanding of COI does not support existing definitions and guidelines which generally stipulate that whilst some instances of COI preclude engagement, other instances require actions to mitigate risk such as declaration, recusal from meetings/decisions etc.[107] The perception of COI expressed by participants can be seen as supporting Adams' argument that taking a binary interpretation of COI tends to lock understandings into all-or-nothing positions, thereby discouraging reflection and discussion regarding ethical and moral issues of working with unhealthy commodity industries.[105]

The binary approach taken to COI by some participants may be a reflection on the 'hurtful stalemate' described above, whereby advocacy coalitions refuse to engage to seek policy progress or compromise due to experiences of 'devil shift'. The core belief expressed by a number of "public health coalition" members that the alcohol industry had an inherent COI in relation to alcohol policy goals to reduce harm was evidenced by numerous examples of how the alcohol industry had obstructed health policy. The list of examples used awarded participants confidence in their description of alcohol industry COI. Their shared beliefs on this issue contrasted with their struggle to articulate COI as a concept. This struggle resulted in demonstrable self-reflection during interviews about participants' beliefs relating to COI

and alcohol industry engagement in policy settings. This self-reflection can be seen as a result of the interview process and forms part of the data analysis. The lack of understanding of COI amongst participants indicates that guidelines may be necessary to inform and educate policy actors on this issue, to increase confidence in their understanding of and communication about their beliefs relating to COI. Several participants described how the guidelines currently used by their respective organisations were limited in scope, often dealing solely with financial COI, which was described as inadequate.

The process of self-reflection instigated during the interview process provided a window of opportunity to elicit views and beliefs from participants about what information would be necessary to inform future guidelines for addressing COI in the alcohol policy subsystem. The purpose of this study is to explore in more depth the perceptions of policy actors about COI amongst different alcohol industry groups in specific policy settings. Responses to initial interview questions demonstrated a need to further explore and refine policy actors' existing beliefs and definitions of COI. This study can therefore be seen as fulfilling an important objective of refining the term of COI by unpacking existing beliefs and definitions used by policy actors and creating sub-categories that can be applied in practice. Further refinement of participants' understanding of COI in alcohol policy settings was attempted by using the data analysis framework as a guide during interviews to elicit more nuanced views about risks associated with different aspects of industry engagement in the policy process. Discussion of the findings is given below.

## 5.3.  COI related to alcohol industry engagement in policy

A variety of secondary beliefs were identified amongst interview participants relating to COI and alcohol industry engagement in policy processes. The range of different alcohol industry actors described provides evidence of an understanding amongst participants of the diverse nature of the alcohol industry, which was perceived to encompass individuals, organisations and businesses across multiple sectors. Participants from both advocacy coalitions described how the alcohol industry was split between producers, retailers and trade associations, with each group making a distinct contribution to alcohol policy subsystems. Retailers were described as split between on- and off-trade and producers were divided between their geographical scope (i.e. multinational versus domestic) and by different beverage category. This comprehensive articulation of the alcohol industry by alcohol policy actors may inform the development of a global definition of what constitutes the alcohol industry. As outlined in the introduction, calls have been raised from public health researchers and NGOs for governments and UN institutions to establish a clear definition of alcohol industry economic operators for the purposes of developing policies to manage COI.[9]

Building a definition of the alcohol industry, incorporating different sub-categories of actors, enabled participants to reflect on the different levels of COI presented by individuals and

organisations. For the purposes of managing COI in policy settings, "public health coalition" members identified actors as belonging to the alcohol industry if they received financial contributions or payments from alcohol companies. For this reason, NGOs, think tanks and expert individuals such as medical advisors and academics were described as presenting a COI in alcohol policy processes if they received funding from alcohol companies. Members of the "industry partnership coalition" similarly described NGOs such as Drinkaware in the context of belonging to the industry, although these participants were less likely to describe such NGO involvement in policy processes as presenting COI.

Participants from both advocacy coalitions described how different types of alcohol industry actor may present different forms and levels of COI in policy settings. In some instances, commonality in beliefs across both coalitions could be identified. For example, participants from both the "public health coalition" and "industry partnership coalition" described how on-trade alcohol retailers, such as pub landlords, presented a lower level of COI than off-trade retailers such as supermarkets and off-licenses. Similarly, participants described the COI associated with multinational producer involvement in alcohol policy processes as greater than domestic or artisan producers. While the relative scale of COI described by participants from competing coalitions followed a similar trajectory for these actors, the absolute level of risk associated with COI was described as higher for all industry actors by "public health coalition" members. This is an important finding and may enable policy brokers to negotiate with "public health coalition" members if all engagement with alcohol industry is framed as at risk from COI, with the purposes of any guidelines on industry involvement in public policy being to mitigate against that risk. This is especially interesting given that some members of the "public health coalition" described, at the beginning of the interviews, the existence of COI (in abstract terms) as precluding any engagement in public policy processes. The process of assessing COI according to different aspects of alcohol policy allowed greater reflection by participants on their beliefs regarding alcohol industry engagement, with secondary beliefs identified that could be subject change.

The level of COI associated with NGOs and expert individuals in receipt of funding was described by "public health coalition" members as variable and context specific. Whilst SAPROs such as Drinkaware and think tanks such as the Institute for Economic Affairs were described as presenting high levels of conflict, NGOs that received modest sums of money from alcohol industry (but did not rely on industry funds to exist) and whose organisational objectives and activities were perceived as in the public interest were considered as presenting less of a conflict. This secondary belief relating to how an organisation's aims aligns with "public health coalition" objectives and the extent to which an organisation relies on industry funding to survive supports findings from this study discussed above, that when assessing levels of COI, "public health coalition" members place value on assessing the 'purpose' of organisations. This belief suggests that organisations or individuals that are described by "public health coalition" members as belonging to or closely associated with the

alcohol industry, may legitimately engage in alcohol policy processes subject to an assessment of criteria relating to the level of industry funding received and the purpose of the organisation. Both of these criteria (whether the 'purpose' of the organisation in receipt of funding and the funder diverge and the 'extent' to which the recipient organisation relies on the industry funding) are included in Adams' PERIL framework.[105] While this framework was designed to inform decisions relating to receiving funds from dangerous consumption industries for research purposes, the findings of this study suggest it could be a useful tool for informing decisions about engagement with different alcohol industry actors in public policy processes.

Similar patterns of convergence and divergence of views between members of the two advocacy coalitions were identified in relation to alcohol industry involvement in different types of alcohol policy. Participants from both coalitions described how policy areas related to the 'core business' of the alcohol industry, such as server training programmes and product reformulation, were topics where industry involvement in discussions was considered legitimate and presenting lower level of COI. Conversely, alcohol industry involvement in developing pricing policies was described as illegitimate by participants from both advocacy coalitions due to a perceived high level of COI. The extent to which members of competing coalitions agreed on the variable level of COI presented by industry engagement in alcohol policy subject areas implies that consensus might be possible to achieve in developing principles to manage COI in alcohol policy settings. However, the clear differences in opinion described by participants from competing coalitions with regards policy topics of education and provision of information, voluntary partnerships and marketing regulation, imply that consensus would be difficult to achieve across all alcohol policy topics. "public health coalition" members demonstrated clear beliefs that alcohol industry involvement in the provision of health information and regulation of marketing practices presented too great a COI to legitimate engagement on these policy topics. This belief is supported by a body of evidence that demonstrates alcohol industry self-regulation and provision of health information show little to no impact on improving public health and can result in deleterious outcomes, such as exposure of young people to harmful advertising practices.[2] The range of views described by participants in this study suggest that achieving consensus on alcohol industry engagement in alcohol policy settings may be more likely if the focus is on policy topics where consensus is greater as opposed to areas where contention is high: i.e. proposals may be better received by the two advocacy coalitions if they describe specific, defined areas where industry can engage, as opposed to where they cannot.

Focussing on policy topics related to the 'core business' of the alcohol industry aligns with the recommendations in the WHO Global Alcohol Strategy which states that governments could encourage economic operators in the area of alcohol production and trade to consider ways in which they could contribute to reducing harmful use of alcohol in their core areas. The core roles identified by WHO for industry are as 'developers, producers, distributors and marketers

and sellers of alcohol'.[4] Product reformulation and server training initiatives can be seen as relevant industry policy topics in this context, alongside policies to regulate marketing and promotion of alcohol. Given the support for WHO policy recommendations demonstrated by members of the "public health coalition", it is conceivable that alcohol industry engagement in policies related to such core business, if framed in terms identified by WHO, could be supported. The findings of this study suggest that support already exists for industry engagement in product reformulation and server training, however engagement in policies to regulate marketing and promotion was contested. Greater understanding of the perceived risks of COI associated with different stages of the policy process and different forms of industry engagement may inform future decisions related to contested policy subject areas such as marketing, with possible opportunities for policy brokers to build consensus with public health advocacy coalition members around industry engagement in specific contexts.

Agreement was evident across both advocacy coalitions with respect to the scale of COI associated with alcohol industry engagement at different stages of the policy process: the policy formulation and implementation stages were described as opportunities for industry to inform and enact policies by drawing on their technical expertise and capabilities, and therefore stages where the risk of COI was relatively lower. Conversely, industry involvement in legitimation and evaluation was identified by representatives from both coalitions as presenting higher levels of COI. These beliefs imply that activities such as responding to public consultations and making representations to decisionmakers would be perceived as legitimate activities for the alcohol industry to pursue, whereas drafting legislation and assessing the successes and failures of alcohol policy programmes would be inappropriate. It was clear that members of the "industry partnership coalition" held strong beliefs relating to the alcohol industry's 'right' to be consulted on matters that would affect their interests, in the interest of democracy and good governance. The industry's 'right' to exist as a legitimate business was echoed by some members of the "public health coalition", which is discussed in more detail below. This study's exploration of participants' views of different stages of the policy process may inform future discussions on engaging alcohol industry actors in policy areas which are highly contested. If industry representatives can make formal, recorded, representations to policy officials and submit consultation responses in relation to subjects such as alcohol pricing interventions and provision of health information to consumers, opportunities for reaching policy consensus may become apparent. Recommendations for how to practically manage COI presented by alcohol industry in policy settings is discussed in more detail below.

The most notable difference in beliefs between the two advocacy coalitions relating to industry engagement at different stages of the policy cycle was regarding the initial 'agenda setting and problem identification' stage. "public health coalition" members clearly articulated a strongly held belief that industry involvement in the early stages of setting the policy agenda presented high levels of risk that COI would obstruct public health goals.

"Industry partnership coalition" members argued that alcohol industry involvement at the beginning of the policy process was integral to the success of any policy goals that would impact on their business. This was due to their ability to inform policy debates with technical expertise and also to build sector-wide support for government decisions. Despite describing industry's involvement in the agenda setting stage as presenting a high level of COI, "public health coalition" members were not forthcoming with suggestions for how to mitigate the risks of involving industry or exclude them from this stage of the process. Greater attention was awarded to concerns about informal versus formal engagement with decisionmakers at the agenda setting stage: unrecorded meetings with policy officials and corporate hospitality outside parliament was perceived by members of both coalitions as presenting higher risk of COI than recorded meetings and entertainment within parliament. Transparency in relation industry engagement in the policy process was described by participants as a key tool for managing and mitigating risks associated with COI. This is discussed in greater detail below.

## 5.4. Suggestions for managing COI

Participants' understanding of government motivations for engaging with alcohol industry representatives provides useful insights into the perceived conflict between alcohol industry economic objectives and public health goals. "public health coalition" members were more likely to describe government policy officials as naïve to the COI presented by the alcohol industry or somewhat unaware of the evidence to support regulatory measures that restrict the alcohol supply chain in order to reduce harm. However, policy officials and parliamentarians belonging to the "industry partnership coalition" described the alcohol policy subsystem as a contested space, where support across government and amongst the public for alcohol regulations was low. This lack of support was identified as a major barrier to introducing policies with the strongest evidence of effectiveness, more so than the influence of the alcohol industry. Rather, engagement with alcohol industry was seen as the main option available to government in order to take any action to reduce harm in the absence of support to introduce evidence-based measures. It could be argued that a greater understanding of the political context in which alcohol policy decisions are made, and the competing interests within governments, may inform "public health coalition" members' secondary beliefs about industry engagement: health campaigners may choose to focus more energies on building support amongst the general public for alcohol regulations, or they may be more inclined to accept the principle of industry engagement in the absence of regulatory measures, if the COI presented by industry was adequately addressed. Participants from the "public health coalition" implied that they would not oppose industry activity in restricted areas such as product reformulation, if such initiatives were based on evidence of effectiveness and were independently evaluated. A more transparent process for engagement which acknowledged alcohol industry COI in policy settings could better inform "public health coalition" members about the political trade-offs associated with alcohol policy decisions and build support for activities under certain circumstances.

An interesting finding from this study relates to how "public health coalition" members perceive the COI presented by the alcohol industry in comparison to the tobacco industry. Calls have been made from international public health researchers and campaign groups to apply the same restrictions on alcohol industry engagement in public policy as is currently applied to the tobacco industry under article 5.3 or the WHO Framework Convention on Tobacco Control (FCTC).[13, 25] However, little support was identified amongst participants for treating alcohol industry bodies the same as tobacco companies. There was an acknowledgement that public health goals for tobacco control and alcohol harm reduction were divergent in their end games: the UK aspired towards a smoke-free society, but no public health groups sought complete alcohol prohibition. The alcohol industry was perceived as a legitimate actor within UK society with a 'right' to exist and therefore a 'right' to engage with government on issues that affect their business. It can be argued that participants from both advocacy coalitions held core beliefs relating to democracy and the importance of stakeholder consultation in good governance processes, which took precedence over secondary beliefs relating to the risk of alcohol industry COI in health policy decisions: i.e. participants placed greater value on the alcohol industry's 'right' to be involved in policy decisions than the risks to public health associated with their involvement.

Excluding the alcohol industry entirely from public policy processes was not supported by participants. This finding was perhaps the most surprising for me as the researcher, as it indicated that private beliefs held by participants from the "public health coalition" diverged from public position statements identified in the literature review. It is also interesting because it implies that public health actors working in alcohol policy hold divergent beliefs to public health actors working in tobacco control, where evidence suggests no forms of engagement with industry in health policy processes are acceptable.[67] It can be seen that the interview process for this study had allowed for reflection and a "safe space" for participants to share more nuanced views on a highly contested subject. However, despite indications that some levels of industry engagement may be supported by "public health coalition" members, participants agreed that industry involvement should be subject to certain restrictions and rules relating to transparency. It was notable that no guidelines exist to inform alcohol policy processes at present, although participants demonstrated an appetite for the development of guidelines which could be agreed upon as a working framework.

Financial COI was described as the simplest form of COI to manage for the purposes of protecting alcohol policy decisions from undue industry influence. Whilst participants from both advocacy coalitions identified examples of non-financial COI that could influence public policy, these were perceived as at risk of being nebulous and difficult to regulate. Financial COI was perceived as variable depending on the context: as discussed above, the extent to which the purpose of an industry funder conflicted with public health goals could determine

the level of COI associated with their engagement. Participants described different levels of COI associated with industry funds linked to historic sales of alcohol (held for example by trusts and foundations) compared to those linked to current sales of alcohol (held by a producer or retailer). Participants also described how instances could be identified where use of industry funds could be beneficial to public health policy processes if decisions about the allocation of those funds were made entirely separately to the industry, for example in a blind trust arrangement. The variation in financial COI levels described by participants from both advocacy coalitions implies that consensus could be reached in certain contexts if the concept of financial COI was refined and sub-categories were developed according to the type of industry actor, stage of policy process, topic of alcohol policy and type of engagement activity.

Transparency was considered a key factor in managing COI and protecting public policies from undue influence. Participants from both advocacy coalitions described how unrecorded, informal engagements with decision makers were undesirable and could lead to deleterious outcomes. Formal engagements in the policy process that were a matter of public record such as meetings with officials and entertainment within parliament could be considered as acceptable forms of alcohol industry engagement by "public health coalition" members. However, whilst declarations of interest were described as important, they were not described as tools that would eliminate or reduce COI. Rather, they were described as instruments to manage COI and mitigate risks associated with covert influence. Calls for greater transparency in UK alcohol policymaking align with international guidelines for governmental institutions on engaging with non-state actors: The WHO handbook for engaging with non-state actors mandates that all WHO interaction with non-State actors must be managed transparently,[108] and the US Centre for Disease Control guiding principles for public-private partnerships identifies transparency as a core principle for effective communication with the private sector.[107] This study finds evidence to suggest policy actors from "public health" and "industry partnership" advocacy coalitions would support the development of guidelines designed to manage COI in UK alcohol policy settings which introduced greater transparency about alcohol industry financial involvement in policy processes.

## 5.5. Strengths and limitations of study

My position as both a researcher, and also as an active policy actor working in this field, is of key importance in the development and execution of this thesis. This enabled me to draw on, and caused me to reflect upon, my own background, values, knowledge and interpretation of the findings. Whilst there are many benefits of this positionality, including tacit knowledge of the policy world being investigated, detailed understanding of the relevant policy processes and the institutional contexts within which policy actors operate, reflexive consideration of my role was required throughout the research process. This led to a study design which strives to create sufficient critical distance between my positionality as a researcher and the findings

generated through continued critical self-reflection. The use of theoretical frameworks and established alcohol policy taxonomies (such as the WHO Global Alcohol Strategy[4] and Hillman and Hitt corporate political activity taxonomy[20]) identified in the literature review provided structure for the data analysis as opposed to developing new interpretative schemata and themes inductively in ways which may have been overly influenced by personal opinion and experience. Furthermore, data collection techniques were re-evaluated when interview recruitment of industry participants proved challenging, possibly due to my position as an active policy actor with perceived values and judgements on the issue of COI. Triangulation of data from interviews and document analysis also allowed for critical reflection on findings and 'testing' of interpretation against other, independently generated data sources.

The chosen focus of this research, the role of alcohol industry actors in policy processes, presents data on a limited aspect of stakeholder engagement. Other stakeholder groups and aspects of policymaking; for example the role of public health actors, the role of evidence in policy decisions, the role of media and public opinion, whilst touched upon in this study, would require further, more focussed exploration to give a more holistic picture of the role of policy actors in influencing decisions. This holistic approach was out of scope of this study, which has a narrower, specific focus.

The qualitative methods chosen generated data which is subject to interpretation. There may have been important aspects of alcohol industry involvement in policy processes which were not identified or interpreted by me as other investigators may have done. The interpretative nature of this study means it does not claim to unveil any universal truths which are automatically generalizable to other settings. However, the research methods adopted, and the interview protocol could be used for investigation in other country contexts and/or assessment of other stakeholder groups and their involvement in alcohol policy.

The strengths and limitations of the chosen theoretical frameworks were discussed in detail in Chapter 2, theoretical approaches and conceptual lenses. The chosen frameworks will have limited the scope of this study. Other policy analysis frameworks could have been chosen, for example more recently devised policy development frameworks (such as punctuated equilibrium theory or policy innovation and diffusion models) [74, 109] to describe how policy change occurs, rather than the use of the policy stages model which has limited value in reflecting 'real world' policy processes. However, as outlined in the theory chapter, the chosen frameworks were assessed on the basis of their relevance to the research questions and were considered appropriate tools for guiding the generation and analysis of data. This thesis did not seek to understand how alcohol industry actors influenced policy change, rather, it sought to investigate policy actors' perception and understanding of the role of the alcohol industry in public policy settings. Therefore, the chosen frameworks were deemed appropriate for this purpose.

## 5.6. Originality and contribution to knowledge

Prior to this investigation the issue of COI in alcohol policy settings was ill-defined and under-researched. This is the first study of its kind to explore UK policy actors' perceptions of COI in relation to alcohol industry engagement in public policy processes. It is also the first study to apply the ACF to assess how policy actors coalesce around ideas relating to COI and corporate sector involvement in public health policy. As outlined in the introduction, past studies have assessed how alcohol industry activities have impacted on policy outcomes, and how the alcohol research community views alcohol industry involvement in science.[54] Alcohol industry's COI in public health outcomes has been identified as a major cause for concern by public health actors and academic researchers. However, no investigations have been conducted assessing the views of UK policy actors, including politicians and civil servants and alcohol industry representatives, about alcohol industry's (appropriate) role in the policy process. This study therefore makes an important contribution to a growing body of evidence about alcohol industry's involvement and impact on public health. It has identified that perceptions of COI relating to alcohol industry engagement in public policy may be acting as a barrier to policy progress and has, importantly, provided an in-depth analysis which seeks to identify areas for potential consensus that policy brokers may be able to focus on in future negotiations.

This study has made an important contribution to knowledge regarding policy theory and the application of theoretical frameworks to analyse policy subsystems. The purpose of this study was not to develop a new theory per se, but to use existing frameworks in a new policy context. By using the ACF as an analytical device, I was able to identify key findings that are likely to advance policy progress to reduce alcohol harm and potentially ease enduring conflicts between alcohol policy actors. In this highly contested policy subsystem, use of the ACF helped to acknowledge that achieving consensus will be challenge and differences in deep core and policy core beliefs are likely to persist. However, assessing secondary beliefs could provide opportunities for identifying sufficient commonality to enable policy brokers to advance certain policy initiatives in pragmatic and practical ways. Whilst the data from this study shows important differences exist between advocacy coalitions in terms of their secondary policy beliefs, actually there exists sufficient common ground that offers the possibility of moving forward beyond protracted conflict. This could be done through formalising policy processes such as the development of guidelines for managing COI and principles of engagement with the alcohol industry.

By exploring perceptions, understanding and interpretations of alcohol policy actors and their lived experiences of industry involvement in UK policy, this study helps to enhance the understanding of how commercial economic operators interact with public health policy processes. These findings may be used to inform the development of guidelines on the issue

of conflict of interest and alcohol industry engagement in public policy, across all UK government departments. It is also possible that these findings may be applied to other public policy areas that are subject to contestation due to the involvement of "unhealthy commodity industries".

## 5.7. Recommendations for policy and practice

This study finds evidence to suggest policy actors from "public health" and "industry partnership" advocacy coalitions would support the development of guidelines designed to manage COI in UK alcohol policy settings. The process of developing such guidelines could facilitate policy learning among policy actors by working to agree definitions of both COI and what constitutes an alcohol industry representative. These findings indicate that greater understanding on these two issues is required.

However, this study also identified strong policy beliefs among members of the "public health coalition" that alcohol industry bodies are inherently conflicted in health policy decisions due to their economic objectives. Such beliefs have clearly led to public health actors disengaging with policy processes that involved the alcohol industry in the UK. It is recommended that any policy broker seeking to build trust and agreement with "public health coalition" members on the role of the alcohol industry must acknowledge the risk of COI and that scenarios exist where it is not appropriate to engage. The data analysis framework used in this study could provide a useful tool to facilitate discussions with policy actors about the varying risks associated with industry engagement in different policy scenarios.

Findings from this study indicate that UK guidelines on engaging with the alcohol industry in public health processes should be applied across government departments and not limited to health agencies. Guidelines on how to identify, manage and protect against COI in alcohol policy settings, informed by experiences of policy actors, would assist decision makers and nongovernmental actors in managing potential COI in order to advance public health interests.

## 5.8. Conclusion

This study sought to investigate how UK policy actors understand the issue of COI and alcohol industry involvement in health policy settings (see 1.3.1 for research questions). This line of questioning, which seeks to build a greater understanding of how policy actors conceptualise and make sense of the environment within which they operate corresponds to interpretive approaches to research which seek to *understand* rather than *explain* actions or processes. This study presents findings which enhance our knowledge about how alcohol policy actors understand the concept of COI in relation to alcohol industry engagement in policy processes. In doing so, it underlines how the UK alcohol policy subsystem is a complex and contested

space, however areas for potential consensus were identified that have as yet not been recognised in scholarly literature or current policy debates.

This study found evidence that alcohol policy actors perceive risks associated with COI and alcohol industry engagement in public policies designed to reduce rates of alcohol harm. Some evidence was found to indicate that perceptions of COI and alcohol industry involvement in public health policy processes may act as an obstacle to policy progress. An interesting finding was that, despite expressing strong beliefs that COI exists in alcohol policy settings, many participants struggled to articulate a clear definition of COI. This results from a lack of agreed definitions, norms and standards relating to COI in alcohol policy settings. In response to this gap in knowledge, this study explores and refines the concept of COI as perceived by alcohol policy actors, building a greater understanding of this issue which helps to inform this important debate.

Through the application of ACF, two competing advocacy coalitions within the alcohol policy subsystem were identified: a "public health coalition" and an "industry partnership coalition". Whilst members of the two coalitions expressed 'competing' beliefs about the nature of alcohol harm and the appropriate government policy response, a more in-depth, nuanced exploration of beliefs relating to COI and alcohol industry involvement in public health policy identified some areas for potential consensus on this issue. This finding is interesting as it deepens our understanding of a policy debate which is often presented in scholarly literature as simply a binary choice between engagement and non-engagement with alcohol industry bodies. Yet the reality is more complex than this and the implications for practise more nuanced. Rather, risks associated with COI and alcohol industry involvement in alcohol policy were described by members of both coalitions as variable and context specific, depending on the type of industry actor, the stage of policy process, the topic of alcohol policy and the type of engagement activity. Members of both coalitions described risks associated with alcohol industry engagement, however "public health coalition" members described these risks as more pronounced. Support among both coalitions was identified for certain types of industry engagement at specific stages of the policy process, such as implementation of server training schemes for licensed retail staff. This finding is important because it implies that, contrary to beliefs held by public health actors working in tobacco control, there are certain scenarios where public health alcohol actors believe the alcohol industry can legitimately be involved in health policymaking and implementation. This belief was not identified in the scholarly literature, where calls were found to subject the alcohol industry to the same restrictions as the tobacco industry under the WHO FCTC.

Whilst no support was identified to completely exclude the alcohol industry from the public policy process, certain forms of engagement were considered high risk and therefore inappropriate. These included industry involvement in drafting legislation, setting alcohol prices and government officials accepting corporate hospitality outside of parliament.

Members of both coalitions agreed that greater transparency in the policymaking process would counter risks associated with COI.

These insights were derived through the application of policy theory, in particular the ACF, to assess policy subsystems. This study demonstrates the utility of such theoretical frameworks can advance knowledge and understanding of policy communities and inform policy processes to improve public health. The findings of this study suggest that a more nuanced understanding of COI among UK alcohol policy actors, gained through policy learning, may enable policymakers to build consensus between advocacy coalition members on some aspects of alcohol policy. The data analysis framework developed for this study may prove to be a useful guide for future discussions on the role of alcohol industry actors in public health policy processes. The development of guidelines on managing COI in alcohol policy settings, that established principles of engagement with alcohol industry actors, could facilitate progress towards public health goals. The findings from this study may also inform the development of guidance on engaging with the commercial sector in other areas of public health policy where economic actors are becoming increasingly involved, such as gambling. The role of the commercial sector in health governance is one of the key issues faced by the public health community today and this study makes an important contribution to knowledge that can inform future policy frameworks for managing COI.

# DrPH Integrating Statement

The Doctor of Public Health (DrPH) programme at LSHTM "aims to equip its graduates with the experience to deal with the particular challenges of understanding and adapting scientific knowledge in order to achieve public health gains, as well as the analytical and practical skills required by managers and leaders in public health." This dual focus on training in research and leadership skills has been hugely beneficial to my personal development. I came to the DrPH programme with five years' work experience at the Institute of Alcohol Studies (IAS), a UK NGO that works to advance the use of the best available evidence in public policy decisions on how to reduce alcohol harm. I had recently been promoted to the position of Director and was seeking to 1) gain formal research training, 2) enhance my knowledge about the use of evidence in policymaking and 3) learn more about managing, developing and leading organisations. My overarching goal was to enhance the credibility and capabilities of my organisation to better achieve its aims of helping to reduce alcohol harms across society. What follows is an overview of my progress against these objectives.

The taught element of the DrPH programme allowed me to further develop my analytical skills and ability to critically appraise research. This comprised two modules, Evidence Based Public Health Policy (EBPHP) and Understanding Leadership Management and Organisations (ULMO). My first assignment for the EBPHP module was to produce a systematic review of the evidence to indicate a relationship between exposure to alcohol sports sponsorship and alcohol consumption. I enjoyed learning to navigate online databases and develop search strategies according to established criteria. By taking a structured, methodical approach to this review I was able to secure my first lead author publication in the peer reviewed journal, *Alcohol and Alcoholism*. This review has since been cited 40 times and was included in Public Health England's major evidence review of effective and cost-effective interventions to reduce alcohol harm, demonstrating that my newly acquired research skills had better equipped me to inform government policy with the latest available evidence on alcohol harm.

My second EBPHP assignment was to develop a knowledge transfer and influencing strategy to get a research-driven issue onto the policy agenda of a Ministry of Health. My chosen topic was to raise awareness of the links between alcohol consumption and increased cancer risk by developing a strategy to build support for health information on alcohol product labels. This task enabled me to acquire new skills and knowledge with respect to stakeholder analysis, advocacy coalitions, policy actor networks, message framing and the role evidence plays alongside competing interests, values and judgements. I particularly found the literature on influencing policy change, such as John Kingdon's multiple streams framework, helpful in guiding my own approach to research promotion. The skills I developed also helped me to identify key influencers and gain 'buy-in' from colleagues for my ideas: My campaign strategy was presented to the Alcohol Health Alliance UK (AHA), a coalition of medical royal colleges,

health charities, patient representatives and alcohol campaign groups that agreed to make calls for health information on alcohol labelling one of two key strategic priorities.

The Understanding Leadership, Management and Organisations' (ULMO) module introduced me to an entirely new area of research. My knowledge and expertise relating to leadership, management and strategy development had largely been acquired through on-the-job training and a handful of short vocational courses. I found the introduction to literature on organisational structures and change management extremely useful and enjoyed exploring the use of theoretical frameworks to organise my approach to strategic planning. My assignment for this module was to provide an organisational analysis of IAS, which included recommendations for future change. I used a number of theoretical frameworks including Handy's Typology and Kotter's Eight Steps for Organisational Change, and several strategic planning tools including SWOT[4], PESTL[5] and the McKinsey 7S Framework[6]. My conclusions from this analysis included recommendations for managing change, leadership style, improved evaluation and stakeholder engagement. A number of these recommendations have since been adopted, including the development of an organisational mission statement, the appointment of external Information Technology Helpdesk consultants, the introduction of project management protocols and the development of three-year business plans with measurable key performance indicators. Our stakeholder engagement activity has increased and as a result I was able to secure funding from a major cancer charity to appoint an additional staff member to coordinate the policy and campaigning activity of the AHA.

The skills and knowledge I acquired from the taught modules informed my approach to the Organisational Policy Analysis (OPA) project. For this assignment I travelled to Australia for a work placement at the Foundation for Alcohol Research and Education (FARE) a national NGO with the aim of 'stopping alcohol harm'. FARE had undergone significant change in the five years leading up to my placement, making a transition from a grant-making research institute to a policy, advocacy and campaigning body. The objectives of my OPA were to 1) review the organisational change process which had taken place through the application of models for change management in published literature, 2) to evaluate the success of these organisational changes and 3) identify recommendations for FARE to inform its future strategy. By conducting this analysis, I was able to practically apply the qualitative research methods I had learnt about in the taught modules, which included semi-structured interviews, document analysis and participant observation. I was also able to further develop my understanding of and ability to use theoretical frameworks to guide my data analysis. The stakeholder mapping exercise I conducted for this report alongside my position as an 'external

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[4] A SWOT analysis explores the strengths, weaknesses, opportunities and threats faced by an organisation
[5] A PESTL analysis assesses the external environment of an organisation according to political, environmental, socio-cultural, technological and legal contexts
[6] The McKinsey 7S model assesses organisational capabilities according to seven criteria: structure, strategy, systems, skills, style, staff and shared values

evaluator' allowed me to reflect on the role of alcohol policy organisations in the public health sector. It was an inspiring experience to learn about a larger, better resourced organisation with great ambition. I also learnt about the value of strategic planning according to available resources and managing expectations of staff, as one of the issues identified was that FARE resources were being spread too thinly and team morale was affected. This experience taught me the value of being focussed and identifying clear strategic priorities to guide organisational activities that are adequately resourced. My visit to FARE also strengthened IAS international collaborations and provided opportunities to further develop my research skills: IAS and FARE subsequently conducted joint research projects on alcohol licensing policy and alcohol industry corporate social responsibility initiatives, both of which resulted in publications that helped to raise IAS' profile.

All of the learning from the taught component of the programme and the OPA informed the approach to my thesis. The experience I had gained in developing research protocols, conducting fieldwork and analysing data were extremely valuable. Producing the thesis has been possibly the most rewarding stage of the programme as it has allowed me to step outside of my comfort zone and see alcohol policy debates from multiple perspectives. My chosen topic was 'exploring alcohol policy actors' perceptions of conflict of interest and alcohol industry engagement in UK policy processes'. My research questions were 1) How do UK alcohol policy actors understand the concept of conflicts of interest in public health policy making? 2) How do UK alcohol policy actors perceive the actual and potential involvement of alcohol industry bodies in public health policy making? 3) How does policy actors' understanding of COI influence their ideas about the legitimacy of industry involvement in public health policy making and implementation related to alcohol? And 4) How do UK alcohol policy actors' understanding and perceptions of COI and alcohol industry involvement in public health policy converge and diverge across different stakeholder groups? My motivation for exploring this topic was my involvement in a number of government initiatives to promote partnership working between public health and alcohol industry bodies that had ended in failure because public health actors objected to the involvement of alcohol industry bodies due to the perceived COI between economic objectives and public health goals. I had identified that the perceived COI relating to alcohol industry involvement in health policy may be acting as a barrier to policy progress. Furthermore, when I began my research there were no specific UK Government guidelines to manage COI in alcohol policy settings. I therefore identified a gap in knowledge that I believed warranted further investigation to stimulate policy learning. I am pleased with the findings my thesis has generated and am confident they will be useful in informing alcohol policy decisions. I have presented early findings at two international alcohol policy and research conferences and have been invited to sit as an expert advisor to a WHO Europe project on devising guidelines for member states to manage COI when engaging the alcohol industry.

As demonstrated by the information outlined above, I am satisfied that I have achieved the aims and objectives I set myself at the beginning of the DrPH programme. Since registering for the DrPH IAS has undergone two strategic reviews and has doubled in size, both in staff numbers and budget. My learning from this programme has advanced my strategic leadership skills and enabled me to succeed in gaining trust and support from funders, staff and external stakeholders. It has also enabled me to pursue a work programme that has bolstered IAS' ability to better meet its objectives of promoting effective policy to reduce alcohol harm.

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# Appendices

## Appendix A: Template email invitation to interview participants

Dear [insert name]

I hope this email finds you well. As you may be aware, I am currently studying (part-time) for a Doctorate in Public Health (DrPH) at the London School of Hygiene and Tropical Medicine (LSHTM). In order to complete this qualification, I am required to write a research thesis.

A topic that has always held my interest is how the commercial sector engages with public policy. Given my background in alcohol policy, I have chosen to focus my study on how policy actors perceive conflicts of interest with regards to engagement of the alcohol industry in public policy.

In order to generate data for inclusion in this study I will be conducting interviews with relevant individuals. I consider you as a person with key knowledge and experience that will help me explore this topic, therefore I am requesting that you consider participating.

Attached is an information sheet which provides more detail for your consideration. Interviews can be arranged at a time and location that is convenient to you and I expect they will last no longer than 1 hour.

Please note, this is not an Institute of Alcohol Studies (IAS) research project. Whilst I remain employed by IAS, my doctoral studies form part of my personal professional development and are conducted under the LSHTM research guidelines. Throughout the project I will fully acknowledge and reflect on my own position as a policy actor in the space which I am studying.

I hope you agree this is an important and underexplored area of research and will accept my invitation to interview. Please do not hesitate to contact me with any questions.

All good wishes

Katherine Brown

Version 3
Approved by LSHTM Ethics Committee 4 January 2018

**Conflicts of Interest and Alcohol Industry Engagement with Public Policy**

**Researcher: Katherine Brown**

You have been invited to participate in a research study. Before deciding whether to take part, please read the following information and discuss it with others if you wish. Please ask Katherine Brown if you have any questions, contact details below.

**Background**

This project forms the thesis component of a Doctorate in Public Health (DrPH) that is being undertaken by the investigator, Katherine Brown, at the London School of Hygiene and Tropical Medicine, University of London. The DrPH degree programme aims to equip its graduates with the experience to deal with the particular challenges of understanding and adapting scientific knowledge in order to achieve public health gains, as well as the analytical and practical skills required by managers and leaders in public health. For more information about the programme please visit https://www.lshtm.ac.uk/study/courses/research-degrees/drph

In England, alcohol places a significant burden on the NHS and public services, with 1.3 million hospital admissions and 22,000 deaths attributable to alcohol each year, alongside more than one million crimes[7]. Alcohol industry organisations occupy a prominent position in alcohol policy circles in the UK and their involvement has been contested by public health bodies. A recent report by Public Health England found evidence that alcohol industry involvement in policymaking was problematic due to their active opposition to policies recommended by the World Health Organisation to reduce alcohol harm[i8].

**Study aim and conduct**

This project aims to investigate the understanding of conflicts of interest (COI) and engagement with the alcohol industry amongst UK policy actors. It will explore, via interpretive policy analysis, how different policy actors perceive alcohol industry involvement in public policy.

A series of in-depth interviews with a range of policy actors will be conducted alongside a document review of reports and papers pertaining to COI and alcohol industry engagement with public policy. All data will be subjected to thematic coding according to a data analysis framework and will be triangulated for exploration of key themes. The primary output of this project will be a doctoral thesis and subsequent articles in academic journals may also be published using the data generated.

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[8] Ibid.

**Your participation**

Participation in this research is confidential and entirely voluntary. Any quotes taken from interviews and presented in the final report(s) will be attributed in a way that has been agreed by participants in advance. If you agree to take part, you will be invited to participate in an interview to explore your views in more detail. If consent is given, the interview will be recorded on a digital recorder. Interviews will last approximately one hour and the investigator will arrange a time and place that is convenient for you. You may ask to stop the interview at any time and/or withdraw from the study up to 14 days after the date of the interview. Upon withdrawal from the study all data collected from you will be destroyed. Please note Katherine Brown will be responsible for interpreting and presenting all data collected as part of this study, which will inform her doctoral thesis.

**Data management and how confidentiality will be ensured**

The audio files of interviews will be available to the investigator only, who will transcribe them verbatim. Transcripts will be labelled according to the identifier agreed by each participant as outlined in the signed consent form. Transcripts may be shared with the researcher's supervisory committee who will be bound by the same LSHTM confidentiality commitment as the researcher. Only the researcher will have access to a record of the identity of each interview participant, which will be kept in a separate document in a password protected file on the researcher's personal desktop computer.

Information obtained through interviews and observation will largely be used in aggregate form. Where transcripts are quoted they will be attributed to the agreed identifier as outlined in the signed consent form. All transcripts will be kept by the investigator in a secure password-protected file on her personal desktop computer for the duration of the doctorate candidature followed by a period of ten years in accordance with the LSHTM Research Data Management Policy.

**Funding**

This project forms part of the doctoral studies of Katherine Brown. Katherine is employed by the Institute of Alcohol Studies (IAS) and IAS pays her LSHTM tuition fees. IAS will fund any travel expenses related to this project.

There is no financial reimbursement for taking part in the study.

**Ethical approval**

This study has been approved by the London School of Hygiene and Tropical Medicine's Research Ethics Committee.

If you have any further questions or queries about the study please do not hesitate to contact me at kbrown@ias.org.uk 020 7222 4001

Katherine Brown
Chief Executive, Institute of Alcohol Studies
Alliance House
12 Caxton Street
London, SW1H 0QS

**Phone:** (+44) 0207 222 4001
**Email:** kbrown@ias.org.uk

# **Informed consent form**

Project title: Conflicts of interest and alcohol industry engagement in public policy
Consent form version: 2
Date approved by LSHTM Ethics Committee: 4th January 2018
Investigator: Katherine Brown

|  | Please initial |
|---|---|
| I agree to take part in the study | |
| I confirm that I have read and understood the information sheet for the above study.  I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily | |
| I understand that my participation is voluntary and that I can stop the interview at any time without giving a reason | |
| I understand that I can request to withdraw from this study prior to or during the interview, and up to 14 days after the interview has taken place | |
| I understand that if I decide to stop the interview and/or withdraw from this study up to 14 days after the interview all data collected will be destroyed | |
| I agree to have this interview recorded | |

Data use: Please select **one** of the following options:

| | |
|---|---|
| A) I agree that material from my interview may be quoted and that these quotations may be attributed to me | |
| B) I agree that material from my interview may be quoted, but I would like my name to be anonymised | |

| C) I agree that material from my interview may be quoted, but I would like my name to be anonymised as well as any other information that might be used to identify me including where necessary the organisation that employs me and my position within it. | |
|---|---|
| D) I do not agree that any material from my interview may be quoted, but the researchers may use information from my interview to inform their analysis | |

Name of Participant (please print):…………………………………………………………….

Signed:………………………………………..
      Date:…………………………............

*Complete in duplicate*
*One copy to be retained by participant*
*One copy to be retained by researcher*