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Alcohol health promotion via mass media: The evidence on (in)effectiveness

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Alcohol health promotion via mass media

- Educating individuals on drinking issues and choices via the mass media (responsible drinking, drink-driving, standard drinks, laws etc.)
- US = 'public service announcements' (PSAs)
- Social marketing (targeting audiences, eg youth)
- Counter-advertising – messages warning about alcohol's effects, industry interests, etc - can include warning labels on containers or advertisements

Introduction

Mass media health promotion campaigns are used to educate the public about alcohol issues with the aim of influencing individuals to change their drinking behaviour. Campaigns usually focus on issues and causal factors identified from broad population data and aim messages to broad general or youth audiences. They are often about things like responsible drinking and the risks of drink driving but can also provide information, such as what a standard drink is, or raise awareness about alcohol laws.

In the USA, mass media health promotion campaigns are called 'public service announcements' and airtime may be donated by broadcasters. 'Social marketing' focuses on particular target groups and their motivations. In the USA the term 'counter-advertising' is usually used for health promotion that directly attacks alcohol products or the industry, including its advertising strategies. Warning labels are a form of counter advertising. But a key purpose of all publicly-funded health promotion messages about excessive drinking or reducing alcohol related harm is to try and counter the hugely well-resourced, one-sided messages that come from the alcohol industry.

As the World Health Organisation has stated, changes in individual behaviour 'would seem to require both the provision of accurate information and the reduction of misinformation' (WHO 2002: 27).

The bad news

- Education and persuasion policies rates ineffective
  - Increase knowledge without changing behaviour
  - small positive effects are short lived
- "Despite good intentions, PSAs are an ineffective antidote for alcohol advertising."
- Little evidence of effectiveness or cost effectiveness. WHO (2002) *Prevention strategies*

The bad news is –
Most mass media health promotion campaigns on alcohol and other drugs can increase knowledge but appear to have little impact on actual behaviour. *Alcohol: No Ordinary Commodity* (Babor et al. 2003), the recent review of alcohol policy research sponsored by the World Health Organisation, looked at the effectiveness of different strategies. For mass media campaigns, a high level of evaluation research was noted but the review gave this policy strategy a zero rating for effectiveness. In fact, it gave a low rating for all education and persuasion strategies that target individual behaviour.

Evaluation research shows school-based or community based promotions targeted to particular groups of teenagers can result in some improvements, but effects are short lived and seldom do more than delay the increases in drinking that typically occur through the teenage years (see also Foxcroft et al. 2003; Midford and McBridge 2001).

Mass media alcohol health promotion campaigns (PSAs) targeting a general audience or audiences of young people are not effective. Barbor et al. (2003: 190) concluded that:

> "Despite their good intentions, PSAs are an ineffective antidote to the high quality pro-drinking messages that appear much more frequently as paid advertisements in the mass media."

Some studies showed changes in knowledge or in campaign awareness and recall – but little change in behaviour. Overall, Babor et al. (2003) found the weight of the negative evidence was more convincing than some small positive findings in some studies.

This is not news – the evidence has been around for some time. The World Health Organization's review of strategies for reducing substance abuse also found little evidence that mass media campaigns have been effective, or cost effective (WHO 2002).

For example, in Denmark a mass media campaign, supported by community action, was undertaken between 1990 and 1996. Evaluation was an integral part of the campaign strategy. Its goals were to encourage drinking in moderation and to reduce overall consumption. Evaluation found high levels of awareness of the campaign and fairly high knowledge about standard units of alcohol, particularly for beer, which was one of the campaign's messages. But only 4-5 percent of respondents said they had been influenced by the campaign to change their drinking behaviour. Twelve percent said they had reduced their alcohol consumption, with most saying this was for health reasons. The best results were obtained in the year a provocative message was used. Results were lower the next year with a softer message and a smaller campaign budget. The researcher concluded that continuous effort was needed to maintain and increase campaign effects (Boots and Midford 2001; Strunge 1998).

This Danish campaign was reviewed by Kevin Boots and Richard Midford (2001) alongside a more successful designated driver campaign as part of the Harvard Alcohol Project. This included using mass media entertainment as a vehicle for the message. Evaluation after 5 years showed two-thirds of adults said they assigned someone as the designated driver when they went out drinking. It should be noted, however, that this campaign changed *driver behaviour,* not drinking behaviour. Babor et al. (2003) reviewed studies of designation driver promotions in bars. They found impacts to be small: even intensive promotions showed modest results.

Limitations

- Difficulties measuring effects
  - Availability of indicator data may be limited
  - Outcome data reflect *all* contributing factors, not just mass media campaign
- We expect fast effects from public money, but cultures changes by slow cumulative effects
- Individuals don't change if nothing around them changes
- Alcohol health promotion is always paddling against the stream
  - large scale advertising and other marketing by alcohol industry
  - that builds on a well established culture of drinking

Limitations

Why aren't mass media campaigns more effective, when they cost so much?

Part of the problem may be the difficulty of *measuring* the effectiveness of public messages (WHO 2002; Agostinelli and Grube 2002; Boots and Midford 2001), whether these are health promotion messages or alcohol advertising itself. One difficulty is that the baseline and outcome data may be limited. Effectiveness may have to be measured against whatever relevant statistical indicators are available. Most indicators of behaviour or harm that we want to affect – total alcohol consumption, youth drinking, drink drive statistics – are outcomes that are at a considerable distance from a response to a particular message or a particular campaign on television. This is why media evaluation often looks at responses rather than behaviours. A second difficulty is that these drinking outcomes are influenced by a great many other factors in life, including policies. It is difficult to isolate the impact on outcome indicators of any one factor or strategy. However, the lack of impact by mass media campaigns on their own seems confirmed by evaluations of education and persuasion programmes for local or school populations, which can track the responses of specific groups over time but shows changes in knowledge rather than behaviour.

Health promotion campaigns are generally short and effectiveness needs to be demonstrated quickly to justify spending public money. But it may require thousands of exposures with cumulative effects to reshape a drinking culture. Research indicates that this is how commercial advertising works (Kelly et al 1996; Gerbner et al. 1986; Petty and Caccioppo 1981).

Individuals seldom change their behaviour if nothing around them changes. Drinking, including excessive drinking, is social behaviour imbedded in communities and cultures. As teenagers grow up in a drinking culture, each year brings a new cohort of young risk-takers into the alcohol market. Wagenaar and Perry (1994) point out that, for this reason, targeting young people for alcohol education and health promotion is less cost-effective than an environmental approach that, once set in place, can shape the behaviour of successive groups of young people.

A key problem for mass media health promotion is that it is always swimming against the stream – an Amazon flow of drinking culture and history fed by constant streams of alcohol supply and marketing by the industry. The alcohol industry is also a drug educator whose messages compete with those of health promoters (Stewart and Casswell 1990).

It seems to me that the small positive results from health promotion programmes are often because some people have decided not to go with the flow for one reason or another – health concerns, pregnancy, greater media or marketing 'literacy', getting a job as an alcohol researcher….

One series of health promotion ads in New Zealand took this as a theme. It depicted various situations in which, if your mate doesn't want to drink, you should respect that– "They have their reasons." This particular message may also reinforce current drinking norms, however. It appears also to be saying that any New Zealander who doesn't drink needs to have a good reason.

Social marketing

- Social goal but commercial marketing techniques
  - 'starts where people are' with the 'consumer orientation' of target groups -
  - 4P principles – product, price, place and promotion
  - Price is costs/benefits of behaviour change

  1) identify determinants/barriers of behaviour/behaviour change
  2) test and develop to 'get the message right'
  3) decide how best to deliver it to target group

- To be effective message must match readiness for change, eg. pregnant women
- Most research focuses on developing message, not evaluating its effectiveness
- Approach questioned on i) ethics ii) targeting individuals
- Social norms marketing does not decrease student drinking

Social marketing

The term 'social marketing' is used to describe recent approaches to mass media health promotion. Social marketing contrasts with 'commercial marketing' in that it has social goals. But it borrows commercial marketing techniques. The idea is to 'start where people are' and identify the 'consumer orientation' of the particular target group (Buchanan et al. 1994) – say, young teenagers, or rural male drivers in their 40s, or males aged 18-24 who go to night clubs on the weekend.

It borrows the '4P principles' of commercial marketing– product, price, place and promotion – to try and change behaviour (Ratzan 1999; Smith 2000; Buchanan 1994). Price in this case means the costs and benefits of changed drinking behaviour.

Social marketers research the needs and motivations of the target group to identify determinants of behaviour and barriers to change. They test the group's perceptions of different prevention strategies or campaign slogans, so as to create the right message for the target group. Then they decide how best to deliver that message to them (Burns and Thompson 1998; MacStravic 2001; Buchanan 1994).

Is this new social marketing approach more effective? It is often assumed that well-packaged information alone will improve health status, but there is not a lot of evidence. Most social marketing research focuses on uncovering reasons for alcohol 'demand' among young people. There is much less monitoring whether or how the messages have been received by the 'customers' and any impacts on their behaviour (MacStravic 2001). Population data on drinking is not a good measure of whether marketing messages contributed to changed behaviour or affected onset of drinking by young teenagers (Buchanan et al. 1994).

To be most effective, a message must be right for the targeted person and reach them when they are at the stage of acknowledging the problem and being ready to change (Boots & Midford 2001; Agostellini and Grube 2002). As an example, some messages that have been successful in targeting pregnant women about Foetal Alcohol Syndrome. The message matched the circumstances in which the women were ready to change their drinking behaviour.

A current New Zealand ad depicts a pregnant young Maori woman who is quitting smoking because 'it's no longer just about me'. Family, particularly descendants, is a traditional value among Maori and has been identified by social marketers as a key motivator. Evaluation shows greater attitudinal response among Maori to an 'It's about whanau' (family/extended family) advertisement series than to concurrent ads with the more individual message 'Every cigarette is doing you harm'. However, the follow-up survey one year after the campaign showed little behaviour change over baseline quit rates (Quit Group 2003).

This approach with Maori has not yet been used for alcohol. The Alcohol Advisory Council is currently planning a major social marketing campaign that aims to change the drinking culture in New Zealand among all ages and target groups.

Research shows heavy drinkers tend to underestimate risks and overestimate how much most other people drink. Campaigns in some US colleges now focus on giving students information about drinking norms among their peers. The messages avoid a moralistic tone or focusing on negative consequences. Some peer reviewed evaluations that look at drinking outcomes from these campaigns have methodology problems. A well-designed evaluation of social norms programmes in 37 colleges, based on 1997, 1999 and 2001 data from the Harvard College Alcohol Study, showed no decreases on seven measures of drinking and significant increases on two measures: 'alcohol use in the past month' and '20 or more drinks in the past month'. Those colleges with higher drinking rates at base line remained high at follow-up. Colleges that did not use social norms programmes did not show increases (Wechsler et al. 2003). This suggests that messages about norms may encourage drinking among those whose consumption is below average, but is not effective in persuading heavy drinkers to drink less.

In most cases, health promoters are trying to persuade people to give up alcohol products that the market sells them only too successfully, and to do so whether or not the consumer believes there is any risk or problem. For this reason, the whole parallel between health promotion and commercial marketing has been questioned (Brenkert et al. 2002; Buchanan et al. 1994). Questions have been raised about the ethics of borrowing manipulative commercial techniques. For example, if it is unacceptable for alcohol advertisers to imply that drinking brings sexual success, isn't it unethical for social marketers to suggest that boys who don't get drunk will be more attractive to the opposite sex? (Buchanan et al. 1994).

Brenkert et al. and Buchanan et al. believe that a moral perspective is more appropriate than a marketing one, and this should include questioning whether it is appropriate to see the individual as the 'problem' to be fixed. In their view, more focus needs to be placed on the social and policy context that shapes drinking behaviour. As the European Health Ministers have stated (Stockholm, 2001), that context includes the commercial pressures on young people to drink, including alcohol advertising, sponsorship and other marketing.

There is some evidence that redefining the problem in this way could be a more effective approach for health promotion. Some limited evaluation research shows that increasing media literacy about alcohol advertising – that is, helping children learn to be sceptical about alcohol advertisements and the industry motives behind them – can increase resistance for some months or years (Anon.2000; Austin and Johnson 1997).

There is strong evidence from US campaigns targeting the tobacco industry that mass media counter-advertising campaigns can be effective (Babor et al. 2003). Teenagers may resist parental views or education about health risks but did show a significant response to hard hitting television advertising about how the tobacco industry tries to manipulate them into smoking (Farrelly et al. 2002; Sly et al. 2001). The campaign was pulled after a year for cost reasons.

This response by young people in the US goes beyond one ad campaign against tobacco, however. Alcohol as well as tobacco are among the examples of manipulative brand marketing cited by anti-globalisation campaigners (Klein 2001). Many of the techniques of modern marketing were developed in these industries (Clark 1989; Buchanan and Lev 1989).

Counter-balancing alcohol advertising?

- Counter-advertising that targets industry may change motivation, but "Nothing in the research to suggest powerful outcomes within realistic budgets." (Barbor et al)
- Huge differences in resources and exposure between alcohol ads and health promotion ads
- Policy on alcohol advertising and other marketing is key to alcohol health promotion effectiveness
- Precautionary approach recommended (Babor et al. 2003)

Can health promotion counter alcohol advertising?

Babor et al. report that, in most countries, alcohol health promotion messages are a fraction of the total volume of alcohol advertising and are seldom seen on television. Here we return to the image of alcohol promotion chugging against the stream, reaching out to young swimmers and drowners, while the ship of commerce cruises past on a flood of alcohol.

Let's look at the New Zealand example. New Zealand does have frequent alcohol health promotion ads on television and radio. Free broadcasting time is provided for alcohol health promotion advertising as part of the 1992 deal that allowed alcohol brand advertising on television after 9 pm. Anti-drink-drive advertisements are made by the Land Transport Safety Authority, which is funded from petrol taxes. Moderate drinking campaigns are made by the Alcohol Advisory Council (ALAC) which is funded from a 2 percent levy on alcohol.

But these alcohol health promotion messages are swamped by commercial messages promoting alcohol. In 1997 alcohol advertising exposure in all media was around 10 times greater than alcohol health promotion exposure (Hunter 1997). In 2000 a sample of weekend television showed a ratio of one alcohol health promotion ad to every five alcohol ads. This count did not include alcohol brand logos at the beginning and end of each segment of alcohol sponsored sports programmes, which may be on at any time (Hill 2000).

In September 2003 the New Zealand self-regulatory body for advertising standards extended the permitted hours of alcohol advertising from 9 pm to 8.30 pm. The change was opposed by public health organisations, including the Ministry of Health and ALAC. At that time, 26 percent of 10-17 year olds are watching television, dropping to around 10 percent by 11 pm.

Given the difference in resources between the industry and health promotion agencies, government policy on alcohol advertising is of key importance. There is now a large body of research evidence showing how alcohol advertising influences the attitudes of young people towards alcohol and their later drinking behaviour (Babor et al. 2003; Hill and Casswell 2001).

Self-regulation of alcohol advertising by the industries concerned is not a satisfactory approach. Voluntary rules are vulnerable to collapse, as with the Australian code on alcohol advertising in 1991. A great deal of public health effort goes into contesting the content of advertising codes and making complaints about advertising that bends the rules. But the codes are largely irrelevant to the way alcohol advertising and other promotional strategies work. They cannot address the way modern marketing links alcohol to the lifestyles to which young people aspire and embeds brands and drinking into their lived experience through sports, music and other activities (Hill and Casswell 2001).

A key aspect of alcohol advertising under voluntary codes is that it takes an important aspect of health policy out of the hands of government and leaves decisions to be made by industries with a vested interest.

Many countries have policies or restrictions limiting alcohol advertising in the broadcast media. Most bans are partial – restricting the hours of broadcasting or what beverages may be promoted or to commercial channels or stations only. The research evaluating bans on broadcast alcohol advertising

is not extensive. Although bans implemented for a short period did not impact on total alcohol consumption, there is some evidence of effectiveness in reducing alcohol related harm.

In considering policy on alcohol advertising, Babor et al. (2003) recommend that governments should be guided by guided by the Precautionary Principle.

It seems to me quite illogical that the sale of alcohol is a regulated licensed activity in all developed countries, yet the marketing and promotion of alcohol is left to industry self-regulation as if this were not about alcohol sales at all. Reducing the promotion of alcohol is surely the first step towards making alcohol health promotion and other alcohol policies more effective.

Responsible alcohol advertising?

- Alcohol warning labels – little evidence of changed behaviour
- Alcohol company 'responsibility ads'
  – placements mean adults twice as likely to see them as teenagers
- Drink-drive messages in bar promotion ads *reduce* perceptions of risk
- Industry partnerships with public health on responsible advertising
  – helps them set limited agendas and constrain public health strategies
- Government policy on alcohol advertising key to alcohol health promotion

One way of trying to counter alcohol promotion, while conceding 'freedom of commercial speech', is to require health warnings on alcohol containers or on alcohol advertisements. There is some evidence that US warning labels on alcohol and tobacco do reach target audiences – for example, increasing awareness of foetal alcohol syndrome among pregnant women. Warnings on alcohol containers do not appear to increase perceptions of risk among student drinkers, however. Babor et al. (2003) conclude that alcohol warning labels can increase awareness but, as with other education and persuasion strategies, there is little evidence that they change drinking behaviour.

Health promotion's focus on the drinker and individual behaviour, rather than the risks inherent in the product, is reinforced by alcohol producers. Positioning themselves as good corporate citizens, they support policies and promotions that educate young people to drink responsibility. This may include educational messages from alcohol companies themselves, perhaps forestalling health warnings or possible regulations imposed by government.

In the USA, resources for health promotion are limited and alcohol companies have become a primary source of television messages about alcohol abuse. The Center on Alcohol Marketing & Youth undertook a study of 'responsibility ads', based on industry data from national network and cable and local broadcast channels. The study included all television ads in 2001 that had a clear unambiguous message about drinking responsibly, drink-driving or underage drinking. Industry expenditure on this responsibility advertising was 2.9 percent of the amount they spent on product advertising. Audience exposure (age 12+) was 45 times greater for alcohol advertising than for responsibility advertising. The findings on ad placement are interesting. Adults were twice as likely as 12-20 year olds to see the responsibility ads. The researchers noted that alcohol companies were better at reaching young people with product ads than they were at reaching them with responsibility ads (CAMY 2003). Or are adults perhaps the best target audience for corporate responsibility messages?

How are responsibility messages in alcohol ads perceived by young drinkers? An experimental study looked at student responses to messages about drink-driving responsibility on advertisements for bars that offer free appetisers, a happy hour or other cut-price promotions. The messages influenced the students' perceptions about management concern for customers, but *reduced* their perceptions of drink-drive risks. Students who typically drank at hazardous levels responded more strongly than non-

binge drinkers to the cut-price promotions and largely disregarded the responsibility messages (Christie et al. 2001).

A precautionary approach should be taken to alcohol companies or industry-funded 'social aspects' organisations who propose a partnership approach to health promotion. Experiences of partnerships with industry show that their purpose is to secure a place at the table and influence strategies. With industry involvement, alcohol health promotion will continue to focus in individual responsibility, 'problem' drinkers and changing the 'culture' of heavy drinking while ignoring industry interests in normalising and extending consumption (Anderson 2000; McCreanor 2000).

An example of protecting industry interests was the Partnership for a Drug Free America. The involvement of alcohol, tobacco and pharmaceutical companies kept these substances off the agenda, despite causing more harm than illicit drugs (Buchanan and Wallack 1998).

Conclusion

- Mass media campaigns and education
  "Cost-effectiveness and cost-benefit are poor." (Babor et al. 2003)
- Stronger strategies are availability restrictions, taxation and enforcement
- A package of policies implemented systematically
- Role of mass media campaigns in package
  - raising awareness of issues and policy package
  - increasing legitimacy of regulatory strategies

Babor et al. (2003) concluded that mass media alcohol health promotion campaigns on their own or as a main strategy show poor cost-effectiveness and cost-benefit. The policy evaluation research shows clearly that availability restrictions, taxation and enforcement of alcohol laws are much stronger strategies than mass media alcohol health promotion.

Babor et al. also conclude that complementary strategies that seek to restructure the total drinking environment are more likely to be effective than single strategies (p. 271). They recommend using multiple policies in a systematic way.

Mass media campaigns have been part of successful packages of policy strategies. Their role can be to raise awareness of the issues and increase the legitimacy of policy strategies being put in place, such as increased law enforcement. For example, in regard to drink-driving in New Zealand, a policy package in 1993 included law changes to allow random compulsory breath-testing, with high profile police enforcement (using 'booze buses'). There is dedicated funding for police enforcement of traffic laws. As part of the package, media campaigns carried very hard-hitting messages about the risks and consequences of killing other and about the new law on random compulsory breathalysing – 'anywhere, anyone, anytime'. The proportion of traffic fatalities involving alcohol fall from 40 percent in 1991 to currently 22 percent (Guria et al. 2004). Comparison with an earlier advertising campaign against drink driving showed that it was the link to strong enforcement that made the media campaign effective (McPherson and Lewis 1998).

This reduction in drink-drinking was not accompanied by change to more moderate drinking. In fact, amounts and frequency increased among young drinkers over the 1990s, a period in which licensing laws and alcohol advertising was liberalised. The NZ Drug Foundation is currently advocating the following package of policies to address hazardous drinking:

- higher excise tax rates to affect prices
- a higher minimum age of purchase and a requirement to actually ask for photo IDs
- increased resources for enforcing licensing laws
- greater local control over location of licensed premises, density and hours of trading

- community action including enforcement, health promotion and media advocacy
- discontinuation of alcohol advertising on radio and television.

This package of policies includes the tax and availability restriction strategies that Babor et al. found to be most effective. Mass media campaigns as part of are likely to be more effective as part of this package than relying on social marketing campaigns alone to change the drinking culture and behaviour of individuals.

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