(PART 1)

Donald Cameron
State Director for Victoria
People Against Drink Driving

6 Edgewood Ave
Castle Hill
NSW 2154

Ph (02) 9894 1292
Email: bitsy2@optusnet.com.au

SUBJECT OF SUBMISSION: "Alco-Pops" and related matters (Part 1)
Part 2 follows commencing with COVER PAGE Selected items of "BRIDGING THE GAP".

Attention: THE SECRETARY
Senate Community Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

The following information has been sourced from various publications and listed accordingly.

It's quite clear about alcohol!

By Rev Dr Gordon Moyes
From the Uniting Church News Magazine

The people at Drug-Arm Australia would like adults to take a second look at that apparently healthy stuff that many young teenagers are carrying along to parties and friends' places these days.
It may be that the young people are being exploited by big business, and they or others may suffer.
For it may be that the clear glass bottle with the fashionable clear liquid inside is not just mineral water or spring water, but alcoholic lemonade, or alcoholic fruit juice rather than plain, healthy fruit juice.
They go by names such as Sub-Zero (soda with 5.5 per cent alcoholic content), e33 (an alcoholic cider and soda by Orlando), and a few others such as Orange Jubilee, Kiwi Lemon, LXR8 and Vault.
The president of Drug-Arm Australia, the Rev. Gordon Moyes, says Generation X-ers consumed more than 3 million cases of these drinks last year.
They all look like the sort of drink that could be found in kids' schoolbags, he says. "The trouble is, where they *are* being found, and people are not aware that they are more potent alcoholically than beer".
Some more awareness of this among parents and friends of young people is one of the results hoped for by the organisers of Drug and Alcohol Awareness Week.
Dr Moyes also wants the churches to name the brewers, retailers and advertisers of such products as drug pushers.

ALCOPOPS, LIQUOR POPS AN ATTEMPT TO ENTICE YOUNG PEOPLE AND CHILDREN TO USE ALCOHOLIC DRINK.

Manufacturers and suppliers of Alcopops have admitted targeting under-age drinkers to investigative reporters from The Sunday Times UK. (a)

Alcopops are drinks with alcohol added and may be in the form of fruit juice, lemonade, soda water, milk etc. and they contain 4-6% alcohol.

Liquor Pops are fruit-flavoured ice blocks in plastic tubes, containing 6 per cent alcohol- stronger than the average beer.

Children will invariably get their hands on alcoholic icy poles as once the wrapper is removed the Liquor Pop will look like any other icy pole.

It is recognised by some media that Liquor Pops set out to appeal to the young people in our society. (b)

These were likely to be classified as food - like liqueur chocolates, thus exempting them from liquor laws.

Both these products may only be available from licensed outlets, but once they are placed in the family refrigerator, or freezer they are available for use by any child who can read that the label shows fruit juice, lemonade, milk etc.

Therefore controls to ensure that these are only sold in liquor outlets have little effect on preventing children accessing them.

The Federal Health Minister, Dr. Michael Wooldridge, has condemned the sale of alcoholic icy poles, calling on the manufacturers to withdraw the products from sale for the health and well being of young people. "Enticing young people, especially pre-teens, with a confectionery type product which is laced with alcohol is unconscionable."
"The manufacturer, Unique Beverages, is behaving in a totally irresponsible manner and I call on them to rethink placing this potentially dangerous product on the market." he said. (c)

(a) The Sunday Times UK, 11th May 1997
(b) Daily Telegraph NSW, Jan 2nd 1999 p 7
(b) Herald Sun NSW, 12th Jan 1999 p 1 & 2
(c) Media Release Dr. Michael Wooldridge, Jan 12th 1999

Binge Drinking

By Dr Keith Suter, Consultant for Social Policy.

Alcohol Pricing
The World Health Organization has supported the publication of "Alcohol-No Ordinary Commodity" in which it lists 32 policy options for combating alcohol-consumption. Top of the list are increasing the price of alcohol and limiting its availability.
This is in direct contrast with the global pattern of alcohol pricing. In virtually every country, the price of alcohol has gone down in recent years. For example in the UK, alcohol costs roughly half what it did in the 1970s. Governments have been reluctant to keep taxation on alcohol in line with inflation. In the UK, the Blair Government in its published new strategy on combating alcoholism has ruled out a tax increase. In the US, the federal tax did not increase at all between 1951 and 1990.
Young kids, with less money to spend, are most sensitive to price hikes on any goods or services. There is a flow on effect: if your friends cannot afford to buy alcohol, then there is less chance that you will. The message is clear: increase the tax on alcohol.

This material was broadcast on Radio 2GB's "Brian Wilshire Program" on 8/10/04

Time to reassess the role of alcohol in our lives

There has been concern for many years now that too many alcoholic beverages are being marketed to the young - the lure of the so-called "alcopops" that taste like soft drink but pack the full punch of the alcohol in them. It is high time manufacturers started to be more responsible about who is drinking these products – after all, the point of having a legal drinking age is that our society deems alcohol unsafe for people under 18. At the same time, we need to consider how alcohol is advertised, how it is made available, how well-policed underage drinking is and what kind of education programs are in place for young people.

The Age Newspaper Melbourne 15 April 2007

Time Bomb Waiting to Happen

By Jill Stark *Melbourne Age 5 May 2007*

Drinking Levels

41% of 18-24 year olds who regularly drink so much pass out.

33% regularly drink more than 10drinks in 1 sitting.

22% have passed out at least once.

51% of Victorians aged 16 to 24 drink at risky or high risk levels.

35% rise in alcohol-related emergency department presentations in Victoria.

10% of Australians drink enough to risk brain injury.

35% of 14 to 19-year-lod Australians drank at dangerous levels either weekly or monthly in 2004.

Cost of Alcohol

$7.6 billion to Australian economy.

$1.2 billion lost by Australian business.

$7.5 million in working days lost.

$50 billion annual turnover of alcohol beverage industry.

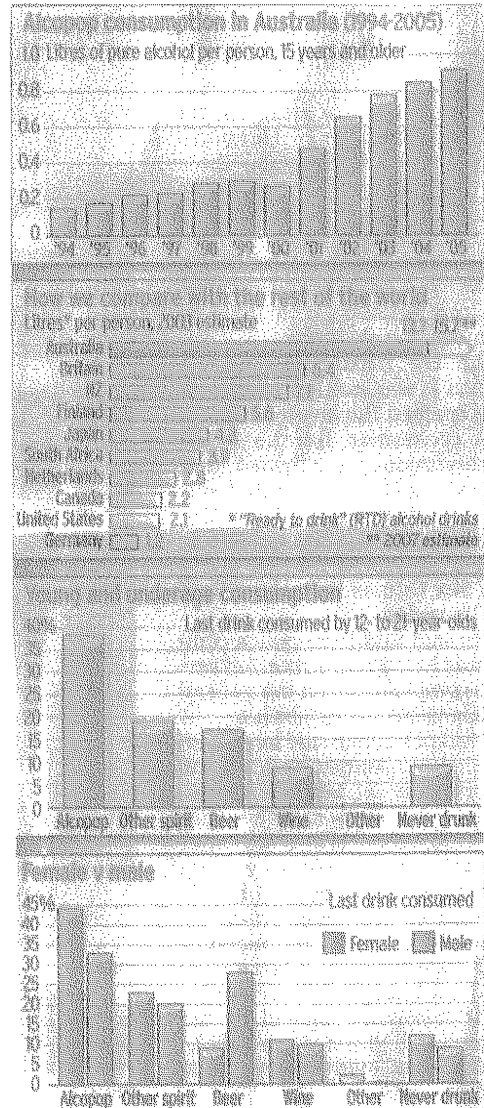
2.5% Alcohol industry's contribution to the nation's gross domestic product.

170 People, in hundreds of thousands, employed in alcohol industry.

$7 million Funding, in 2002-03 to political parties from the alcohol beverage industry and hotels association.

Vodka alcopops sales soar

By Adele Horin
The Sydney Morning Herald 26May 2008



Vodka-based alcopops that appeal to girls and young women have become the fastest growing part of the $2.5 billion a year ready- to- drink market, overtaking growth in whisky and rum-based drinks for the first time, industry figures obtained by the *Herald* reveal.

New data from the Nielsen ScanTrack Liquor survey, shows that while the whisky and rum premixed drinks comprise three-quarters of the alcopop market, the light alcopops, mainly vodka-based drinks, have soared in popularity.

Since 2005 growth in the light ready-to-drink products increased by 23 per cent compared to 15per cent growth in the dark ready-to-drinks. Within the light category, the highest growth has been in high alcohol content-7 per cent and above-products.

The chief executive of the Alcohol Education and Rehabilitation Foundation, Daryl Smeaton, said the big increases in sales of light alcopops was consistent with the evidence that younger women were drinking more of these types of drinks.

He said, "We know that 23 per cent of young women aged 14-19 are binge drinking at least weekly, and anecdotally the evidence is they're drinking RTDs.

We appreciate the opportunity to participate in this enquiry and hope to furnish you with evidence pertaining to the requirements as specified.

Yours sincerely

Donald Cameron

State Director for Victoria
PADD

PRE-MIX QUICK WAY TO GET DRUNK

Chloerissa Eadie, 18, Perth

"I occasionally drink pre-mix with friends. They're cheap and people drink them to instantly get drunk."

Megan Levvey, 18 Kew

"I prefer pre-mix. I don't like the taste of beer. You definitely see people out there who drink them just to get drunk."

Josh Saunders, 18, Camperdown

"I drink pre-mix for the taste, but they are too expensive for session drinking. I think the vodka pre-mix are made to be attractive to girls."

Brodie Galbraith, 19, Mansfield

I dodge the binge drinking thing. People definitely drink the pre-mix to get drunk quickly and for the lack of alcoholic taste.

Simon Dortmans, 19, Leongatha

"We'll drink pre-mix before we go out to the pub. Drinking at the pub is dear so we start on those. You drink them when you're 16 as you can buy them for nothing and get drunk quick. They go down easy."

James Hopton, 19, Darwin

"The pre-mix tastes is sweeter and they get you drunk quicker. When you're young you feel the burn of alcohol. Making it sweeter is easier to consume and the higher alcoholic content makes it cheaper in the long run."

Elizabeth Woollard, 18, Perth

"I don't drink them that often, but people drink them to get drunk quicker. I think they are definitely targeted to young people which is bad. There should be more education about it."

M

The Australian 4.1.07

Parents warned on drinks for teens

Adam Cresswell
Health editor

PARENTS who allow their children small amounts of alcohol in an attempt to instil safe drinking habits may be setting them on the path to becoming binge drinkers.

The first international comparison of underage alcohol use, conducted by Australian and US researchers and involving 6000 children, has found rates of binge drinking are up to three times higher among Australian Year 9 students compared with equivalent American teenagers.

Australian parents often introduce their children to small amounts of alcohol early, in the hope this "harm minimisation" strategy helps them learn to control their behaviour in later life. By contrast, US attitudes tend to emphasise a zero-tolerance approach, and the legal drinking age is also higher — 21 compared with 18 in Australia.

The study's authors said the findings of higher binge drinking rates in Australia will be "counter to the expectations of harm-minimisation advocates", and showed the Australian approach was not working.

John Toumbourou, one of the co-authors of the study, due to be published in the US journal *Health Education & Behaviour*, said the rising rates of Australian teenagers being admitted to hospital for alcohol-related injuries made the findings of serious concern.

"My suggestion to parents would be to recognise that there's no protective effect from giving children alcohol," said Associate Professor Toumbourou, from the Centre for Adolescent Health at Melbourne's Murdoch Childrens Research Institute.

Instead, he suggested parents "explain to children that alcohol use is harmful", and make a rule that children will not be allowed to drink until they approach the legal age. "Right throughout high school that needs to be the message, and communities need to back parents with that message," he said.

However, he conceded that it was speculation to conclude that the Australian practices were directly causing the higher rates of binge drinking.

Paul Dillon, of the National Drug and Alcohol Research Centre, said the findings exposed the lack of guidelines available for parents.

"Parents are confused because for quite a long time they were told 'Introduce your child to alcohol before someone else does'," Mr Dillon said. "It's the No 1 question I get asked — when should I be introducing my child to alcohol?

"Every family is different — you have to look at your own drinking behaviour and where it fits in your own life."

The findings are based on the first stage of the International Youth Development Study. Researchers surveyed 6000 children, about half in Victoria and the other 3000 in the northwest US state of Washington, which was selected for the similarity of its demographics, industrial and social background and size.

In collaboration with researchers from the University of Washington, the authors asked children about the frequency and extent of their alcohol use.

By the age of 11, half the Australians had drunk a full glass of alcohol, and by 15, almost one-third (30.1 per cent for boys, and 31.1 per cent for girls) had been binge drinking in the previous two weeks.

Binge drinking is defined as five or more drinks on any one occasion. Among the American 15-year-olds, the rate of binge drinking was 9.1 per cent for boys and 11.7 per cent for girls.

Australians also reported higher use of tobacco and inhalants, while US students were more likely to use marijuana.

"You have to set rules ... but as much as parents believe it's their children's peers (who influence alcohol habits), it's parental behaviour in the early years and early teens that has a significant influence on whether children drink responsibly or not," Mr Dillon said.

PART 2 OF SUBMISSION FOLLOWS. (SEE OVER)

It is not just those who drink very heavily who suffer alcohol-related problems. Many alcohol-related problems occur from single episodes of intoxication, and thus the vast majority of drinkers are at risk occasionally [12]. In some situations even small amounts of alcohol carry considerable risks, for example, prior to swimming, operating machinery, or driving.

Today, there is wide consensus that the most effective preventive strategy is to reduce capita consumption rates by targeting everyone's drinking, rather than the traditional focus on "alcoholics" [13]. It is a prevention paradox that even if one could succeed in getting very heavy drinkers to cut down, the impact on Australia's levels of alcohol-related harm would be slight compared to getting the bulk of moderate drinkers to regulate or reduce their intake.

There is then, a sufficiently strong association between availability and consumption warrant the restriction of availability as a central plank in a broader preventive response alcohol problems. Reducing the availability of alcohol, or at the very least restricting further extension of availability, is essential if alcohol consumption is to be decreased [13]. Additionally, emphasis needs to be directed at outlets and retail activities which are associated with risky outcomes from intoxication; for example, concurrent sales of cask fuel and alcohol, alcohol outlets placed near freeways, alcohol sold at workplaces, alcohol sales at boating clubs.

Calls for restrictions on alcohol availability are currently being made in a climate of further liberalisation of licensing hours in Australia. This is being fuelled by the desire to cater for and expand tourism, amongst other things [14]. Short-term economic interests hold sway over health concerns despite the massive long-term costs associated with alcohol-related harm. To illustrate the momentum for liberalisation of liquor licensing can be noted that the hotel industry in NSW is campaigning for a trial of 24 hour trading [15]

References:

1. Makela, K., Room, R., Single, E., Sulkunen, P., & Walsh, B. (1981) *Alcoh Society and the State: A Comparative Study of Alcohol Control.* Toronto, Addiction Research Foundation.

2. Centre for Education and Information on Drugs and Alcohol, NSW Departme Health. (1986) *An Australian Guide to Drug Issues.* The Drug Offensive. Canberra, AGPS.

3. Grant, M., Plant, M. & Williams, A. (1983) *Economics and Alcohol.* London, Croom Helm.

4. Commonwealth of Australia. (1987) *Alcohol, the Facts.* The Drug Offensive. Canberra, AGPS.

5. Corti, B. (1988) *Women's Issues : Alcohol and Other Psychoactive Drugs.* Addiction Studies Unit, Foundation Unit Study Manual, Curtin University of Technology.

6. Davies, P. & Walsh, D. (1983) *Alcohol Problems and Alcohol Control in Eur* London, Croom Helm.

(h)

TO HELP AVERT DAMAGE TO THE LARGE NUMBER OF ALCOHOL CONSUMERS

ALCOHOL RISKS TO HEALTH

About 80% of the Australian population drinks alcohol. Presumably this figure does not take into account the vast amount of under-age and therefore dangerous illegal children's' drinking.

P.A.D.D. reasons that because alcohol can impinge on the Australian population as a whole, from cradle to grave and even before and after conception, it seems that if alcohol risks to the population could be presented to the Australian public to cover the varying age levels involved in risky "across the board" alcohol use, then potential harm would be averted by alerting the populace.

To substantiate this claim, we offer the following quotes.

As alcohol is an anaesthetic and because drinking and driving are legalised, prior consumption of alcohol before driving can lead to drowsiness and death.

After ingestion of alcohol it goes to the nervous system and brain and begins to affect reaction time, judgement and vision. As full faculties are required to cope with emergencies, an alcohol-free driver is therefore safer.

To support this claim is the following quote from Commonwealth Government sources. "Any alcohol will begin to impair driving performance".

Hospital operations which involved alcoholised patients are messier, more difficult and slower to heal. Such operations, being very numerous, take up more hospital time and a disproportionate amount of doctors' time to the detriment of other patients needing treatment. (J. Birrell) Former Police Surgeon.

Alcohol is second only to tobacco smoking as the biggest killer drug of addiction and greatest threat to health.

That is, no doubt, one of the reasons why the World Health Organisation has moved to proclaim alcohol as a global health risk.

Alcohol is toxic if consumed in large quantities resulting in death and severe health impairment.

Young alcohol drinkers of around 13 years of age are at four times the risk of having alcohol problems later in life.

A certain fact is that a significant proportion of users of drug alcohol will become addicted and therefore of potential danger to themselves and others.

Alcohol is a proven cause of cancers to many parts of the body.

At least 50% of alcohol drinkers also smoke to feed their respective addictions and suffer the cumulative results of these drugs in combination to the consequent detriment to their health.

RATIONALE DEMONSTRATING HOW THIS ACTIVITY WOULD HELP TO CONTROL HARMFUL OR ABUSIVE BEHAVIOUR TO OR BY HUMAN BEINGS.

SOME QUOTES AND RATIONALE FOR PADD'S PROPOSED ALCOHOL RISK BOOK

"There is no level of alcohol consumption that can be designated as safe for all or any individuals under all circumstances."

SOURCE OF QUOTE. Page 2 of the 2nd edition of the National Health and Medical Research Council book 1992 - Titled *"IS THERE A SAFE LEVEL OF DAILY CONSUMPTION OF ALCOHOL FOR MEN AND WOMEN?"*

There is also strong evidence that *per capita* consumption is associated with the diverse problems related to alcohol consumption. As (*per capita*) consumption increases, so do the problems and as it decreases, so do the indices of harm. (Ref. Page 5 of the above Book).

ABS studies by Corti and Ibrahim shows that in all age groups of women consumption of more than 20 grams of alcohol (daily) had increased significantly. The increased consumption resulted from women drinking significantly more wine and also spirits, whilst beer consumption fell slightly overall.

(From Page 4 of book)

There is evidence that young women are binge drinking more commonly over recent years.

"Finally and perhaps most importantly) quote from Page 21. The majority of alcohol related problems are not caused by the sub-population of the heaviest drinkers, but by the majority of the population, those who are "normal" or "social drinkers", simply because of their number. Ref. de burgh S. The Ledermann theory in historical perspective in proceedings of the NIDA and NIAAA meeting. 1-2 October 1984, Washington.

- From a population perspective, to focus preventative efforts on the high risk groups, rather than use strategies addressed at large numbers of people who have a low level of risk, whilst having many important benefits for individuals will have less substantial effects on the health of the population as a whole. (from Rose, G. Strategy of Prevention lessons from Cardiovascular disease). British Medical Journal.

Donald Cameron
end of part one of submission
(see over)
PART 2 "BRIDGING THE GAP"

COVER PAGE

"BRIDGING THE GAP"
(SELECTED EXTRACTS)

Donald Cameron
State Director for Victoria
People Against Drink Driving

6 Edgewood Ave
Castle Hill
NSW 2154

Ph (02) 9894 1292 EMAIL ADDRESS SEE FRONT COVER PAGE (a).

SUBJECT OF SUBMISSION: "Alco-Pops" and related matters (PART 2)

Attention: THE SECRETARY
Senate Community Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

PART 2 OF PADP SUBMISSION

BRIDGING THE GAP –

A EUROPEAN ALCOHOL POLICY CONFERENCE, JUNE 16-19,2004, WARSAW, POLAND

Nearly 400 participants from 43 countries gathered in Warsaw in June for the Bridging the Gap conference, a major initiative sponsored and organised by Eurocare with the financial support of the European Commission.
Co-sponsors included the World Health Organisation, the European Cultural Foundation and the Polish State Agency for Prevention of Alcohol Problems.

A SELECTION OF THE MATERIAL PRESENTED FOLLOWS:

PAVEL TELICKA, European Commissioner Designate

Europe has the highest alcohol consumption in the world. Alcohol is therefore one of the key health determinants in the European Union sadly, alcohol-related harm comes directly after tobacco and high blood pressure as a cause of ill-health. The negative impact of alcohol on health and social well being plays an important role in the future development of public health policies in the European Union of 25.

We have also reason to fear that the harmful impact of factors like alcohol on public health and society is likely to increase, for example excessive and harmful alcohol consumption is behind a high proportion of premature deaths in the European Union. 25 per cent of European men and 10 per cent of European women consume alcohol at levels hazardous and harmful to their health. Alcohol consumption is clearly related to a wide range of social problems: violence, child abuse, work-related problems and intoxication and heavy drinking *are more frequent among adolescents and young adults.*

Now alcohol beverages are not all bad; they can give pleasures as well as problems but I would like to underline that we, working in the public health field, do not need to give more information on the pleasures of alcohol or encourage people to drink more alcohol. Our task is to provide information on alcohol's impact on health and welfare and take relevant actions to protect people from alcohol-related harm. Actions to reduce alcohol-related harm do not in any way jeopardise the positive benefits of alcohol.

Alcohol has a darker side. As you will all know better than me, alcohol is a substance that affects both the body and the brain. It can contribute in among other things, acute toxic affects, alcohol dependence, liver cirrhosis, cancers and contributes to overweight and obesity. We need to do more to minimize alcohol-related harm. Public authorities in Member States here in

Europe have the primary responsibility to protect their citizens. Health promotion, prevention and health education are tasks for the public health community and of course the health promotion community.

The beverage alcohol industry has a clear responsibility with regard to its products to ensure that they do not sell, serve or market alcohol in a way that contributes to increased alcohol-related harm. Non-governmental organisations have a particular role to inform and mobilise civil society to advocate for the implementation of evidence-based alcohol policy. They also make an invaluable contribution to preservation and health promotion.

So let me underline that what we want is an integrated approach to combating alcohol issues and we want an integrated approach with action by all agencies. This task concerns the family and the school but it also extends to alcohol producers, pubs and bar owners, advertisers and national regulators. All have their role to play.

The Commission is currently looking at a tool kit of actions that could be part of a comprehensive and coordinated approach to alcohol. Such a strategy will deal with topics such as drink driving, commercial communication, under age drinking and information of consumers. The Commission is determined to take these issues forward and to contribute to the protection of our citizens and especially young people from alcohol-related harm.

MICHAEL MARTIN, Irish Health Minister and the Chair of the EU Council of Health Ministers

Delegates attending this conference will know that inappropriate alcohol consumption is one of the most important public health issues in the European region. Levels of alcohol consumption, harmful drinking patterns and related harm are a major concern among the public health community in Member States

European countries rank as the world's biggest drinkers and the total burden of disease, injury and premature death attributable to alcohol is estimated to be in the region of 10 per cent. Across the European Union deaths and the range of problems experienced in Member States reflects in large part the drinking culture and drinking patterns.

Harmful drinking such as binge drinking is not just a feature of youth drinking but is also very common among young adults, especially males. In fact most of the alcohol-related harm across Europe is caused amongst the adult population.

willingness to recognize the seriousness of alcohol problems and the wide-ranging damage caused by alcohol in society is a further obstacle.

TAX

There is increasing evidence showing the effect of different alcohol policies, where pricing and taxation are shown to be effective. The effects of the most recent 45 percent decrease in spirit taxation in Denmark and Finland are not yet evaluated, but initially spirits sales went up 40 per cent and in both countries the level has stabilized at a 20 per cent increase. The impact of alcohol advertising is difficult to measure, but researchers have found that exposure to repeated high-level alcohol promotion results in pro drinking attitudes and increases the likelihood of heavier drinking.

The huge increase in sale of ready to drink products during the last 3-5 years and the intensive marketing of these products indicates a relationship between advertising and behaviour. During recent years the amount of alcohol advertising has increased. Young people and adolescents have become the group that is targeted more heavily by advertising.

Bans on advertising, standards for testing alcoholic beverages, health warnings, etc. are efficient policy measures that could be implemented in a coordinated way throughout Europe.

And the reason for adopting an international convention on alcohol products is that alcohol is not an ordinary commodity.

PETER ANDERSON, Policy Advisor to Eurocare

The More Alcohol An Individual Drinks, The Greater The Harm. For all types of alcohol-related harm, including social harms, accidents and violence, alcohol dependence, cirrhosis of the liver, cancers and cardiovascular diseases, the more an individual drinks, the greater the risk of harm. The risks are due to alcohol and come from all beverage types, including wine.

TOTAL BEN. OF VAUNTED ALCOHOL HEALTH CLAIM

Alcohol reduces the risk of heart disease; a large amount increases the risk. One drink every second day gives almost all the protection that alcohol has on reducing the risk of a heart attack. This protective effect is not relevant for people who are at low risk of heart disease, which includes young people everywhere. Above two drinks a day the risk of heart disease goes up, with the more alcohol drunk, the greater the risk.

GREATER RISK OVER 2 DRINKS

The Less A Country Drinks, The Less The Harm. The lower the average alcohol consumption of a country, the less harm there is from alcohol. For example, European countries with a male adult per capita consumption of about 14 litres of alcohol have about twice the death rate from liver disease

Because alcohol has so long been part of our many social and cultural traditions and because many of us can enjoy a drink sensibly I think that we have all been slow at recognizing the real cost of alcohol-related harm and as such are playing catch-up in terms of developing strategies to tackle the problem. However I do believe there is real effort to catch-up. This is borne up by developments at European Union Ministerial level. The Health Council in June,2001 unanimously decided on the need for a comprehensive European Union community strategy to reduce alcohol-related harm.

The Health Ministers conference, which I chaired on June 2nd, , includes support, for example, for the Commission's ongoing work to develop a comprehensive strategy for alcohol which would highlight a more balanced approach where more attention is given to public health aspects in other policy areas.

Special attention should be given to young people and alcohol within such a strategy. I know that across Europe there is a growing awareness of the harm caused by alcohol; the social and cultural acceptance of inappropriate alcohol consumption.

LARS MØLLER of WHO Europe

Basically what we have managed is to move alcohol up the public health agenda of Europe. The European Region of WHO is the region with the highest alcohol intake worldwide and alcohol is the main burden of disease among developing countries with high mortality. The world health report 2002 presented figures by attributing 16 percent of total deaths in central Europe to alcohol.

There is evidence that both the volume of alcohol consumed and the drinking pattern are relevant to health. It is still doubtful if some alcohol products are more harmful than others, but there is a close-response relationship between alcohol consumption and morbidity/mortality.

Specific policy efforts to reduce drink-driving illustrate effective policy measures at country-level, whereby many countries have lowered their blood alcohol limits and increased enforcement. In general, western European countries have moved towards stricter alcohol control policies. Especially the southern European countries have reduced per capita consumption levels and they have lowered alcohol related harm to a greater degree than many of the countries in the central or eastern part of the Region. External pressures from the alcoholic beverage industry, commercial marketing and illegal trade militate against further progress. The lack of a collective

(a sensitive indicator of alcohol-related harm) than countries with a per capita consumption of about 7 litres of alcohol. Also, the lower the average alcohol consumption of a population, the proportion of heavier drinkers is smaller.

A Country That Reduces Its Consumption Reduces Its Harm. As a country reduces its alcohol consumption, alcohol-related harm also reduces. On average, as European countries in the middle range of alcohol consumption reduce their average male alcohol consumption by 1 litre per person, the risk of male death from accidents is reduced by 4 per cent, from cirrhosis of the liver by 9 per cent, from homicide by 11 per cent and from heart disease by 2 per cent

Alcohol Causes Nearly 1 In 10 Of The Burden Of Ill-Health In Europe.
The World Health Organisation's Global Burden of Disease Study finds that alcohol is the third most important risk factor for European ill-health and premature death, after smoking and raised blood pressure. Alcohol is more important than high cholesterol levels and overweight, three times more important than diabetes and five times more important than asthma.

It causes nearly 1 in 10 of all ill-health and premature death in Europe.

THE FINANCIAL COSTS AND BENEFITS OF ALCOHOL by Christine Godfrey

Alcohol Industry View   Economic arguments are frequently used in discussion of alcohol policies. From the industry, claims are frequently made about the economic importance of the industry and the benefits it brings. It is suggested that any policies to control the problems of alcohol would have a major economic impact.

Three types of costing studies are considered:

- Cost of illness.
- Externality types.
- Economic evaluation/cost effectiveness.

Variations in the types of costs and benefits included and some examples of the different studies are discussed.

Health And Other Policy Advocates View   Health and other policy advocates will, in contrast, highlight the harms caused by alcohol and the costs they impose on society. Policy makers are increasingly suggesting they would like to follow evidence-based policy-making and as such are looking for economic

evidence such as the cost –effectiveness or value for money of different policy alternatives.

Terminology Economics is a subject with its own language and as in many areas common words are often used to represent very specific economic meaning. *Costing studies are no different and it is useful to begin by* defining how specific words will be used in this paper. Alcohol is a substance used by many in every European country. The consumption of alcohol obviously brings some benefit to those individuals. The value of this consumption is referred to in this paper as the private benefits of consumption.

Alcohol consumption is also associated with a range of costs to the consumer. There is the monetary amount that alcohol costs. Also where there are availability controls, consumers may incur additional financial and time costs in acquiring their alcohol.

However, alcohol consumed in the wrong quantity of pattern or in the wrong situation, for example at work or while driving, is also associated with a range of costs that fall on the individual. This can include short and long-term effects on health, lower earnings through sickness absence or a range of alcohol related workplace effects, etc. These costs are in terms of both monetary amounts, e.g. lost earnings or non monetary effects such as the loss of health related quality of life. Economists frequently attempt to value these non monetary or sometimes called intangible impacts. Together all these impacts are defined as private costs.

In a market economy it is usually assumed that consumers take all of the private benefits (monetary and non monetary) and all the private costs (monetary and non monetary) into account in making their decisions. In contrast some effects of consumption decisions may have impacts on others than the individual drinker. This is most clearly seen in the victims of alcohol related accidents, such as those killed or injured by drunk drivers. These third-party effects are called external costs by economists.

However another type of external cost occurs when resources are used by the state to deal with alcohol related problems. For example, health care resources used to treat alcohol dependence could have been devoted to other illness. In systems where the individual does not pay (or pay fully) for their health care, these alcohol treatment costs are not borne by the alcohol misusers directly. Therefore alcohol misusers are imposing external costs on the non alcohol misusers. These are often referred to as institutional externalities and obviously they depend on the exact health and welfare systems of each individual country.

Similar effects can occur in the workplace if employees do not lose wages in the event of a period of sickness or absence but the employer or other employees have to bear the cost of their loss of productivity

Many estimates of the cost of the alcohol include the monetary value of factors such as the loss of life or the fear of crime or violence. These economic estimates are a means of imposing a common value system of a range of different, real effects. However, the sum denoting the loss of a life cannot be conventionally realised in financial terms. In other studies the term financial is restricted to the impact on government or public finance. Some of the differences between studies, and which types of costs and benefits are included, are explored in the rest of the paper. For this paper, the focus is on economic costs, including both monetary and non-monetary impact of alcohol.

Cost of Illness Studies A number of studies have produced estimates of the costs of alcohol for a particular country in a particular year. Frequently the estimated total figures are expressed as a percentage of Gross National Product. This gives a useful advocacy tool in demonstrating the size of the impact of alcohol. Most of these published studies have used the cost of illness approach. The question addressed in these studies is to estimate the costs of alcohol compared to the hypothetical situation that there was no alcohol consumption. However, the specifics of the question do vary from study to study. Some consider only the costs associated with alcohol misuse, while others cover all alcohol use and attempt to factor in the potential benefits of lower alcohol consumption.

There are some common contents of these studies including normally:

- Health care costs;
- Loss of life;
- Productivity costs associated with sickness absences and excess unemployment;
- Alcohol related crime costs;
- Accidents, including road traffic accidents;
- Loss of job;
- Policy and research costs.

All studies have some estimate of the health care costs of alcohol related illnesses. The estimates are based on international reviews of the relative risks of alcohol consumption on a range of diseases. These relative risks combined with information about the drinking patterns in a specific country in a specific year. Combining relative risk information with consumption patterns yields estimates of the attributable risks or proportion of each disease category that can be attributed to alcohol. These proportions can then be applied to disease based costs of health services.

However, not all countries will have health care accounts by classification of diseases. Even where figures are available some health services such as primary care and emergency care may be excluded and therefore alcohol related costs may often be underestimated. Another potential source of underestimation is that costs for those with alcohol related problems are often higher than those with the same disease problem without alcohol involvement. Harwood et al (1997) in one US study did attempt to adjust figures for this impact. Health care costs typically make up between 5 percent to 20 percent of the total estimates.

The impact of alcohol on the workplace is also generally included but the data available for such estimates varies widely. Rather than evidence being available from international systematic reviews, specific country studies are used to provide some guidance to the costs involved. There are a variety of different costs that can be included in the section (Godfrey et al, 1997). Most studies include some estimate of the productivity costs of alcohol related illness, particularly longer-term illness related to alcohol dependency. Depending on the country and the particular workplace these costs may fall all or partly on the employer or be borne in part by the state or the individual drinker. More difficult to measure but likely to be of sizeable impact are the short-term absences, especially those associated with binge drinking. Another area of more controversy is the impact of drinking on the productivity of those at work.

It is clear that in many work situations the poor performances of those with alcohol problems whether short term or longer-term are a cost on fellow workers and their employers but this may not necessarily be reflected initially in their earnings. Very heavy and chronic drinking is associated with excess unemployment.

Finally there are other impacts of alcohol on the workplace, which may be of particular significance to employers, including legal liability for health and safety and return on training and investment in key workers. These aspects will be considered further in workshops at this meeting

Crime costs vary considerably between studies In Rannia's (2003) study for England crime costs account for a much higher proportion of the total at nearly 60 percent compared to, for example, the most recent Australian study where crime only accounted for 16 percent of the total (Collins and Lapsley,2002).

Also the costs of crime included not only the criminal justice costs but also costs involved in prevention of such crimes and the property, production and victim costs associated with the crimes. These victim costs for the alcohol related crimes accounted for 68 per cent of the total crime costs.

A major component of all cost of these studies is the value given to premature mortality related to alcohol use. The figures of premature deaths are calculated using the same sorts of epidemiological reviews of relative risks for different diseases employed for estimating health service costs.

Using more conventional values for the loss of life would yield much higher values. For example, Rannia (2003) had an average value of £147.187 per alcohol related death. These deaths include 500 related to road traffic accidents where a significant number could be of "innocent" victims - a true external cost of alcohol use. If these deaths had been valued by the willingness to pay methodology, the Government's own estimate of this value was £1,144.890 (Department of Transport,2000). Replacing this valuation for the one used in the study would raise the total figure from £20 billion to £43 billion.

Not surprisingly in most studies the value put on premature deaths is one of the largest items of the calculated costs.

Estimates of alcohol related costs have generally risen in countries which have performed more than one study as more data on the risks associated with alcohol become available. Potentially this is one of the values of undertaking these studies as it does reveal the range and extent of alcohol related health, workplace and crime related costs.

Nuisance from alcohol related violence clearly impacts on non drinkers and could be part of these types of study. Reduction in such nuisance would improve social welfare but such improvements would not conventionally appear in national accounts and Gross Domestic Product (GDP).

However, consumer attitudes to risk and information are complex. For smoking risks are often known and sometimes overestimated but smokers still can be rational in demanding government interventions such as increased taxes (see Gruber 2003). For alcohol young people may overestimate risks from life threatening diseases such as liver cirrhosis

(Lundbeg, 2003) but be unaware of many of the more immediate risks from accidents and fringe drinking.

Dealing with the young drinker and dependent drinker raises the question of rationality. If people cannot make choices in their own best interests then there is an argument that social welfare may be higher if resources devoted to alcohol production were switched to other goods or services. Taking a part of the alcohol consumption expenditure into account in cost models (see Collins and Lapsley 1991) could significantly increase the excess costs of alcohol. However, others would argue that even with dependence, consumers do make choices as evidenced by changes in behaviour prompted by economic incentives such as price changes.

In practical terms empirical testing of the models could be conducted using some of the same data as is compiled for cost of illness studies. Indeed in the Australian (Collins and Lapsley,2002) and French (Fenoglio et al. 2003) costs studies some attempt is made to look at just the external costs and compare this to revenue yields. For the UK, the external costs are likely to be in excess of the £200 billion figure and indeed taking loss of life into account and using more usual figures to value this loss could bring the total closer to £45-50 billion for the UK as a whole. This is clearly way in excess of the revenue yield of £12 billion in 2000/01.

IMP.

Economic Evaluations As more evidence becomes available it is likely that in many countries studies could be conducted which suggests governments should be more active in reducing alcohol consumption and problems.

However, these governments will also need to be persuaded about the evidence of effectiveness of different policies and their cost effectiveness or value for money. Economic evaluation techniques have been most developed and used in health care planning. Indeed in many countries there are explicit regulatory frameworks that govern the introduction of new medical technologies.

In the UK the National Institute for Clinical Excellence uses an economic framework to assess the additional costs and effectiveness of the technology under evaluation in comparison to current practice. Technologies yielding health gains of a quality of life year for £30.000 (45,000 Euros) or less are generally recommended for adoption.

The question is whether different alcohol policies would fall below the benchmark.

There is also an increasing literature on the cost effectiveness of different alcohol policies. The WHO CHOICE project is also producing some more

global estimates in terms of costs per DALYs on a range of alcohol strategies. There are also good bibliographies of published economic evaluation studies available through the NIAAA website. There are also more explicit guidelines on conducting studies of costing interventions and evaluating cost effectiveness available from the EMCDDA

Similar evidence in the illicit drug field in the UK led to a major increase in public expenditure for drug treatment but a similar policy initiative has not as yet been put in place for alcohol.

Finally there is accumulating evidence about the cost effectiveness and cost ineffectiveness of different alcohol interventions. A number of empirical studies of face-to-face interventions indicate that implementing these interventions will bring net savings.

ALCOHOL POLICY AND YOUNG PEOPLE

By Anne Hope,M.Sc.Ph.D. National Policy Advisor, Department of Health, Ireland

Introduction The WHO European Alcohol Action Plan 2000-2005 has as its aim to prevent and reduce the harm done by alcohol throughout the European Region. The WH0 aim is reflected in Member States individual alcohol strategies or action plans, including Ireland's National Alcohol Policy. The central issues addressed in this paper are what constitutes an effective policy response to reducing alcohol related harm among young people. How has Ireland acted since the 1990s and what of the challenges.

There can be no more excuses. The scientific body of knowledge has never been more comprehensive in terms of its quality; the strength of evidence and its robustness across cultures, as to which strategies work and how to make them work to prevent and reduce alcohol related problems. In Ireland, we have learned that ignoring the problem and in some instances adding to the problem has carried an enormous human, social and economic cost to Irish society over the last decade. However, there have been some recent positive signs of progress on the alcohol issue.

Young People 'Young people have a right to grow up in a society where they are protected from pressures to drink and from the harm done by alcohol', declared the World Health Organisation, and all European Member States agreed in 2001.
Young people's attitude and drinking behaviour is shaped, to a large extent, by the society they live in. In Ireland, young people recognize the powerful influence of the drinking culture on their lives. Dail na nOg (National Children

Parliament) recently criticised adults for creating and passing on to their generation the problems related to alcohol.

As noted by Donegal Youth Council "we inherit our drinking culture, we celebrate if we win and we celebrate if we lose, any excuse! Even if there's no excuse, we still drink alcohol". Therefore re-shaping the attitudes and behaviours of the adult society is necessary in order to provide a safer social climate for young people to lead healthy and productive lives.

Alcohol and Young People Young people and alcohol, a phrase, often used to imply that alcohol is a problem for young people only, especially those under age, and that the rest of adult society has no problem with alcohol, which belies the facts and figures. However, the focus of this paper is young people, which can be divided into three main groups, young adults (18-30 years), teenagers (15-17 years) and children (under 15) when discussing alcohol.

Teenagers and children tend to follow similar drinking pattern to adults, although at a lesser magnitude. The international survey data (HBSC[4], ESPAD[5]) show that children do experiment with alcohol at very early ages, some regularly consume alcohol and a proportion are involved in high risk drinking (binge drinking and drunkenness). For the most part, alcohol use and abuse increases with age and is higher among boys than girls with wide variation between countries. The critical age for accelerated alcohol use and abuse is between 13 and 15 years of age in many countries. At 16 years about one in four boys in nine of the EU countries are regular binge drinkers. For girls, one in five are regular binge drinkers in six of the EU Member States at age 16 years. Binge drinking was defined as five or more drinks per drinking occasion. Given that alcohol use poses serious risks for children and teenagers still developing and maturing, the main focus is to keep children alcohol-free.

Some factors, identified in the HBSC survey, associated with staying alcohol-free were spending fewer evenings with friends, liking school and less inclined to be truanting from school. For girls, being able to communicate well with their father was important. There was also a strong line between not smoking and not drinking. The consequences of alcohol use by teenagers, reported in ESPAD, include a range of problems affecting their performance at school, being in accidents, difficulties in relationships with others, unwanted sexual experiences, fights and trouble with police.

Effective Acohol Policy – a Review The research evidence is very clear on a number of key issues. Firstly, not all alcohol policy measures are equally effective. Secondly, policy measures that influence and change the physical, social and cultural environment around alcohol are more effective in

preventing and reducing alcohol related harm, than measures targeted at the individual drinker. Thirdly, policies exclusively targeted at young people, while ignoring the wider adult population, are doomed to failure.

TAX

The most recent global review of alcohol policy, supported by WHO, clearly shows that the 'best value' for an effective alcohol policy response should combine measures targeted at the general population (taxes, controlling access to alcohol, RBT Lower BAC), at high risk groups (minimum age, enforcement of on-premise alcohol laws, community mobilisation) and at high risk drinkers (brief intervention)[6].

Controlling the Physical Availability of Alcohol Be it the hours and days of sale, the number and type of alcohol outlets or certain restrictions on access to alcohol, controlling the availability of alcohol is effective in reducing alcohol consumption and related problems. Setting a minimum age for the purchase of alcohol is one of the most effective measures in limiting access of alcohol to young people. In North America, increasing the minimum age from 18 to 21 years reduced drink driving, car crashes and traffic fatalities among young people [7,8]. The majority of European countries set 18 years as the legal age for alcohol purchase[9]. In Denmark, after the introduction of a minimum 15 age limit for alcohol purchase in 1998, a 36 per cent drop in alcohol consumption among teenagers and a 17 per cent drop in older students were reported.

As with all alcohol laws, the critical factor for effectiveness is enforcement with a credible deterrent. Government stores selling alcohol off-premise, removed the pressure to maximize profit, as in the private sector, can limit alcohol consumption and related problems[11, 12].

Such stores mainly operate in the US, Canada and in the Nordic countries. Making alcohol more available increases the likelihood that those under the legal age of purchase can access alcohol more easily and can result in increased youth drinking[13].

The price of alcohol influences frequent and heavy drinkers as well as children and young adults, which means when the price of alcohol increases, alcohol consumption tends to decrease [14].

PRICING ALCOHOL (TAXING ALSO)

Raising alcohol taxes also can help a reduction in a host of alcohol related problems such as drink driving, death from liver cirrhosis, injuries, alcohol related violence and other crimes [14.6]. In UK, it is estimated that a 10 per cent increase in taxes could reduce alcohol related mortality between 7 percent and 37 per cent. (very important)

There is a substantial body of scientific evidence from the USA, Australia , New Zealand, and Finland that a community policy approach is effective.

That is institutions, organisations and groups within a community working together to change policies and practices to reduce alcohol related problems.

However, sustaining the gains beyond the initial time scale of the project remains a challenge. Community mobilisation approaches have been successful in reducing high risk drinking[16,17], violence in and around licensed premises[18 19], alcohol related injuries[20 17], and drink driving[21 22 23]. The community mobilisation approach has also been effective in addressing underage drinking[24]. While alcohol free alternatives (AFA) have not been shown to be effective as a single strategy in reducing underage drinking, AFA have been considered useful when combined with a community policy approach such as limiting alcohol availability through licensing laws, use of bye-laws for restricting drinking in public places and enhanced law enforcement.

Regulating Alcohol Promotion Alcohol marketing is sophisticated in its methods, exceptionally well funded and powerful in its impact on young people including young adults, adolescents and those who have not yet tried alcohol[25 26]. Alcohol marketing places alcohol as a defining feature of youth culture, linking alcohol with social and sexual success.

Alcohol marketing also undermines efforts to communicate health promotion messages to young people. While there is some evidence that bans on alcohol advertising decrease alcohol consumption[27], the other promotional activities, often using the largest part of the marketing budget, also need to be regulated[26]. Such activities include sponsorship, product placement and special alcohol promotions, which especially appeal to young males, the groups mostly likely be high risk and heavy drinkers[6].

The health promotion literature has recognized for over two decades that *information and education does not change complex health behaviours* and that creating a supportive environment with healthy public policies is essential for sustained behaviour change [32 33 34]. The alcohol research literature also concurs that education is not effective in reducing alcohol related harm, but can be useful in increasing understanding and in building life skills. Therefore, education should not be the lead policy measure, but rather an integral part of an overall strategy.

The mistaken over-reliance on education as the key solution to underage drinking has diverted attention and delayed more effective strategies being implemented. Media advertising, warning labels and information at point-of-sale outlets are also useful in creating awareness.

The use of warning labels on alcohol products in the USA increased awareness of the potential risks of alcohol use, among the target groups, in

the areas specified on the labels-pregnancy, driving a car or operating machinery. Recall was also good for warning messages as in media advertisements, and on signs at point-of-sale [35 36]. The value of media campaigns lie in creating greater awareness of alcohol issues and in providing a forum for public debate and support for policy changes.

Alcohol Policy and Young People In Summary, priority should be given to implementing the following effective policies in an integrated way to reduce harm among young people.

*Regulating availability, through minimum age, alcohol taxes, government monopoly of off-license sales, alcohol control enforcement, seller liability.

*Modifying the drinking context by community mobilisation, targeting high risk drinking, violence, drink driving and underage drinking and promoting low strength alcoholic beverage.

*Drink driving countermeasures by graduated license for novice drinkers, lower BAC for young drinkers, random breath testing and license disqualification.

*Regulating alcohol promotion by restricting sport sponsorship, high-risk promotional activities and volume of alcohol advertising.

*Early intervention by screening and brief intervention across health and social welfare services.

*Creating greater awareness and support for effective alcohol policies across society. Providing education as a supporting strategy rather than a lead strategy and link it to drug education.

Consumption and Harm We in Ireland are now amongst the highest consumers of alcohol in the world. Between 1990 and 2002, alcohol consumption per capita increased by 41 per cent, the highest rate of increase in Europe[38]. Alcohol harm is visible on our streets, in our courts, hospitals, workplaces, schools and homes. The vast majority of alcohol harm occurs among the adult population. Alcohol related mortality increased significantly during the same time period.

CRISIS!

The number of people who died (rate per 100,000) from alcohol abuse, dependency increased by a factor of four, cirrhosis doubled and alcohol poisoning almost doubled. High profile cases involving alcohol and violence have grabbed media headlines, but are only the tip of the iceberg Since 1996, public order offences increased by 247 per cent, assaults by

82 per cent and drink driving offences by 125 per cent[39].

One in four attending the hospital emergency room is alcohol related.

ALCOHOL MARKETING PRACTICES

Sponsorship

The current high visibility sport sponsorships, in sports with the highest youth participation, (gaelic football, rugby and soccer), began in 1994 with the Guinness All Ireland Hurling Championship and symbolised a major social shift in a community rich in tradition and culture. The GAA sponsorship deal was followed by the Heineken Cup (rugby) and the Carlsberg League (soccer). Sponsorship deals of this type give in-depth exposure through event naming, product placement, sport commentary and discussions of the sporting event and embed the alcohol product into the daily lives of people. Alcohol sports sponsorship, linking alcohol, masculinity and sport, attracts young males, the groups mostly likely to be high risk and heavy drinkers[6].

Alcohol products: The introduction of alcopops in1995, with a strong sweet taste, disguising the taste of alcohol, attracted many young people into alcohol. The more recent new alcohol products with high alcohol content (shooter, shots) provide for a quick and easy 'fix' of alcohol for those who are interested in getting drunk fast. Drink combinations such as 'vodka and red bull' allow the drinker to consume large quantities of alcohol that the body other wise could not normally tolerate, due to the stimulant affect of red bull. Alcohol promotions such as free alcohol, cheap alcohol and strong alcohol encourage high risk drinking which contributes to increased risk of alcohol related problems.

Alcohol advertising: In Ireland, alcohol advertising is governed by voluntary codes or self-regulation. The codes of advertising all set down certain guidelines to protect young people. However, during the last decade alcohol advertising has increased in volume, as reflected in the advertising spend, from 25.8 million in 1996 to 43.2 million n 2002[43]. The greatest increase happened in spirits advertisements between1996 and 2000, coinciding with the introductions to the market of the new spirits based alcopops – television (+228 per cent), outdoors (136 per cent), cinema (+116 per cent), press (83 per cent) and radio (-62 per cent).

Alcohol advertising also extended its scope by advertising alcopops products on television, despite the voluntary code that spirits drinks would

not be advertised on television. During this time period a new commercial television station came into operation. A study was undertaken in 2000 asking young people how they perceived alcohol advertisements and whether the advertisements were in compliance with the code. The results suggested that alcohol advertisements did infringe the codes in a number of ways. These included linking of alcohol use with social or sexual success, depiction of immoderate drinking, use of characters that appear to be under 25 years implying that alcohol had therapeutic effects or improved physical performance, and alcohol advertisements targeted at young people[44].

FALSE ADS. BY VESTED INTERESTS

In 2003 the Drinks Industry Group established a Central Copy Clearance company to vet alcohol advertising prior to launch to ensure compliance with the voluntary code. However, despite the CCC role, alcohol advertisements continue to breach the code, illustrating the deficiencies of the self-regulation system[45].

Irish Policy Responses

Alcohol availability: In Ireland alcohol is easy to access, as there are *at least 13000 outlets* that sell alcohol. Since the 1980s, alcohol has become more available by increases in the number of exemptions (later opening) and in the number of outlets (restaurants and clubs, off-licenses). During the economic boom since 1994, there was no increase in alcohol taxes (excise duty), although alcohol prices did increase. In response to calls for longer opening hours, from the retail drinks and tourist sectors, a Dail Select Committee examined the issue in 1996. Despite the scientific evidence showing the increased risks of increasing availability presented to the Committee, and outlined in the National Alcohol Policy[46], the Dail Committee decided to recommend greater availability through longer opening hours and more exemptions, which was enacted in the Intoxicating Liquor Act 2000.

LONGER HOURS FATAL

The longer opening hours, combined with no increases in alcohol taxes over a seven-year period and an annual economic growth rate of at least 10 per cent, was akin to throwing petrol on an already burning fire. In contrast, the same legislation[47] introduced strong measures to curb underage drinking by imposing a 'closure order' for those convicted of selling alcohol to those underage, illustrating the misperception that drinking in Ireland is a problem only for those underage.

The Minister of Justice, Equality and Law Reform, established the Commission on Liquor Licensing (CLL) in 2000 to consider reform of the licensing laws. Some of the CLL recommendations, if implemented will further increase availability such as more off-licences, more on-premises bars (café bar model) and distance sales[48] and pose a threat of increased alcohol problems.

Community Approach in the College Environment A *framework for the* development of a college alcohol policy was developed in 2000 with the Heads of Colleges and the Student Union, in response to a growing concern about alcohol promotion practices on campus and related problems49. Five key areas were addressed, controlling marketing, promotions and sponsorship, limiting harm in the drinking environment, increasing awareness and education, encouraging alternatives and choice and providing campus support services.

Information and Education *A three year alcohol awareness campaign (2001-2003) was implemented to raise awareness and create debate on alcohol issues and to highlight the necessity of a public health approach to reducing alcohol problems.*

Youth participation in matters that affect them is a key goal of the National Children's Stratege in Ireland.

The Gaf in Galway, set up by the Western Health Board as a social health project, provides a safe space (alcohol and drug free) for young people can go to meet and hang out with friends, listen or partake in music as well as access information (The Gaf evaluation 2003).

Strategic Task Force on Alcohol The Strategic Task Force on Alcohol (STFA), set up by the Minister of Health in 2002, was asked to bring forward specific measures to Government, based on sound scientific evidence, to prevent and reduce alcohol related harm in Ireland. The STFA first Interim Report41 recommended *specific measures for action* including an increase in alcohol taxes, the introduction of random breath testing, lower BAC, prohibition of service to drunk customers, restrictions on high risk sales promotions and reduced exposure of children to alcohol marketing.

TAXES

Signs of Progress **Increased taxes** Excise duty was increased on cider and spirits by Government in December 2001 and 2002 respectively. Following on the increases in excise duty, the alcohol sales figures both cider and spirits significantly decreased, demonstrating that alcohol taxes can have an influence on alcohol consumption.

LAWS

Stronger laws The Intoxicating Liquor Act 2003 includes measures to combat drunkenness and disorderly conduct, binge drinking and underage drinking. These include a ban on the supply of alcohol to drunken customers and 'closure order" if convicted, a ban on happy hours, reverting to the earlier closing time on Thursday night; restrictions on those under 18 years from bars after 9 pm; a requirement for 18-21 year

olds to carry age document and the provision for plain clothes gardai to enforce alcohol laws. The Road Traffic Act 2003 extended the grounds for requesting a breath test to detect alcohol.

The Minister for Transport is committed to the introduction of random breath testing in the near future. The Minister for Health and Children received government approval to proceed with legislation to reduce the exposure of children to alcohol marketing. The proposed legislation will restrict where alcohol advertisements can be placed, limit content, ban drinks industry sponsorship of youth leisure activities, and require a health warning on advertisements.

ADV.

Challenges

Involvement of Young People All young people have a right to be heard and participate when policies, services and programmes are being developed to meet their needs.

Alcohol a global product, but no ordinary commodity The European Union was developed to provide for a single market where goods can be sold without unneccessary barriers to trade. However, alcohol is no ordinary commodity and its harmful properties result in a wide range of problems, there for the full suites of market rules do not and should not necessarily apply.

VESTED INTERESTS
DENIAL

Alcohol Industry *The alcohol industry exists to sell alcohol. Their aim, like all commercial businesses , is for a better bottom line not for better health for the citizens of Europe. Therefore it is inevitable that effective public health measures will continue to be opposed by the drinks industry if they impact on profits.*

"ONE WAY ADVERTISING"

While the drinks industry says it is committed to reducing alcohol related harm, the continuing call by the industry for education as the lead strategy rings hollow given the research evidence, which shows that education is a supportive rather than a lead strategy. The Drinks Industry of Ireland rejected several of the recommendations in the STFA Interim Report (reduce overall consumption, increase taxes, lower BAC) despite the strong scientific evidence base for these recommendations 51. One can only conclude that the alcohol industry is at best lukewarm on the public health approach.

Conclusion *We must ensure that the public understand and support the need for specific integrated actions., based on what works, in the interest of the common good of society. The reality is, that although alcohol in moderation is enjoyable, sociable and part of the most cultures, there also is an inherent risk with its use as it is a toxic substance and a drug.*

(a psycho-active drug like heroin)
- mind-altering

We do a disservice to our young people in not facing that reality, i.e. that alcohol is no ordinary commodity. We have to adjust our attitudes, behaviours and environments to reflect that sobering reality.

TOWARDS ALCOLHOL FREE ROADS IN EUROPE

Hans Laurell Swedish National Road Administration

Towards Alcohol Free Roads Since almost every fatality in road traffic is autopsied, there is a good basis for a more realistic estimation of the role of alcohol at least concerning active road users who are killed. The proportion of fatally injured drivers who are tested varies considerably among European countries–from no systematic testing to compulsory testing.

This lack of reliable and comparable statistics to describe the situation on the European roads, when it comes to the role of alcohol in accidents, is potentially very dangerous. It is easy to imagine what happens when the road safety people approach the politicians and decision makers in a country which boasts an involvement of alcohol in the fatal accidents of one per cent and ask for resources to fight the problems of drunken driving.

Alcohol On Our Roads When random breath testing was introduced in Australia, fatal crashes decreased by 22 per cent (Homel 1988). Shultz et al (2001) found that 23 studies of random breath-testing yielded an average decline of 22 percent in fatal crashes. It has also been demonstrated that random breath testing is at least twice as effective as selective checkpoints (Henstridge et al., 1997)

Information/Education This is an area which is constantly being discussed It is often claimed that campaigns do not change behaviour. However, it has been demonstrated that, especially if campaigns are combined with other important activities like changes to legislation or extraordinary police enforcement activities, positive effects can be reached.

NEW CAMPAIGNS NEEDED OFTEN TO RE-INFORCE D.D. MESSAGE

It is necessary to introduce the concept of separation between alcohol and driving in each new generation of drivers. This is not enough to keep them from driving drunk, since we often find that they have the best intentions – having decided to use public transportation, but then things go wrong they miss the bus and someone decides to drive. Then it is important that someone stops him from actually doing it and, if no one is able to, at least no one rides with him.

Examples of what may happen when we neglect to address this problem can be found in Sweden where there was a lack of resources for information directed at young people for a number of years. This has led to a shift in the attitudes towards drinking and driving and the proportion of young people who have been driving under the influence or been riding with a drunk driver has increased to very worrying levels.

Legislation Lower legal limits for young drivers may reduce fatal crashes among young drivers by as much as 24 per cent. It is unfortunate that these differences between Euroopean countries still exist. A uniform legal maximum BAC limit would send a non-ambiguous, clear and consistent message to European road users.

There is also evidence that lowering of the legal blood alcohol concentration limit generally produces positive results across all BAC concentrations and reduces alcohol related road accidents (Jonah et al.,2000). Sweden lowered the legal limit from 0.05 per cent to 0.02 per cent in 1990. This led to a reduction of fatal alcohol related accidents of 8 per cent (Norstrom, 1997). Four Australian states went from 0.08 per cent to 0.05 per cent in the time span from 1976 to 1992 and experienced between 8 and 18 per cent reductions of fatal alcohol related accidents (Henstridge et al., 1997). The lowering of the legal limit in France resulted in a 4 per cent improvement and in Belgium an initial improvement of 10 per cent

SAVING LIVES

This led to a reduction of fatal alcohol related accidents in the first year after the introduction of the new law and a further improvement of 11 per cent the following year. In Austria the limit was lowered from 0.08 per cent to 0.05 per cent generally and to 0.02 per cent for novice drivers.

This was accompanied by a reduction in accidents for novice drivers by 32 per cent and for the general driving population by 9 per cent (Barti and Esberger, 2000.

Relicencing Some countries stipulate that the drunk driver, if he was above a certain BAC or reoffended, must participate in a rehabilitation programme or prove that drug or alcohol dependcy is not involved.

This can be done in medical checks over a period of time involving the application of biological marker. Too rigorous programs may lead to increased levels of unlicenced driving, however. This again is probably closely related to the levels of police enforcement.

Sweden has a program which requires that drivers who have been caught with a BAC exceeding 0.1 per cent must prove that they are not

dependent upon alcohol or other drugs in order to have their driving licences reinstated. This program works well but, some 30-40 per cent of these drivers choose not to enter the program and never apply for a driver's license again. It is doubtful whether they refrain from driving.

Rehabilitation The proportion of drink drivers who have a drinking problem is not very well researched and it probably varies somewhat from country to country. In Sweden, an extensive study over 10 years has demonstrated that a majority of arrested drink drivers showed signs of harmful drinking habits or problem drinking (Bergman et al.,2994). Typically drunk driving is a crime with a high degree of reoffending. Some 30 per cent reoffend within three years.

It is therefore important to ensure that drunk drivers are screened for drinking problems and, if found to have such, to provide adequate sanctions which include participation in rehabilitation programs. If this is not provided, we will see a lot of recidivism.

Electronic Driving Licence (EDL) Licence sanction like suspension and revocation are not as efficient as they could be. Although there is an unfortunate lack of tangible data regarding the frequency with which people drive despite suspension or revocation, experience tell us e.g. that between 30 and 40 per cent of such drivers never reapply for a driver's licence in Sweden. These drivers are not reached by measures which target their drinking habits and possible dependency problems.

In order to address this problem, systems have been developed in which the car checks that the driver has a valid licence (Goldberg, 2000). The EDL is a "smart card" which is used as the key to doors and ignition and it is read by an on-board computer which compares the information on the card with information stored in the computer. If the licence number on the card corresponds to what is listed in the computer, the car will start. If the licence is revoked or suspended, this information is beamed to all computers and this licence will not be validated by the on-board computer.

A system like this would give us the driver's licence as a very powerful tool which would effectively prevent unlicenced driving and motivate suspended drivers to participate in rehabilitation programs in order to be relicenced.

Raising The Drinking Age Evidence from the USA (Voas et al., 1999) shows us that the raising of the legal drinking age, which has taken place

over the years in the USA and Canada, has yielded very favourable results. All of the American states and provinces have raised the legal drinking age to 21 years of age. On the basis of an extensive literature review, Tornros (1994) notes that increasing the legal drinking age to 21 years has clear effects.

A drinking age of 21 means that in most states, driving age is separated from drinking age by five years, also meaning that the young drivers are not inexperienced in both driving and drinking at the same time. This unfavourable combination is however being considered in many European countries, where often the driving age and the drinking age coincide. Although proven to be an effective harm reducing measure, it is a politically difficult one since it is probably rather unpopular among the young voters.

IN AUST. 1/3 ARE RE- OFFENDERS

Vehicle Sanctions There is a great tendency for drunken drivers to reoffend. They often ignore driving licence suspension and continue driving, confident the risk of detection is very low. One way of controlling this problem is to impound or forfeit the vehicle or confiscate the licence plates or to mark the licence plates in a conspicuous manner. Sweedler and Stewart (2000) claim high efficiency for all forms of vehicle sanctions even after the expiry of the measure.

FINALLY If we are successful in applying our tools and reduce the problem of alcohol on our roads, we are also giving public health a helping hand. Measures taken in the road traffic system will also create benefits for the whole public health sector.

The world's leading researchers in the field of alcohol and public health list the ten options which *stand out as "best practices"* to avoid the harmful societal consequences of alcohol consumption. (Babor et al. 2003): minimum legal alcohol purchasing age; government monopoly of retail sales, restrictions on hours or days of sale; outlet density restrictions; alcohol taxes; sobriety checkpoints; lowered BAC limits; administrative licence suspension or revocation; graduated licencing for new drivers; brief interventions for hazardous drinkers. It is worth noting that five of the ten "best practices" are directly related ro road traffic.

I am afraid that before we will be able to make any significant progress in reducing the terrible toll that alcohol takes on our roads, it is necessary for us to be able to demonstrate to our politicians and to our decision makers how serious the problem is.

Therefore we must create an accident reporting system which reveals the true role of alcohol and of other drugs on our European roads.

THE 'LOI EVIN': A FRENCH EXCEPTION

BY Dr. Alain Rigaud President, Association Nationale de Prevention en Alcologies et Addictologie
AND Dr. Michel Craplet Medical Advisor of ANPAA, and Chairman of Eurocare

A EUROPEAN-ORIENTED FRENCH LAW The alcohol policy law, the Loi Evin, was passed in France in 1991 in order to control the advertising of alcohol and tobacco. Whilst direct advertising of tobacco had already been forbidden in France 1974 (the Loi Veil), the tobacco articles of the Loi Evin address smoking in public places. Also as regards tobacco, control policy was further strengthened in 2003 through a sharp increase in taxation.

The severity of the law can be understood better in a European context. Formerly, French law on advertising discriminated against foreign products which led the Scotch whisky producers to take the French Government to the European Court of Justice: France was condemned and was asked to change the law in 1980. A first law was passed in 1985 but the government did not produce a satisfactory text until 1991.

(CUT OUT SELF-REG.)

During this ten year period, producers and advertisers flagrantly used this legal loophole to full advantage. This situation led the French Parliament to pass the Loi Even. This series of events explains why - unlike most European countries -the advertising of alcohol in France does not depend on self-regulation or voluntary codes of practice depending on the goodwill of the producers; it is controlled by law and illegal advertisements can be brought before the courts. There are significant penalties for infringement.

Description Of The Law The articles relating to alcohol in the Loi Evin may be summarized as follows:

- A clear definition of alcoholic drinks is given
- All drinks over 1.2 per cent alcohol by volume are considered as alcoholic beverages
- Places and media where advertising is authorised are defined
- No advertising should be targeted at young people
- No advertising is allowed on television or in cinemas

- No sponsorship of cultural or sport events is permitted
- Advertising is permitted only in the press for adults, on billboards2 on radio channels (under precise conditions), at special events or places such as wine fairs, wine museums
- When advertising is permitted, its content is controlled
- Messages and images should refer only to the qualities of the products such as degree, origin, composition, means of production, patterns of consumption
- *A health message must be included on each advertisement to the effect that "l'abus d'alcohol est dangereux pour la sante"; Alcohol abuse is dangerous for health.* VITAL

Effects Of The Law On Advertising Since 1991 many advertisements infringing the law have been condemned by the French courts. Since 1991, more than twenty advertisements were brought to the courts by the French NGO ANPAA (Association Nationale de Prevention en Alcoologie et Addictologie) and eighteen of the adjudications were in our favour. This success story alarmed the alcohol producers, the advertisers and media people.

As a consequence, since 1991, a real change in alcohol advertising is observable: the law has modified the language of advertising which has lost most of its seductive character. For example, it is no longer permissible to use images of drinkers or depict a drinking atmosphere: As a result the drinker has disappeared from the images which now highlight the product itself.

The law has been effective in correcting excesses in the form and the content of advertising messages and it is essential for the implementation of an overall and coherent preventative effort. Moreover, public health programmes should today address the topic of all psychoactive products in a global perspective. This is why we recently developed in France the concept of "addictologie".

A Law Which Could Be Applied In Europe It is imperative that a European legislative framework covering the advertising of alcohol be enacted. This need has been recognised by many organisations for a long time. They have observed the way products and images of alcohol are transmitted across borders. The internationalisation of the styles, particularly those of the younger generation, have been deployed by the multinational drinks industry in the development of their marketing strategies.

This is why ANPAA and Eurocare are working together for a European control of advertising. We are not suggesting the Loi Evin should be transposed directly into the wider European context, but we believe that this French experience should be taken into consideration.

Confronted by various national circumstances and the opening up of the European Union to new Member States, it is more appropriate to propose basic measures acceptable to all, the aim of which is to protect the younger generation. This is not to make young people scapegoats where many adults allow themselves to consume alcohol as they please, whilst at the same time denouncing the spread of alcohol amongst the younger generation.

In fact these measures will be of help to the younger generations in their adult life. In order to limit the influence of advertising on the young, it is important to:

- Control forms of communications (advertising, public relations, sponsorship, patronage) using sporting and cultural international events.
- Forbid all advertisements for alcohol on television.

As far as national events and media limited to one country are concerned, we suggest giving Member States the freedom to regulate local advertising (billposting, radio, cinema, direct mail). In these fields, cultural characteristics play an important role, and prevention must take into account such cultural aspects in order to be acceptable and effective.

A Law That Cannot Be Ignored The Loi Evin has been constantly challenged but these attacks have not been successful. Many observers noticed the strength of the law: "The complaints lodged with Brussels by several alcohol producers against the Evin Law have not been taken up, up to now. The Eurpean Commission has, in fact, concluded the ban on the sponsorship of sporting events by alcoholic beverage producers should not be judged incompatible with Community law...... the European Commission has considered in this instance that the protection of consumers health should prevail over the freedom of the provision of services".

In France, these attacks culminated in 2004 with several proposals for new legislation to withdraw wine from the law. This came after the adjudications of advertisements for Burgundy and Bordeaux wines, the "stars" of French agriculture and culture. In an unstable political situation, these proposals are a cause for concern. On the other hand, it is possible to be cheered by some good from the EU.

On the 11th March, 2004, the Advocate General of the European Union published his opinion7 in the two cases against the Loi Evin before the European Court of Justice. He asserted that French legislation achieves the objective protection of public health.

Moreover, the law made it impossible for the American brewer Anheuser Busch to sponsor the 1998 Football World Cup in France, in spite of heavy lobbying of the French government. It is important to note that a new sponsor was found in the Casio company. This example shows that sport does not die without alcohol sponsorship.

Limits Of The Law It is regrettable that since 1991 some articles of the law have been changed: advertising is again permitted on billboards everywhere (and not only on places of production) and even in sports grounds, but the ban on television transmission restrains this advertising for major events.

It is true that some advertisements illustrating the patterns of consumption are still using a seductive atmosphere and still link alcohol with "beautiful people". Nevertheless the promoters of these advertisements are running quite high legal risks if the court interprets the law severely.

Of course, many marketing tools can still be used: mailing for middle-aged traditional drinkers or the Internet for the young looking for anything new and exciting. Even if official sponsorship is forbidden, alcoholic drinks are central to many social events such as harvesting, fairs, and, obviously enough, the launch of Beaujolais Nouveau and so on.

Assessment Of The Law The effect of the Loi Evin on alcohol problems has not yet been assessed, and it is probably impossible to do so. The French situation makes this assessment even more difficult: the effect of the Loi Evin has been swamped by the general trend towards the reduced alcohol consumption in France. This is a powerful and long running diminution of the average consumption of 1 per cent per year making it decline dramatically from 30 to 13 litres of pure alcohol per capita per year between 1960 and 2004. DRAMATIC IMPROVEMENT

The Symbolic Effect These quantitative considerations have little importance compared to the qualitative and symbolic effect. Advertising is used to strengthen preconceived ideas about alcohol consumption. These ideas have not been forced on potential consumers, they are instead enshrined in our cultural background and advertisers only use pre-existing, conscious and unconscious images.

Whereas the effect on health or masculinity is theoretically no longer used in the Western world –having been proscribed by most codes of practice – alcohol consumption is still very often associated by advertisers with

personal, sexual, and social success. The restrictiveness of the Evin Law was the only way to change this basic, insinuating, seductive language.

Alcohol Control Policy Is Encouraging Freedom *Despite their reputation, public health experts do not wish to regulate peoples' lives nor do they wish to treat them solely as consumers, unlike alcohol producers whose aim is to impose consumption levels and who are paradoxically the new "norms" givers".*

On the contrary, the philosophy of the associations promoting prevention is to give citizens back their freedom of choice regarding products, consumption patterns, and rituals and to prevent these patterns and rituals becoming bounds which limit freedom.

In addition to technical arguments, some non-government organisations such as the French Association Nationale de Prevention en Alcologie et Addictologie and the European association Eurocare have adopted political and ethical positions, arguing that the EU can no longer content itself with economic objectives, but that it must become a social community where the collective interest has priority over particular economic interests. This collective interest is based on the fact that alcohol is not a product like any other: as a harmful product causing addiction, its use must be controlled by the public authorities.

****

GLOBAL STATUS REPORT: ALCOHOL POLICY

The World Health Organisation publishes a new review of alcohol policies around the world. Here Dr.Linda Hill summarises its main conclusions.

WORLD HEALTH ORGANISATION 2004

Alcohol has been identified by the WHO as the fifth largest risk factor for the global burden of injury and disease. It is the third largest risk factor in industrialized countries, in developing countries with low general mortality – mainly countries with growing prosperity – it is now the highest risk factor.

Alcohol policy is a response to alcohol-related harm in the interestsof public health and social well-being. Government measures to control supply and demand, minimize harm and promote public health are important to achieve this, says the report. Alcohol policies can be grouped as

i) Population-based policies that can shape drinking behaviour across the whole population, e.g. taxation, availability restrictions, minimum drinking age;

ii) Policies targeted at particular problems, such as drink-driving or offences like sales to minors;

iii) Policies to help individual drinkers, such as brief interventions or rehabilitation programmes.

In many countries, policy choices may be influenced by economic and commercial interests.

WHO recognises that alcohol-related harm is not confined to small numbers of heavy drinkers or alcoholics, however. Even non-drinkers may be victims of alcohol-related aggression. The largest share of harm is associated with light and moderate drinkers, because they may occasionally drink hazardously and because their numbers are higher.A World Survey

The Global Status Report: Alcohol Policy aims to raise international awareness about the need for alcohol policies.

The report builds on the Global Status Report on Alcohol, 1999, a global survey of consumption data on alcohol, and the Global Status Report: Young People & Alcohol, 2991, as part of WHO's Global Alcohol Database project.

WHO Questionnaire A four-page questionnaire was sent to WHO representatives or key contact people working in the alcohol field in each country. The choice of questions- on price and taxations, restrictions on availability, drink driving and advertising- was based partly on earlier data and partly on research about the effectiveness of different policies.

The report provides a first snapshot, as at May 2002, of alcohol policies in 118 countries with around 86 per cent of the world's population.

FINDINGS The survey is intended as a starting point for developing a minimum set of essential policies.

Defining Alcohol In Law Defining alcoholic beverages in law provides the basis for other policies. Definitions in different countries range from 0.1 per cent to 12.0 per cent alcohol by volume, with around 1.2 per cent the most usual level.

However, in countries with restrictions, these were rarely enforced in 25 per cent and not enforced in 10 per cent This leaves much room for improvement through governmental or local action, the report concluded.

A Minimum Age, Effectively Enforced The age reported was for purchasing beer to drink on the premises and for purchase beer to take away. Eighteen was by far the most common age. There was no age limit in 15 per cent of countries for drinking beer on the premises and no age for purchasing takeaway beer in 12 per cent.The age llimit was 15-16 in 12 per cent and 13 per cent of countries for on- and off-sales respectively.

The age at which young people start drinking has been linked to higher levels of harm, such as injury, and heavy drinking later in life. Research shows that introducing a minimum age or raising the minimum age can reduce harm to young people. The survey did not ask about enforcement, although the report noted research showing that a small increase in enforcement can reduce sales to people below the legal age.

IMP

Blood Alcohol Limit For Drivers In most countries, general laws against drink-driving have been replaced by specific limits on blood alcohol content (BAC).A successful drink-driving strategy requires highly visible, frequent, random road checks, to test both breath and blood.

TAXING

Taxation Affecting Price Alcohol taxes affect price levels, which influence consumptions levels.

In 16 countries, a beer cost less than a cola. In most countries, 1-3 soft drinks could be bought for the price of a beer. Alcohol is sold cheaper in developing countries. Relative to national wealth, one beer in Europe costs the same as nine beers in Africa.

There is good evidence that higher taxes and higher prices can reduce alcohol related harm. It was noted that industrialised countries are not using alcohol tax to its full potential as a public health measure.

Controlling Alcohol Advertising And Sponsorship *Alcohol advertising portrays drinking as socially desirable, while ignoring risks to individuals and to public health. Advertising can potentially promote pro-alcohol attitudes, recruit new drinkers and increase consumption among current drinkers.*

The report considers restrictions on alcohol advertising and sponsorship to be an appropriate part of a comprehensive alcohol policy.

Less than a third of countries that had laws restricting advertising considered that they were fully enforced. About 15 per cent of countries rely on

industry agreements, which appear difficult to enforce effectively because of their ambiguous and voluntary nature.

Sponsorships are becoming increasingly important in alcohol marketing. Only a quarter of countries have laws controlling sponsorship of youth and sports event. Alcohol marketing on the internet is also on the increase, often targeting young people.

Alcohol Free Environments Restrictions on drinking alcohol in public settings has two aims: to ensure a safe public environment for leisure and sports, and to minimize injury and loss of productivity.

CONCLUSION **The Global Status Report: Alcohol Policy emphasises that single policies are less likely to impact on drinking and alcohol related-harm than several policies working together. This is particularly important if all governments policies are not necessarily working in the same direction.**

******************* *******************

THE GLOBE MAGAZINE IS THE SOURCE OF THE FOLLOWING TWO ARTICLES:

"ALCOHOL HEALTH CLAIMS VASTLY OVERBLOWN"

ARTICLE 1

ALCOHOL AND HEALTH: A DRINK A DAY WON'T KEEP THE DOCTOR AWAY by Charles S.Lieber, Professor of Medicine & Pathology, Mt. Sinai School of Medicine, New York City.

Dr. Lieber is recognized as an expert on the toxicology of alcohol and related hepatic as well as nutritional disorders. (Leiber C.S. Alcohol and Health: A drink a day won't keep the doctor away. Cleve. Clin. J. Med 2003; 70-945-953. Copyright 2003 The Cleveland Clinic Foundation. All rights reserved)

We should not advise patients to start drinking alcohol for its alleged cardiovascular benefits. The negative effects of alcohol are well established, and the evidence of alcohol's benefits comes mainly from epidemiologic studies that were not well controlled for other influences, such as lifestyle factors. Moreover, we have other means of lowering cardiovascular risk that are safe and proven. Those who are healthy and whose drinking history shows little risk of developing alcohol dependency may continue to drink moderate amounts. Heavy drinkers should be advised to quit.

IMP.

KEY POINTS

Some reports of coronary and mortality benefits of alcohol were based on the use of negligible amounts of alcoholic beverages, indicating that factors other

than alcohol might have been involved. The most likely explanation is lifestyle factors associated with moderate drinking. eg - exercise, good diet, etc

National guidelines recommend caution when applying the results of epidemiologic evidence of benefit from alcohol consumption to individual patients. Alcohol consumption was shown to increase levels of high density lipoprotein (HDI.) cholesterol, but the HDL subtype that increased may not be one that is optimal for coronary protection.

Claims that wine is healthier than other alcoholic beverages have not been consistently corroborated.

There is no evidence that moderate drinking is detrimental in people who have shown that they are not prone to develop craving and to slip into dependence.

A drink a day does not keep the doctor away. This is what we should be telling patients who ask if they should start having a drink every day because they heard it lowers the risk of heart attack or stroke.

So far the claims of health benefits from moderate drinking come from epidemiologic studies, some which involved the use of so little alcohol that other factors (such as high income and healthy lifestyles) must have been responsible for the risk of myocardial infarction is mediated in large part by increases in both HDI. 2 and HDI 3.

CONFLICTING REPORTS However, these various observations were made in alcoholics with a relatively high intake of alcohol. It is now well recognized that large amounts of alcohol have adverse effects not only on the liver,[9,10] but also virtually on all tissues of the body, including the cardiovascular system [11] and it is generally agreed that such high intakes are not generally associated with protection against coronary heart disease [12].

AGE Recent studies reported that light to moderate alcohol consumption is associated with a lower risk of dementia in people aged 55 and older. The effect seemed to be independent of the source of alcohol [23]. Furthermore, Mukamal et al [24] showed consumption of one to six drinks weekly to be associated with a lower risk of dementia among older adults. However, the amount of alcohol involved was so low as to raise doubts that it could explain such benefits.

IS WINE HEALTHIER THAN OTHER ALCOHOLIC BEVERAGES? Many physicians and patients have heard reports of the "French paradox" or the "Mediterranean diet", in which red wine is supposed to offer significant health benefits. But the data to date do not show that wine is any healthier than any other type of alcoholic beverage.

In some studies, the amount of wine used (as little as one glass a month) was so small that we should doubt whether it could really have been responsible for the beneficial effects observed. The improved outcome could have been due to another factor, such as lifestyle. For example, the Copenhagen heart study 25 found that wine drinkers had a lower relative risk for coronary artery disease, but also that they consumed twice as much fruit and vegetables.

Furthermore, Mortensen et al showed that wine drinking is a general indicator of optional social, cognitve and personality development. Consequently, the association between drinking habits and social and psychological characteristics may explain in large part, the apparent health benefits of wine. This is also the interpretation of some other investigators, including those of the National Institute of Alcohol Abuse and Alcoholism.

DRINKING FOR HEALTH: THE CASE AGAINST There are a variety of reasons not to advocate moderate drinking for the purpose of reducing cardiovascular risk.

NOT ALL STUDIES ARE POSITIVE Contrary to some of the positive studies, a 21-year follow-up of 5,766 Scottish men ages 35 to 64 32 found no cardiovascular or other evidence that alcohol consumption reduced mortality for light and moderate drinkers. Furthermore, higher levels of intake (three drinks per day) were associated with increased mortality in men with previous myocardial infarction 33. Another study of alcohol use in middle-aged people came to similar conclusions 34.

A meta-analysis of many of the alcohol-cardiovascular studies concluded that "the degree of protection from moderate doses of alcohol should be reconsidered, and further research investigating the effect of drinking patterns on the risk of coronary heart disease should be performed 35".

PUBLICATION BIAS In view of the objections raised above, one may wonder why the number of papers reporting positive effects of moderate drinking exceeds the negative ones. It is probably that publication bias led to overestimation of the reported effects 34.

UNDERAGE DRINKING AND TRAFFIC ACCIDENTS At present, alcohol is the leading drug abused by US teens. Underage drinking accounts for 19.7 per cent of alcohol consumption in the United States.

Seventy eight per cent of high school students have tried alcohol. Thirty per cent admit to binge drinking at least once a month. The average age of the first drink is 14 37. Encouraging moderate drinking in adults may

unintentionally encourage drinking in those who are under the legal drinking age which could increase the well-known associated risk of motor vehicle accidents.

RISK OF DEPENDENCE OUTWEIGHS ANY ALLEGED HEALTH BENEFIT There are no people in whom moderate drinking is clearly desirable as therapy. Even if moderate alcohol consumption turns out to be beneficial in some people, the risk of developing alcohol dependence would outweigh any potential benefit in reducing heart disease.

ALCOHOL AN ADDICTION-CAUSING DRUG.

ADVERSE CARDIOVASCULAR EFFECTS OF MODERATE DRINKING Other reasons not to recommend moderate alcohol consumption relate to possible negative health effects. Although the cardiovascular benefits of moderate drinking are often cited, other studies have found negative effects of moderate drinking.

STROKE It has been reported that light to moderate alcohol consumption reduces the overall risk of stroke and specifically the risk of ischemic stroke. However, since the benefit was apparent with as little as one drink per week [39], it is highly unlikely that the effect was due to alcohol per se.

By contrast, a prospective study of the health effects of alcohol consumption in middle-aged and elderly men [40] found that light and moderate drinkers were actually at increased risk for fatal and non-fatal stroke.

ALCOHOL - A BIGGER HEALTH RISK

BLOOD PRESSURE Drinking can raise blood pressure. Increased blood pressure has been observed with three drinks a day [41]. In a Kaiser-Permante Study [42] women who drank two or fewer drinks per day had lower blood pressure than non-drinkers, whereas men and women who took three or more drinks per day had higher systolic pressures. In 1986, the same investigators reconfirmed the relationship of higher blood pressure to alcohol use in both men and women.

ADVOCATION OF MODERATE DRINKING MAY LEAD TO HEAVY DRINKING - TO DRINK MODERATELY OR NOT TO DRINK; MY RECOMMENDATIONS

In view of the lack of definitive evidence for beneficial effects of moderate drinking, Goldberg [45] proposed to settle this issue by assigning patients with cardiovascular disease to an alcohol treatment study. However, such a study would be ill advised because of the risk that a former abstainer might develop alcohol dependence. The consequences for the individual and for society could be catastrophic.

Nearly 20 years ago, in a New England Journal of Medicine editorial [46], I stated that whether a patient should start drinking must take special circumstances into account, and that still holds true today. When intact

judgment and motor coordination are essential, as in driving, temporary cessation of alcohol intake is of course indicated. Abstinence is also advisable under other special circumstances, such as pregnancy, since even moderate amounts of alcohol may adversely affect the fetus.

NONE FOR DRINKING

Advising abstainers to take up moderate drinking to protect their coronary arteries puts them at risk for alcohol dependency and the associated social and medical problems. However, there is no compelling reason to advise abstinence to our patients who are already drinking at a moderate level and have demonstrated the capacity to keep their drinking at an acceptable level.

RISKY ADVICE

****

THE GLOBE MAGAZINE
ARTICLE 2

ALCOHOL ADVERTISING IN NEW ZEALAND:
Time For Second Thoughts on Self-Regulation?

by Linda Hill, Alcohol and Public Health Research Unit, Department of Public Health, Faculty of Medicine and Health Sciences. *University of Auckland, New Zealand*

In September 2003 New Zealand's Advertising Standards Authority (ASA), an industry body representing advertisers and broadcasters, extended alcohol advertising on television by half an hour. The start time changed from 9 pm to 8.30. This was opposed by the Alcohol Advisory Council (ALAC), who wanted the time *pulled back to 10.30, and by the Ministry of* Health who recommended the discontinuation of all alcohol advertising on radio and television.

'Minimising the exposure of young people to alcohol marketing messages' is one of the Objectives of the National Alcohol Strategy adopted by this government in 2001. Between 8.30 and 9 pm, 26 per cent of 12-17 year olds are watching television. This drops to around 10 per cent by 11 pm. Few alcohol ads are scheduled after 11 pm, so bringing the start time forward extending exposure time by 20 per cent.

Why wasn't this stopped? Because in 1993, the year after the 9 pm restriction was set, responsibility for standards in advertisements (rather

than programming) was passed to industry self-regulation under voluntary codes. In 2003 the ASA asserted its right to self-regulation by declining to meet concerned Ministers prior to release of its revised Code on Liquor Advertising with the new start time.

The government has no current powers to intervene on this issue – although it has the power to create some. At the time, there was other legislation before Parliament prohibiting smoking in bars and restaurants, to industry cries of "nanny state".

Liberalisation Of Broadcasting And Alcohol Advertising   New Zealand has had laws about the sale of alcohol since 1842 but the marketing of alcohol is a modern phenomenon that has received less policy attention. For historical reasons related to donations to political parties, alcohol legislation is decided by the individual 'conscience" votes of MPs. This means the health policies of political parties do not include alcohol issues.

In 1981 advertising for bottle stores was permitted on radio and television and from 1987 alcohol companies could broadcast corporate and sports sponsorship ads. Young teenagers thought this simply promoted alcohol.

Public concern led to a review of alcohol advertising by a newly created Broadcasting Standards Authority (BSA) in 1990-1991.

The outcome was a decision that alcohol brand advertising should be permitted with restricted hours of viewing. Part of the deal was that broadcasters would donate their time for alcohol health promotion advertising exposure by ten to one. In a sample of weekend television in February 2002, one health promotion ad was shown for every five alcohol ads.

Organisations for the broadcasting, print media and advertising industries now support the alcohol industry on alcohol advising issues. The alcohol market in New Zealand is dominated by a few main players who are major clients for these industries.

Being a large client has advantages. For example, in 2002 the alcohol advertising sold by the two state-owned television channels cost 54 per cent less than equivalent time charged at standard rates.

Loss Of Policy Control   *At the time, the government was amending the Broadcasting Act to clarify complaints processes. Complaints about programmes would go to the BSA. Complaints about advertisements would go to the Advertising Standards Authority (ASA) that already had a code and a complaints procedure for print advertisements.*

The effect of this amendment was that all matters related to alcohol advertising on radio and television passed out of any direct or indirect control by government.

Self-Regulation And Self-Review The BSA developed the first Code of Liquor Advertising in 1992 but in 1995 the ASA was responsible for a major review of its own new arrangements. The review recommended a committee to pre-vet ads. Unsurprisingly, it recommended continuation of broadcast advertising, despite opposition from the Ministry of Health, ALAC and public health organisations.
Non-industry members have been included on review committees, often with marketing rather than public health expertise.

In 2003 the review team included a Director of Public Health, however. He did not agree to the time change but the review report was released without his dissenting opinion.

Alcohol brand logos can appear at the beginning and end of sponsored sports coverage and other programmes at any time of day. In the February 2002 sample of weekend television, 37 alcohol sponsorship logos appeared within a three-hour period of afternoon sports coverage.

SPORT + ALCOHOL ADS.

Reclaiming Policy Control *Reviews of the Code of Liquor Advertising have been used to deflect efforts to have alcohol advertising policy addressed at the political level.*

On June 9, the Group on Alcohol Advertising supported by the NZ Drug Foundation, presented a petition to Parliament. The presenters wore sandwich boards parodying Tui beer slogans. The petition calls for a Health Committee inquiry into alcohol advertising. The Ministry of Health proposed this in 2001 as an option in a paper to the Ministerial Committee on Drugs, but no action was taken. Following the 2003 ASA review, there appears to be some ministerial support for this approach. The Health Committee inquiry can be a focus for public and political debate that may lead on to policy action.

Second Thoughts On The Drinking Age Alcohol advertising is not the only issue being raised in New Zealand. Since 1989 New Zealand has liberalised liquor licensing, extended hours and days of trading and allowed wine and beer sales from supermarkets, as well as allowing alcohol advertising on radio and television.

In December 1999, the age of alcohol purchase was lowered from 20 to 18. A national survey a year later showed 18-19 year olds are now the heaviest

drinkers. The most marked increases in drinking were among 14-17 year olds.

In 2000-2002 drink driving prosecutions increased among both these age groups. Police in many districts report increases in teenagers drinking in public, too intoxicated to look after themselves.

A recent public opinion poll gave 75 per cent support to putting the age of purchase back up to 20. This is 5 per cent higher than support for 20 before Parliament lowered the age in 1999.

- See www.tui.co.nz for a marketing campaign that targets students and young males with juvenile humour, branded clothing and photo competitions.
- Barb Lash (2004) Young people and *alcohol. Some statistics* to 2002 on possible effects of lowering the drinking age. Final Report. Ministry of Justice. May
- wwwjustice.govt.nz/pubs/reports/2004/youth-alcohol/index.btm/

****

Thank you for the opportunity of contributing.

Sincerely

Donald Cameron

State Director for Victoria

People Against Drink Driving.