The Royal Australasian
College of Physicians

03 June 2008

Mr Elton Humphery
Committee Secretary
Community Affairs Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Mr Humphery

The Royal Australasian College of Physicians (RACP) submission for the *Inquiry into Ready-to-Drink Alcohol Beverages*

The RACP welcomes the opportunity to present its submission for the Community Affairs Committee *Inquiry into Ready-to-Drink Alcohol Beverages*. In 2005 the RACP published its policy on alcohol. [1] This policy document addresses many of the issues which will be highlighted in this submission. It is available on the RACP website at:http://www.racp.edu.au/index.cfm?objectid=49F4AA63-2A57-5487-DB4AE18D11BD69CB.

The RACP comprises over 10,000 Fellows, including Consultant Physicians and Paediatricians and Fellows of the College itself (physicians and paediatricians), and Fellows of its Faculties of Public Health Medicine, Rehabilitation Medicine, Occupational & Environmental Medicine and of its Chapters of Palliative Medicine, Addiction Medicine, Community Child Health and Sexual Health Medicine. The Joint Faculty of Intensive Care Medicine is part of both the RACP and the Australian and New Zealand College of Anaesthetists. In addition, the RACP encompasses 28 Specialty Societies representing the spectrum of practice in Internal Medicine and Paediatrics across 23 sub-specialties.

The College has evolved to bring together different groups of physicians who share common ideals in medical practice. Physicians and paediatricians are medical experts to whom patients with complex and difficult or chronic diseases are referred. They emphasise the treatment of the whole individual within a social context. This requires not only a high level of medical expertise, but high cognitive competence and the ability to communicate exceptionally well with patients, other medical practitioners such as general practitioners, other health team members and medical trainees. These ideals have led the RACP to a unique position among the specialist medical colleges.

[1] The Royal Australasian College of Physicians. *Alcohol Policy: Using evidence for better outcomes*. RACP Sydney 2005.

Not only is the RACP the key professional training and education body for physicians in Australia and New Zealand, it has also emerged as a key informant and influence in health policy over a range of areas.

Inquiry into Ready-to-Drink Alcohol Beverages

Introduction

Adolescence is a time of experimentation with many different types of risks, including the risks of drinking immoderate amounts of alcohol. Deciding when an adolescent has crossed the line and has developed a clinically pathological pattern of alcohol consumption is difficult. Consequently the subject of drinking by teenagers is a source of much anxiety for parents, the medical profession and the community. Acute alcoholic poisoning and episodes of severe intoxication (e.g. blackouts) with or without physical and social harm are all early warning signs of serious problems emerging in a young person. However, many adolescents pass through a temporary phase of high risk drinking during periods of emotional turmoil. Most resolve without any clinical intervention.

In young people with a strong family history of alcohol-related problems, clinicians should ask about alcohol use and advise parents to discuss the risk of heavy drinking and the options available including clinical interventions.[2] Follow-up of these young people and their families is important and helps the adolescent to manage their alcohol intake.[3]

There is growing evidence that family life during the critical developmental phases of early childhood is a significant factor in building resilience and reducing the risk of a range of subsequent social and behavioural problems, including problematic alcohol use.[4] Children and young people are particularly vulnerable during times of developmental change. Transition to high school can herald a period of high risk drinking.[5]

Childhood and adolescence risk factors do not accurately predict which young people will go on to suffer from alcohol-related problems. The interaction between risk and protective factors initiated during childhood and adolescence continues into adulthood and reinforces the importance of prevention and early intervention.[6] [7] [8]

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[2] Conway KP, Swendsen JD, Merikangas KR. Alcohol expectancies, alcohol consumption, and problem drinking: The moderating role of family history. *Addictive Behaviors* 2003; 28(5):823-836.
[3] Winters KC. *Assessment of Alcohol and Other Drug Use Behaviors among Adolescents* Department of Psychiatry, University of Minnesota, Minneapolis 1988.
[4] Homel R, et al. *Preventing alcohol-related crime through community action: The Surfers Paradise Safety Action Project*. In: Homel R, Ed., Policing for prevention: Reducing Crime, Public Intoxication and Injury, Monsey, NY: Criminal Justice Press, 1997; 237: 35-90.
[5] Schulenberg J, O'Malley PM, Bachman JG, Wadsworth KN, Johnston LD. Getting drunk and growing up: Trajectories of frequent binge drinking during the transition to young adulthood. *Journal of Studies on Alcohol* 1996; 57(3):289-304.
[6] Saunders J, Conigrave K. Early identification of alcohol problems. *Canadian Medical Association Journal* 1990; 143: 1060-1068.
[7] Haggerty EL, Effects of alcoholism in and parenting styles on the self esteem and coping styles of children. *Dissertation Abstracts International* 1994; 55(5):2008-B.

Summary

1. Alcohol imposes a big burden of social and health harm, to others as well as to the drinker. Alcohol is thus no ordinary commodity.
2. Strategies to reduce rates of alcohol problems differ in their effectiveness. Among the most effective and cost-effective are slight increases in price and controls on the availability of alcohol.
3. Many alcohol controls have been undercut by competition policy. International trade agreements often undercut alcohol controls.
4. At the international level, a public health convention and a greater focus on alcohol is needed to encourage implementation of more effective policies.
5. At state and local levels, there needs to be more emphasis on evidence-based policy and practice to reduce harm from alcohol in young people.

Suggested approaches to reducing alcohol consumption include:

- Taxation by alcohol content within each beverage class (i.e. lower taxes for lower concentration beverages such as low alcohol beer);
- Taxation by alcohol content across all beverage classes;
- A slight increase in the overall rate of taxation; and,
- Earmarking of a small proportion of alcohol taxation revenue for alcohol-related prevention and health services (i.e. hypothecation for prevention, treatment, research and training).

(a) the effectiveness of the Government's proposed changes to the alcohol excise regime in reducing the claims of excessive consumption of ready-to-drink alcohol beverages;

Tax and price controls can have a profound and rapid effect on consumption of alcohol and harm. Between 1977 and 1978 the excise duty on spirits was increased by 40 per cent. This resulted in a significant reduction in the consumption of spirits. No other single policy has the same potential to reduce the social, health and economic costs of excess alcohol use in Australia as alcohol taxation.[9] [10] [11] [12] The size of the effect varies for different countries, different beverages (e.g. beer consumption is usually less responsive to price changes than is wine or spirits), but the direction of the effect is highly consistent. [2]

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[8] Bonomo Y, Bowes G, Patton G. Transition to alcohol dependence in young people: A representative longitudinal study. *Journal of Adolescent Health* 2000; 26(2): 87.

[9] Ludbrook A, Godfrey C, Wyness L, Parrot S, Haw S, Napper M, et al. *Effective and Cost- Effective Measures to Reduce Alcohol Misuse in Scotland: A Literature Review*. Aberdeen: University of York 2002.

[10] Osterberg E, *Effects of price and taxation.* In Heather N, Peters TJ, Stockwell T (Eds) International Handbook of Alcohol Dependence and Problems. Chichester: John Wiley and Sons, 2001; 685–698.

[11] Ludbrook A, Godfrey C, Wyness L, Parrot S, Haw S, Napper M, et al. *Effective and Cost- Effective Measures to Reduce Alcohol Misuse in Scotland: A Literature Review*. Aberdeen: University of York 2002.

[12] Crosby D, Stockwell T, Wodak A, O'Ferrall T, *Alcohol, Taxation Reform, and Public Health in Australia*: A submission to the Federal Parliamentary Inquiry into Substance Abuse in Australian Communities' 2000.

(b) the consumption patterns of ready-to-drink alcohol beverages by sex and age group;

Young people

Young people are particularly vulnerable to the harmful effects of alcohol because of the combination of inexperience of drinking, and the frequent combination of high-risk drinking with high-risk activity and potential accidental injury. Fortunately, most teenagers drinking at high risk manage to survive a usually brief period of adolescent turbulence without clinical interventions. Some however, will continue to drink at high risk levels and some will suffer irreparable harm.

There has been a significant increase in regular binge drinking (drinking at least 5 drinks in one session) to the point of intoxication in young Australians in recent years. Drinking to the point of intoxication and therefore exposure to risk has become more common among young Australians in recent years. This rise has been especially dramatic in young women.[13] In 2004, 87 per cent of Australian students aged 18-19 years reported drinking at least weekly. [14] In 2004, of all young people aged 14-19, 19 per cent of males and 15 per cent of females drank at least once a month at harmful and hazardous levels. [15]

Comparisons between 1996 and 2003 surveys show that the proportion of female adolescent drinking in excess of drinking levels for chronic harm increased from one per cent to 10 per cent.[16] [17]

- Of risky/high risk drinkers aged 18-24 years, 75 per cent drank ready to drink spirits and liqueurs compared to 56 per cent of low risk drinkers of the same age;
- The apparent annual per person consumption by those aged 15 years and over in Australia in 2004-05, was 4.6 Litres of alcohol (Lal) beer, 3.1 Lal wine and 2.1 Lal spirits, totalling 9.8 Lal per person; [18]
- Of 2.1 Lal spirits apparently consumed per person aged 15 years and over, 0.9 Lal (44 per cent) was in the form of 'Ready To Drink' beverages; [19]

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[13] Mathers C, Vos T, Stevenson C. *The Burden of Disease and Injury in Australia*, Australian Institute of Health and Welfare November 1999. (accessed May 2005) http://www.aihw.gov.au/publications/health/bdia/

[14] AIHW (Australian Institute of Health and Welfare). *Alcohol and other drug treatment services in Australia 2003–04: report on the national minimum data set.* Drug Treatment Series 4. AIHW cat. No. HSE 100. Canberra 2005.

[15] AIHW (Australian Institute of Health and Welfare). *Alcohol and other drug treatment services in Australia 2003–04: report on the national minimum data set.* Drug Treatment Series 4. AIHW cat. No. HSE 100. Canberra 2005.

[16] Young A, Powers J, Brotherston R, Wheway V. *Australian Women and Alcohol Consumption 1996-2003* Australian Longitudinal Study on Women's Health (ALSWH)Report to the Australian Government Department of Health and Ageing 2005.

[17] AIHW (Australian Institute of Health and Welfare). *Alcohol and other drug treatment services in Australia 2003–04: report on the national minimum data set.* Drug Treatment Series 4. AIHW cat. No. HSE 100. Canberra 2005.

[18] Australian Bureau of Statistics, Apparent Consumption of Alcohol, Australia, 2004-05, cat. no. 4307.0.55.001, ABS, Canberra 2006.

- Children have a greater vulnerability to alcohol than adults; as well as being physically smaller, they lack experience of drinking and its effects; [20]
- Young people when intoxicated are more likely to indulge in risky behaviour such as swimming, driving, unsafe or unwanted sex, verbal or physical abuse; [21]
- In 2004, 25 per cent of those aged 14-19 years drank alcohol on a daily or weekly basis in the last 12 months compared to 50 per cent of all persons 14 years and over; [22]
- Among teenagers aged 14-19 years drinking at risky/high risk levels in the long term, 77 per cent of boys usually consumed regular strength beer, while 85 per cent of girls usually consumed bottled spirits and liqueurs. [23]

(c) the consumption patterns of all alcohol beverages by sex and age group;

- Of those who drank at risky/high risk levels (based on their consumption in the week prior to interview), overall and for men the preferred beverage was beer, while women preferred wine/sparkling wine;[24]
- 61 per cent of risky/high risk drinkers consumed beer, compared to 45 per cent of those who drank at a low risk level; [25]
- Of risky/high risk drinkers, 84 per cent of males and 32 per cent of females drank beer, compared to 68 per cent of male and 16 per cent female low risk level drinkers; [26]
- 78 per cent of female and 40 per cent male risky/high risk drinkers consumed wine/sparkling wine, compared to 62 per cent of female and 35 per cent male low risk drinkers. [27]

(d) the impact of these changes on patterns of overall full strength spirit consumption, including any increased consumption of standard drinks of alcohol;

Hypothecated Tax- Redirecting revenue (hypothecation)

Directing a proportion of the revenue collected from taxes on alcohol towards funding the government's response to the health, social, and economic harms resulting from alcohol misuse (hypothecation), has been shown to reduce the level of alcohol-related harm. Despite this, revenue collected from alcohol taxes is primarily allocated to general revenue. The Australian Federal government derives A$4.3 billion from

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[19] Australian Bureau of Statistics, Apparent Consumption of Alcohol, Australia, 2004-05, cat. no. 4307.0.55.001, ABS, Canberra 2006.
[20] National Health and Medical Research Council, Australian Alcohol Guidelines: Health Risks and Benefits, NHMRC, Canberra 2001.
[21] DrugInfo clearinghouse 2002, The facts about binge drinking - for young people, viewed 5 June 2006, www.druginfo.adf.org.au/article.asp?ContentID=the_facts_about_binge_drinking
[22] Australian Bureau of Statistics, Apparent Consumption of Alcohol, Australia, 2004-05, cat. no. 4307.0.55.001, ABS, Canberra 2006.
[23] Australian Bureau of Statistics, Apparent Consumption of Alcohol, Australia, 2004-05, cat. no. 4307.0.55.001, ABS, Canberra 2006
[24] Ibid
[25] Ibid
[26] Ibid
[27] Australian Bureau of Statistics, National Health Survey: Summary of Results, Australia, 2004-05, cat. No. 4364.0, ABS, Canberra 2006.

excise on alcohol beverages. Very little of this revenue is directed towards preventing or alleviating the adverse effects of alcohol. The breakdown of alcohol beverage excise revenue in 2005 was as follows:

- Beer, A$1.6 billion;
- Spirits, A$1.3 billion; and,
- Wine, A$0.6billion.[28]

Less than two per cent of this funding was spent on reducing alcohol-related harm.[29]

Funding allocations for prevention and treatment should reflect the high levels of revenue generated by the sale of alcohol products as well as the burden of alcohol-related harm on the community. In this context, the Australian Government should identify and allocate a standard portion of the revenue collected from a volumetric tax on all alcohol products to help address the damage to the community arising from alcohol misuse. Alternatively, prevention and treatment programs could be funded from a small increase in alcohol taxation which is identified as dedicated for this purpose.

The establishment of the Alcohol Education and Rehabilitation Foundation (AERF) provides some degree of hypothecation of alcohol taxation although it must be noted that this funding has ceased. In Australia, the report of the first four years of the Northern Territory's *Living with Alcohol* (LWA) program found that a tax increase of only five cents on a standard drink containing more than three per cent alcohol contributed to an average reduction in consumption of about 22 per cent per person. In the first four years, a total of A$18 million of the levy raised paid for a broad range of new prevention and treatment programs in the Territory. It was estimated that only one extra cent levied nationally for each standard drink (10g of alcohol) would raise approximately A$100 million per year for alcohol prevention and treatment initiatives.[30]

(e) the evidence underpinning the claims of significant public health benefit in the increase of excise on this category of alcohol;

- Alcohol is the second largest cause of drug-related deaths and hospitalisations in Australia (after tobacco); [31]
- Alcohol is the main cause of deaths on Australian roads. In 1998, over 2,000 deaths of the total 7,000 deaths of persons under 65 years, were related to alcohol; [32]

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[28] Econtech Pty Ltd. *Modelling health related reforms to taxation of alcoholic beverages.* Report prepared for the Alcohol and other Drugs Council of Australia. Canberra 2004.
[29] Alcohol and other Drugs Council of Australia, *Drugs, money and governments*, Alcohol and other Drugs Council of Australia, Canberra 1999.
[30] Curtin University of Technology: Health Science National Drug Research Institute: Media Release, *Alcohol Taxation Good for your Health* March 2000.
[31] AIHW (Australian Institute of Health and Welfare). *Alcohol and other drug treatment services in Australia 2003–04: report on the national minimum data set.* Drug Treatment Series 4. AIHW cat. No. HSE 100. Canberra 2005.
[32] Ridolfo B, Stevenson C, The Quantification of Drug-caused Mortality and Morbidity in Australia, 1998, Drug Statistics Series No. 7, AIHW Cat. No. PHE 29, AIHW, Canberra 2001.

- In 2004, the age standardised rate for male deaths due to alcoholic liver disease as the underlying cause was 5.5 per 100,000, compared with 1.5 per 100,000 for females. [33]
- In 2004, the age standardised rate for male deaths with mental and behavioural disorders due to alcohol as the underlying cause was 1.9 per 100,000, compared with 0.4 per 100,000 for females. [34]

(f) applicability of incentives to encourage production and consumption of lower alcohol content beverages;

From the international evaluation literature a list of 9 "best practices" was:

Alcohol control policies

- Alcohol taxes;[35] [36] [37]
- Minimum legal purchase age;[38] [39]
- Government monopoly of retail sales;[40]
- Restriction on hours or days of sale;[41]
- Outlet density restrictions.[42] [43]

Drink-driving countermeasures

- Sobriety check points;[44]
- Lowered BAC limits;[45]
- Administrative license suspension;[46] [47]
- Graduated licensing for novice drivers.[48] [49]

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[33] Australian Bureau of Statistics, Apparent Consumption of Alcohol, Australia, 2004-05, cat. no. 4307.0.55.001, ABS, Canberra 2006.
[34] Ibid.
[35] Wagenaar AC, Harwood EM, Toomey TL, Denk CE, Zander KM, Public Opinion on Alcohol Policies in the United States: Results from a National Survey, *Journal of Public Health Policy* Vol. 21, No. 3 (2000), pp. 303-327.
[36] Dave D, Kaestner R, Alcohol taxes and labor market outcomes *Journal of Health Economics* 2002; 21: (3): 357-371.
[37] Chaloupka FJ, Grossman M, Saffer H, The Effects of Price on Alcohol Consumption and Alcohol-Related Problems. *Alcohol Research & Health* 2002; 26: (1):22-34.
[38] Du Mouchel W, Williams AF, Zador P, Raising the Alcohol Purchase Age: Its Effects on Fatal Motor Vehicle Crashes in Twenty-Six States *The Journal of Legal Studies* 1987;6:(l): 249-266.
[39] Scribner R, Cohen D, Effect of Enforcement on Merchant Compliance with the Minimum Legal Drinking Age *Law Journal of Drug Issues* 2001; 31 :(4):857- 866.
[40] Holder HD*,* Wagenaar *AC,* Effects of the elimination of a state monopoly on distilled spirits' retail sales: a time-series analysis of Iowa *Addiction* 1990; 85 :(12):1615-1625.
[41] Howat P, Sleet D, Elder R, Maycock B, Preventing Alcohol-Related Traffic Injury: A Health Promotion Approach, Traffic Injury Prevention, 2004; 5:3, 208- 219.
[42] Holder HD, Gruenewald PJ, Ponicki WR, Treno AJ, Grube JW, Saltz RW, Et Al. Effect of Community-Based Interventions on High-Risk Drinking and Alcohol-Related Injuries *JAMA.* 2000; 284:2341-2347.
[43] Grube JW, Stewart K, Preventing impaired driving using alcohol policy. Traffic Inj Prev. 2004; 5(3):199-207.
[44] Elder RW, Shults RA, Sleet DA, Nichols JL, Zaza S, Thompson RS, Effectiveness of Sobriety Checkpoints for Reducing Alcohol-Involved Crashes *Traffic Injury Prevention* 2002; 3:4, 266- 274.
[45] Shults R, Reviews of evidence regarding interventions to reduce alcohol-impaired driving American *Journal of Preventive Medicine* 2001; 21: (4): 66 - 88.
[46] Nathens AB, Jurkovich GJ, Cummings P, Rivara FP, Maier RV, The Effect of Organized Systems of Trauma Care on Motor Vehicle Crash Mortality *JAMA.* 2000; 283:1990-1994.
[47] Chaloupka FJ, Grossman M, Saffer H, The Effects of Price on Alcohol Consumption and Alcohol-Related Problems. *Alcohol Research & Health* 2002; 26: (1):22-34.

(g) the modelling underpinning the Government's revenue estimates of this measure;

Alcohol taxes are an attractive instrument of a policy for reducing alcohol related harm as they can be used both to generate direct revenue and to reduce the alcohol-related harm and therefore have the highest cost-effectiveness of all measures for Australia. [50] The most important downside to raising alcohol taxes is smuggling and illegal alcohol production. Modeling health-related reforms to taxation of alcoholic beverages has demonstrated that alcohol tax reform on its own is not effective and must be carried out in conjunction with other strategies. [51] Alcohol is relatively price-inelastic compared to almost all other commodities. This means that an alcohol price rise results in a relatively small fall in consumption (and *vice versa*) compared to most other commodities.

There have been several significant developments in the alcohol market over the past 30 years. [52] One has been the rise in the popularity of Australian and 40 per cent increase in taxes on spirits in 1977/78 New Zealand wine, both domestically and internationally. This has been encouraged by a favourable taxation regime for wine in comparison with beer and spirits. This situation has encouraged the widespread distribution and consumption of cheap packaged wine and the production of "ready to drinks" (RTDs).

(h) the effectiveness of excise increases as a tool in reducing the levels of alcohol related harm;

The alcohol tax system in Australia, on the one hand, reduced taxes on RTDs to a rate slightly higher than full strength beer and, on the other, increased taxes on alcoholic sodas and lemonades with a wine base to the same level as RTDs. The result appears to have been a switch in market share from full strength beer to RTDs, though the net level of alcohol consumption has remained static.[53]

In Australia, the introduction of the Wine Equalisation Tax (WET), for example, benefits cask wine producers (mostly large multinational companies) at the expense of Australia's premium wine producers. The WET also imperils the health and well-being of many disadvantaged communities where the price of cask wine is a primary factor influencing the quantity of alcohol consumed.[54] Under the GST package, there has been a continuing failure to tax the alcohol content of drinks in order to maintain

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[48] Ferguson SA, Other high-risk factors for young drivers—how graduated licensing does, doesn't, or could address them *Journal of Safety Research* 2003; 34:(1): 71-77.
[49] Foss R, Goodwin A, Enhancing the effectiveness of graduated driver licensing legislation *Journal of Safety Research* 2003; 34: (1): 79-84.
[50] Chisholm D, et al. On behalf of WHO-CHOICE Reducing *the global burden of heavy alcohol use: a comparative cost-effectiveness analysis.* WHO (working paper): Geneva 2003.
[51] Econtech Pty Ltd. *Modelling health related reforms to taxation of alcoholic beverages.* Report prepared for the Alcohol and other Drugs Council of Australia. Canberra 2004.
[52] Stockwell T, Crosbie D. Supply and demand for alcohol in Australia: Relationships between industry structures, regulation and the marketplace. *International Journal of Drug Policy* 2001; 12:139–152.
[53] Distilled Spirits Industry Council of Australia Inc. *DSICA Submission to the Senate Economics Legislation Committee.* DSICA, Melbourne, Australia 2002.
[54] Crosby D, Stockwell T, Wodak A, O'Ferrall T. *Alcohol, Taxation Reform, and Public Health in Australia*: A submission to the Federal Parliamentary Inquiry into Substance Abuse in Australian Communities' 2000.

incentives for drinkers to choose low alcohol varieties and to create disincentives for heavy drinkers to choose cheap bulk drinks. [55]

The alcohol beverage industry is an important contributor to the Australian economy. It has an annual turnover in excess of A$50 billion and employs one in five of the manufacturing workforce. It is Australia's largest manufacturing sector - employing about 170,000 Australians and contributing 2.5 per cent to gross domestic product.[56] Australia's food, drink and grocery product industry is a substantial contributor to the economic and social welfare of all Australians. From 2002 to 2003, the funding to Australian political parties from the alcohol beverage industry and hotel association was just under A$7m.[57] The economic contribution of alcohol to the Australian economy is substantial, contributing A$13bn in retail sales, with Australian household spending on average A$908/yr on alcohol or 2.5 per cent of total Gross Domestic Product (GDP);

- Government revenue from indirect tax on alcohol is estimated to be in excess of A$4.3bn or 2 per cent of total government revenue;
- Wine exports account for approximately half of all wine produced in Australia, with exports growing at a rate of 25 per cent per year. In 2000/01, the value of wine exports was A$1.6bn. Between 2000 and 2001, funding for the prevention of harmful or hazardous drug use was A$146.2 million.
- Alcohol-related programs received A$9.2 million;
- Tobacco-related programs received A$3.6 million; and
- Illicit and other drugs of dependence program received A$34.6 million.[58]

Estimated total expenditure on health in Australia in 2001–02 was A$66,582 million or 9.3 per cent of national GDP. In 2000–01, estimated national expenditure on public health by the Australian Government and by state and territory health departments was A$987.0 million. This amounted to 1.7 per cent of total recurrent expenditure on health during that year. A significant area of expenditure was for prevention of harmful or hazardous drug use (A$146.2 million). For 2000–01, cardiovascular disease was the most expensive health related group (A$5.4 billion), and accounted for 38 per cent of deaths.[59]

(i) the empirical evidence on which the government's decision to increase the excise on ready-to-drink alcohol beverages was based;

The best practices in reducing high risk or risky drinking differ in cost-effectiveness[60] Cost effectiveness per DALY saved:

- Taxes (even without counting revenue from taxes)

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[55] Crosby D, Stockwell T, Wodak A, O'Ferrall T. *Alcohol, Taxation Reform, and Public Health in Australia*: A submission to the Federal Parliamentary Inquiry into Substance Abuse in Australian Communities' 2000.
[56] http://www.afgc.org.au/index.cfm?id=117 (Accessed 30.05.2005).
[57] http://search.aec.gov.au/annualreturns/arwdefault.asp?submissionid=5 (Accessed on 2.07.2004).
[58] Australian Institute of Health and Welfare (AIHW*). National public health expenditure report 2000–01*. Health and Welfare Expenditure Series no. HWE 25. Canberra, AIHW 2004.
[59] Australian Institute of Health and Welfare. *Australians' Health 2004*. Canberra: AIHW 2004.
[60] Analysis for WHO as part of CHOICE (Choosing Interventions that are Cost-Effective) Programme– D. Chisholm, J. Rehm, M. van Ommeren, M. Monteiro & U. Frick, "The comparative cost-effectiveness of interventions for reducing the burden of heavy alcohol use". *Journal of Studies on Alcohol* 65:782-793, 2004.

- Advertising ban
- Screening and brief medical advice
- Weekend closing day
- Random traffic breath tests~5-fold difference between most and least cost-effective
- Combination of top 3 estimated to save 983 DALYs/million population at a cost of US $2528/DALY

(j) The effect of alternative means of limiting excessive alcohol consumption and levels of alcohol related harm among young people.

Summary of efficacy and cost effectiveness of interventions for young people

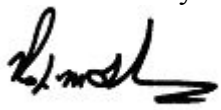
Intervention	Effectiveness rating	Breadth of research support	Cost to implement and sustain
Preventive case management;[61]	+	+	High
Parent Education.[62]	+	+	High
School preparation programs.[63] [64]	0	+++	High
Family interventions can be useful to ameliorate problems associated with adolescent drinking behaviour.[65]	++	++	High
Mentorship programs.[66] [67]	+	+	High
Community mobilisation. [68]	++	++	High
School based interventions. [69]	No effect	+++	High

[61] Soref SM, Soref HK, Foundation. *No Safe Haven: Children of Substance-Abusing Parent* The Edna McConnell Clark Foundation January 1999.
[62] Toumbourou JW, Gregg ME, Working with families to promote healthy adolescent development. *Family Matters* 2001; 59:54-60.
[63] Roberts I, Kwan I, and the Cochrane Injuries Group Driver Education Reviewers. *School based driver education for the prevention of traffic crashes* (Cochrane Review). In: The Cochrane Library, Issue 4, Chichester, John Wiley & Sons, Ltd. 2004.
[64] Spoth R, Redmond C, Hockaday C, Yoo S, Protective factors and young adolescent tendency to abstain from alcohol use: A model using two waves of intervention study data. *American Journal of Community Psychology* 1996; 24:749-770.
[65] Toumbourou J, Patton G, Sawyer S, et al. Evidence-based health promotion: Resources for planning No 2 Adolescent Health, Health Development Section, Public Health Division, Victorian Department of Human Services, Melbourne 2004.
[66] *Join Together. Save lives: Recommendations to reduce underage access to alcohol and action steps for your community*. Boston, MA 1998.
[67] Cavell TA, Meehan BT, Heffer RW, Holladay JJ, Natural mentors of adolescent children of alcoholics (COAs): Implications for preventive practices. *Journal of Primary Prevention* 2002; 23(1):23-42.
[68] Toumbourou J, Patton G, Sawyer S, et al. Evidence-based health promotion: Resources for planning No 2 Adolescent Health, Health Development Section, Public Health Division, Victorian Department of Human Services, Melbourne 2004.
[69] Babor T, Caetano R, Casswell, S, Edwards G, Giesbrecht N, Grahm K. et al. *No ordinary commodity: Alcohol and public policy*, Oxford, Oxford University Press 2003.

The College also would like to express an interest in attending any hearings in relation to this enquiry.

If you require any further clarification of the endorsement please contact Ms Mary Osborn by email on mary.osborn@racp.edu.au.

Yours sincerely



Professor Napier Thompson
President RACP