The Royal Australasian College of Physicians (RACP)
Submission to:

The Senate Committee Inquiry into the Alcohol Toll Reduction Bill 2007

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Introduction

1 The Royal Australasian College of Physicians (RACP) takes this opportunity to make the following submission to the Senate Committee Inquiry into the Alcohol Toll Reduction Bill 2007

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The proposed Alcohol Toll Reduction Bill 2007 identifies four broad areas

- Require health information labels on all alcohol products;
- Restrict TV and radio alcohol advertising to after 9pm and before 5am, to stop alcohol being marketed to young people;
- Require all alcohol ads to be pre-approved by a government body comprising an expert from the medical profession, alcohol and drug support sector, accident trauma support sector and the alcohol industry;
- Ban alcohol ads which are aimed at children or which link drinking to personal, business, social, sporting, sexual or other success.

The RACP endorses these proposals, and recognises that they will go towards reducing alcohol related harms in the Australian community. However, the RACP believes that additional action should be taken to create a culture of responsible drinking and to facilitate a reduction in the alcohol toll resulting from excessive alcohol consumption. The RACP recommends that the Senate Committee to consider the following areas in relation to the proposed Bill:

1. Alcohol taxation reform and pricing

- consider alcohol taxation from a public health perspective as well as an economic perspective;
- move from ad valorem to volumetric taxation;
- substantially reduce the differences in rates of taxation between and within beverage types, whilst encouraging taxation relief for low-alcohol beverages (e.g. light beer)
- set aside a proportion of taxation dedicated to funding alcohol prevention, treatment and research.

2. **Ensure a harm reduction framework in addressing alcohol-related harms in the community by:**

- Increasing knowledge about responsible drinking;
- Promoting awareness of the adverse effects of alcohol consumption during high risk periods such as adolescence and pregnancy;
- Promoting the use of clear, easily readable labelling which indicates alcohol content;
- Facilitating community action to prevent and address alcohol-related problems, particularly in Indigenous communities;
- Advocating for a reduction of alcohol-related crime and violence through environmental changes that reduce damage created by and to intoxicated people.

3. **Drink driving counter measures**

- Ensuring that a high proportion of drink driving offenders are successfully referred to intervention programs which are based on evidence of effectiveness;
- Increasing the availability and utilisation of ignition interlock devices both on a voluntary capacity and as part of sentencing to convicted drink drivers; and,
- Fostering mandatory referral of severe or recurrent drink driving offences to alcohol treatment services.

4. **Advertising and promotion**

- Increasing the independence of the regulatory system for screening all advertisements prior to display or broadcasting;
- Promoting an advertising system which encourages people to complain, if they regard the alcohol advertising as an infringement of the agreed guidelines;
- Introducing the hypothecation of alcohol taxes to fund targeted and well evaluated awareness programs;
- Introducing an independent statutory body to develop and run an independent regulatory system funded by hypothecated alcohol taxes;
- Ensuring that community representation and alcohol beverage industries have equal power on decision making; and,
- Promoting the widespread dissemination of code violation by industry.

5. **Treatment**

- Expanding health workforce capacity to deliver treatment interventions for individuals with alcohol problems;
- Increase the number and accessibility of effective treatment options, including detoxification, counselling and pharmacotherapy-based (e.g. acamprosate, naltrexone and supervised disulfiram) treatment;
- Developing effective services targeting alcohol misuse in young people;
- Promoting through systematic marketing alcohol treatment services such as is done for tobacco cessation;
- Encourage greater use of screening for alcohol-related problems, particularly in acute hospital and primary care health settings;
- Facilitate and monitor the implementation of brief alcohol interventions in primary and acute care health settings;
- Encourage multidisciplinary treatment systems;
- Identifying occupations in which workers are at higher risk of alcohol-related problems and enhance the capacity of occupational health services to identify and treat people with alcohol-related problems in these industries; and,
- Improving accessibility of services to Indigenous and ethnic minorities.

1. Background

In 1977, a Senate Standing Committee on Social Welfare ('Drug Problems in Australia – an Intoxicated Society?) determined that 'alcohol problems were of endemic proportions'. Per capita alcohol consumption in Australia reached a peak in the early 1980s and has since declined by about 25%. There is a close correlation between per capita alcohol consumption and alcohol-related harm for individuals and in the community because the majority of alcohol consumed in a community is drunk at high risk of acute or chronic harm. The focus of a policy should be to reduce the health, social and economic costs of alcohol and that can only be achieved by reducing the quantity of alcohol consumed at high risk of acute or chronic harm.

Alcohol imposes a huge burden on Australia. It causes as much death and disability globally as measles and malaria. Far more years of life are lost to alcohol in the form of death and disability than for tobacco or illegal drugs.[1] High levels of serious harm should not be regarded as inevitable. There is strong agreement among researchers into alcohol policy around the world about which policies are effective and which are ineffective.

Each year there are an estimated 3,500 alcohol related deaths. Every such death represents a loss of 20 expected years of life. Experience of social harm is common with 21.9% of Australians reporting being verbally abused by a person affected by alcohol in the previous 12 months, 11.8% put in fear and 3.7% physically abused by an intoxicated person. Alcohol cost the Australian economy an estimated $7 billion in 2003/04.

Evidence based alcohol interventions are common practice even though these approaches have been shown repeatedly to not work. The general rule is that "what's popular doesn't work and what works isn't popular". In Australia the major political parties receive generous donations from the alcohol industry. The Royal Australasian College of Physicians (RACP) recent publication, Alcohol Policy: Using evidence for better outcomes is an attempt to develop an evidence-based approach to the problems associated with alcohol should reflect the work of the Senate Committee as well as the World Health Organization publication, 'Alcohol: No Ordinary Commodity.'

Increasing alcohol prices and reducing availability are the single interventions best supported by evidence of effectiveness in reducing problems at the population level.

The RACP recommends the following strategies to reduce the alcohol related morbidity and morality.

2. Alcohol taxes and prices

The single intervention best supported by evidence is slightly increasing alcohol prices. Australia should move towards taxing drinks according to their alcohol content rather than according to their beverage class or price (*ad valorem*). Hypothecating a small proportion of alcohol taxation to pay for alcohol prevention and treatment ensures strong community support (even if it is guaranteed to get Treasury offside).

The Federal government has increased taxes on beer and spirits, but without an increase in the tax on wine, the net effect will simply be a gift to the wine industry. Cask wine, one of the favourite beverages of low-income groups in Australia, is currently taxed at a fraction of bottled wine. Correcting these anomalies will be a huge boost to public health, especially Indigenous Australians, but may cost some political capital. Also, raising alcohol taxes is inflationary. Alcohol taxes are mainly generated at the Federal level while expenditure (e.g. hospitals, police, prisons) is predominantly at the state level. Thus one of the alcohol taxation policy questions which needs to be thought about is the matter of vertical fiscal imbalance.

This means that the impact of alcohol taxation policy on state and territory expenditure should be taken into consideration. Nor is the need for alcohol taxation reform simply required on the grounds of public health.

When alcohol taxes were increased in the Northern Territory in the 1990s, there was a remarkable decrease in several indices of alcohol related harm. Unfortunately, this tax had to be terminated after a High Court decision determined that it was unconstitutional. This approach, termed the 'Living with Alcohol' program was regarded as highly effective and had strong community support. It deserves to be revived and made a national program.

Alcohol problems have been increasing alarmingly in Britain since 1998. In March 2008, the Chancellor of the Exchequer, Alistair Darling, announced that alcohol taxes would increase by 2% more than inflation for the next four years. Opinion polls showed that this policy was strongly supported by the public.

Increasing the price of alcohol reduces consumption and reduces harm. Alcohol dependent persons also reduce their consumption when prices are increased. Alcohol prices have increased in line with inflation since a reform in the early 1980s. However the real price of alcoholic beverages has actually decreased in many countries over the last 50 years. Care must be taken to increase prices and taxes to a level which dissuades smuggling or illicit production but keeps level with other consumables. Reducing taxes on low alcohol content beverages has proved very effective in Australia and highlights the need for more alcohol taxation reform notwithstanding the political difficulties of achieving this.

3. Availability

Slightly reducing the availability of our favourite drug by reducing the number of outlets and restricting outlet conditions reduces the harms resulting from alcohol. Increasing the responsible serving of alcohol reduces aggression and violence. Requiring more safety measures in pubs reduces harms resulting from intoxication. This could include mandatory shatter proof glasses and the introduction of chairs and tables that are too heavy for drunken patrons to pick up and throw. Alcohol availability is mainly decided at the jurisdictional and local level. Often the substantial resources of powerful alcohol retail outlets are pitted against weak communities.

Access to alcohol can be reduced by decreasing the hours and/or days of opening (such as limiting weekend trading) and the number of dispensing venues.[2] Levels of alcohol-related harm in a given geographical area are closely related to the number of alcohol outlets in that area. Even small changes in late night hours can assist to reduce local levels of harm.[3] Another successful strategy for limiting access includes reducing and enforcing the minimum legal purchase age.[2]

Also highly effective is limiting on-premises alcohol sales. It has been found that on-premises drinking accounts for the minority of consumption, but is the most prone to cause trouble.[2] Effective measures to limit alcohol consumption and therefore to lower Blood Alcohol Counts (BACs) include serving food, promoting low alcohol beverages, changing serving policies to cease sales to intoxicated patrons, and training bar staff in managing problem behaviour. Banning of happy hours and discounting drinks can also assist.[3] In addition, American literature reviewing dram shop laws in the US and Canada that allow persons injured by an intoxicated person to sue the licensee who served the alcohol show these to have a slight deterrent effect.[3] Government monopolies of alcohol sales assist to regulate alcohol availability and pricing.[2] Privatisation increases the levels of alcohol consumption and problems.

4. Drink driving countermeasures

Drink driving strategies work best if enforcement results in swift, certain and severe punishment. Australia has a good record in this area. Alcohol measures have helped Australia to reduce our road toll by about two thirds over the last thirty years.

Stricter driving regulations are more effective if measures are highly visible and enforced repeatedly and consistently. Proven measures include immediate licence suspension for drink-driving charges; obvious sobriety checkpoints with non-selective breath testing for drivers; a low legal limit of blood alcohol content for drivers; interlock devices in cars to link alcohol content with car ignitions for high-risk repeat offenders; and graduated licences for novice drivers proscribing the hours and places they can drive. [2]

5. Advertising and promotion

Advertising promotes the view that alcohol can be consumed without risk. The alcohol beverage industry in Australia decides the rules, appoints the judge and jury and then runs the system. There is no evidence that self regulated alcohol promotion and advertising is effective. Beer advertising still flourishes at all five major motor sports events in Australia each year. Yet the alcohol beverage industry in many other countries do not advertise alcohol at motor sports events. Although increasingly restricting alcohol advertising is regarded as the centre piece of the forthcoming Senate enquiry, the evidence available does not justify this strategy having this priority. At best, restricting alcohol advertising and ending self regulation should be regarded as supportive but not primary strategies.

Government regulation of alcohol advertising has been found to be effective whereas voluntary codes are ineffective. [1] Warning labels has not proved effective in changing behaviour. [4]

6. Education campaigns

Conducting education campaigns is a popular strategy despite evaluations demonstrating that these campaigns have at best only small and transient benefits. Physicians know from first hand more about the damaging effects of alcohol than any other professional or occupational group in the community. Yet the medical profession is one of the occupations most severely affected by the devastating effects of heavy drinking.

7. Treatment

Treatment and early interventions have been shown to be effective for people troubled by alcohol in a large number of rigorous trials. However, the severe stigma of alcohol dependence and the consequent parsimonious funding provided to alcohol treatment means that only a small proportion of those in trouble ever benefit. What is needed is more support for self help groups, detoxification, pharmacological treatments and brief interventions. Hospital based alcohol and drug departments make a significant contribution by providing treatment to the large volume of alcohol dependent patients attending major hospitals, by educating medical and nursing students and through much-needed public advocacy.

A number of treatments and interventions work for those with alcohol dependence, for those who have perpetrated violence while intoxicated and for those who have driven while intoxicated. Counselling programs work best when they are of longer duration than 10 weeks, with rules of attendance prescribed by a court. Behavioural treatments are more effective than treatments based on insight. Brief counselling interventions have been shown to ameliorate harm from alcohol. [2]

There is a dearth of detoxification units, rehabilitation centres and counselling services. Those that exist are substantially under-funded. For example, the 20-bed detoxification unit at St Vincents Hospital is under-funded by about $400,000 per year. This shortfall is met with great difficulty through fundraising.

Increasing treatment options goes hand-in-hand with ensuring appropriate education for health and welfare professionals. The RACP have proposed that financial support schemes be reinstated to support education in addiction medicine for health professionals. There should be appropriate training of all health care workers in the recognition and management of alcohol use disorders, with an emphasis on indigenous alcohol and drug workers. The Colleges have undertaken to use their own resources to ensure appropriate training measures are available for their Fellows. This should be supported politically and financially by government. [6]

Greater encouragement is required for the use of pharmacotherapies such as acamprosate, naltrexone and supervised disulfiram which have been proven to be extremely effective for alcohol dependence. [2, 6]

8. Alcohol consumption, costs and benefits

Many Australians enjoy alcohol. The industry also employs many people. Draconian policies are unnecessary and are also unsustainable. There is copious information available to guide an evidence-based Prime Minister in choosing reasonable and effective policies.

The 20% heaviest drinkers in a community consume about 70% of the alcohol. The drinks industry knows that without people drinking at high risk of acute or chronic harm, their industry would earn a fraction of its current profits. Australians now consumes about 25% less alcohol per person than we did when a Senate Committee concluded that 'alcohol problems' were of 'endemic proportions'. But we are still drinking more per person than we did for most of the last century. Reducing the quantity of alcohol consumed at high risk will inevitably decrease the high health, social and economic costs we currently pay for our favourite drug.

The increasing emphasis on promoting competition to improve economic efficiency has undermined many alcohol control policies. [2] In addition, alcohol is a part of everyday life. It is an important part of our social fabric, a critical ingredient in our rest and relaxation, an element of celebration and partying, a symbol of adulthood and of mateship. [2] The complicated relationship between alcohol consumption and mortality has been grossly over - simplified to encourage increased alcohol consumption as a way of improving health. Yet there are many safer and more effective ways of improving the health and well being of the community without taking the risks associated with increased alcohol consumption. [1]

For most of the population, the net effect of alcohol is negative. This is because most of the harm that stems from intoxication is associated with those people who do not generally drink excessively, but only occasionally drink to intoxication and beyond. As at least two-thirds of alcohol in Australia is consumed in this way, measures that reduce overall consumption will also reduce risky consumption and *vice versa*. [2]

Alcohol also makes an important contribution to the Australian economy. This includes the influence of the alcohol and hotel industries, the overseas success of Australian wines and the part that alcohol plays in many people's livelihoods, from supermarkets to restaurants.[3] However, the health, social and economic costs to Australians are very substantial and it is unclear whether the net economic effect of alcohol is positive or negative.

Medicine and science have identified effective intervention strategies. But the evidence-based interventions which have been shown to lower the unacceptably high costs of alcohol on our health, society and economy are difficult to thread through the political maze. The adoption, implementation and funding of these strategies is determined through the political process.[4] Strategies which are least supported by evidence are often the first to be adopted even though "the difference between good and bad alcohol policy is not an abstraction, but very often a matter of life and death". [2]

It is important to remember that the alcohol beverage industry represents about 2-3 % of GDP. The industry commands great political influence. Advertising placed by the industry in the media is another important factor which also makes it difficult to adopt and implement effective alcohol control policies which will inevitably decrease alcohol per capita alcohol consumption as such a large proportion of alcohol consumption is drunk at high risk.[4] Although there are some small areas where the interests of the community and the interests of the alcohol beverage industry do overlap, mostly the interests of the community and the alcohol beverage industry are in conflict. Many effective alcohol control policies have been introduced in Australia over recent decades despite vigorous opposition from the drinks industry. Australia may have been the first country in the world to introduce low alcohol beer. This occurred despite sustained opposition from the drinks industry.

There is increasing consideration being given to the possible need for an international convention to respond to global alcohol issues. These issues include the globalisation of the alcohol beverage industry. Production of beer and distilled spirits for export is concentrated in the hands of a few large companies mostly based in developed countries. These companies have recently intensified their efforts to establish new markets in developing countries and countries in transition, and among groups who have traditionally drunk very little such as women and young people.[1]

The World Health Assembly of WHO has shown increasing interest in tackling alcohol problems including the appointment of a WHO Expert Committee on Alcohol in 2006, the adoption of a Regional Strategy to Reduce Alcohol-related Harm by the WHO Western Pacific Region, and a resolution for consideration this year on alcohol problems co-sponsored by 40 member countries.[4] WHO have also highlighted the need for an international convention to treat alcohol differently, labelling its 2003 report "Alcohol: No Ordinary Commodity."[2] Such a convention would enable alcohol to be separated from GATT and WTO agreements and enable a higher degree of domestic control over alcohol taxes. [4]

It is also important to be realistic about strategies which are often popular despite being ineffective. Ineffective strategies include prohibition, education and persuasion programmes, including school programmes, promoting alternatives to alcohol (such as sport) and designated driver and ride services. [2]

In one study, a combination of taxes, advertising bans and brief interventions saved 983 Disability Adjusted Life Years (DALY), at a cost of $US2528 per DALY. [4,a]

[a] The Disability Adjusted Life Year or DALY is a health gap measure that extends the concept of potential years of life lost due to premature death (PYLL) to include equivalent years of 'healthy' life lost by virtue of being in states of poor health or disability. The DALY combines in one measure the time lived with disability and the time lost due to premature mortality. One DALY can be thought of as one lost year of 'healthy' life and the burden of disease as a measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability. DALYs for a disease or health condition are calculated as the sum of the years of life lost due to premature mortality (YLL) in the population and the years lost due to disability (YLD) for incident cases of the health condition:

Adoption of these strategies in Australia will guarantee a reduction in the harm caused by alcohol. Provision and funding for evaluation should of course be built into any programmes initiated, in order to add to the global evidence regarding their effectiveness.

The RACP would be pleased to speak to the Committee to expand on these issues.

References

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[4] The Royal Australasian College of Physicians (RACP) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) (2005). *Alcohol Policy: Using evidence for better outcomes*. Sydney: Royal Australasian College of Physicians.