



BREWERS
ASSOCIATION
OF AUSTRALIA & NEW ZEALAND Inc.

SUBMISSION TO THE

PREVENTATIVE HEALTH TASKFORCE

– December 2008 –

**Brewers Association
of Australia and New Zealand Inc**

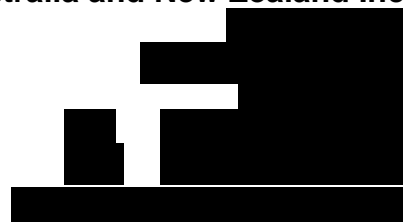


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ABOUT THE BREWERS ASSOCIATION



The Brewers Association of Australia and New Zealand Inc (‘the Brewers Association’) represents Australia and New Zealand’s major manufacturing breweries on regulatory issues and broader public policy issues. Our members produce approximately 98 percent of the beer brewed in the trans-Tasman market.

Formed in 1967, the Brewers Association has a proud history of contributing to public debate across a variety of issues including taxation, advertising, and alcohol education. We have representation in both capitals – Canberra and Wellington.

As well as responding to contemporary public policy reviews or inquiries, the Brewers Association also:

- Actively supports school based education through *Rethinking Drinking*, an initiative that has funded the development of classroom materials based on harm minimisation and has successfully trialled *Alcohol Information Nights* for students and parents; and
- Has an honorary medical advisor, based in New Zealand, to keep the Brewers Association up-to-date on developments in medical and epidemiological research in the areas of alcohol and health.

The members of the Brewers Association are the major brewers in the Australia and New Zealand marketplace including:

- Coopers Brewery
- DB Breweries
- Foster’s Group
- Lion Nathan Limited

EXECUTIVE SUMMARY



In mid 2007, Mr Rudd announced a focus on preventative health, with a particular focus on chronic disease, particularly diabetes and cardiovascular diseases (CVDs). Moderate consumption of alcohol provides protection against both type 2 diabetes and CVDs.

In early 2008, Prime Minister Rudd launched a binge drinking strategy, the core components of which focus on consumer behaviour.

The brewing industry supports both initiatives.

In late 2008, the Preventative Health Taskforce released a discussion paper that proposes an Agency which will fund additional research (including 'centres of excellence'). This proposal ignores the protective benefits of alcohol and seeks to target industry behaviour rather than consumer behaviour.

The core policy ambition of the proposal for alcohol is to further raise price, further restrict availability and further restrict (or potentially ban) marketing.

The proposed Agency seeks to reduce alcohol consumption indiscriminately, rather than target high-risk drinking behaviour despite:

- The extensive range of population based strategies already in place which focus on industry behaviour, for which Australia is already highly regarded internationally;
- Many existing, well designed and independently evaluated initiatives which target high-risk drinking behaviour by consumers being available which need ongoing funding;
- Strong community support for the latter;
- The risks to the existing prevention dividend posed by indiscriminate non-targeted measures (including a warning of these risks from the taskforce's own preferred modellers, Collins and Lapsley);
- A conclusion by Babor et al. that targeting high-risk drinking behaviour is equally cost-effective (which is grossly misrepresented in the Taskforce discussion paper); and
- Evidence that drunken behaviour is most strongly moderated by cultural expectations rather than price or availability.

The emphasis of the proposed Strategy is to use public funds to support further research to target Parliamentarians with the aim of further restricting industry in areas of broadly settled policy and indiscriminately reducing consumption.

We do not support this model: It is a classic case of policy based evidence, rather than evidenced based policy.

We believe the emphasis should be to use public funds to implement campaigns which target high risk drinking which, on the evidence, would provide greater gains

for prevention without risking the current prevention dividend from moderate alcohol use.

In our view, the opportunity cost of pursuing a ‘more of the same’ approach and getting diminishing returns at best, over a fresher approach to changing the drinking culture is enormous.

The following table sets out the broad categories from the current debate:

Focus on Industry Behaviour	Focus on Consumer Behaviour
<i>Product integrity & safety (inc. labelling)</i>	<i>Drink driving</i>
<i>Outlet density</i>	Primary health care (inc. GPs)
<i>Licensing restrictions</i>	Other brief interventions
<i>Advertising restrictions</i>	Targeting high-risk sub-groups: teenagers (and their parents), pregnant women, sports clubs, etc.
<i>Taxation</i>	Pharmacotherapies

The shaded areas represent mature policy debates in Australia. The shaded areas on the left are the primary focus for the proposed Agency with a research focus.

According to the discussion paper, work on the unshaded areas is supported by the community. Recent government and industry initiatives seek to explore these areas targeting high-risk drinkers.

Further investment in these areas could deliver real gains for prevention without jeopardising the current prevention dividend from alcohol, that is, that almost three quarters of Australian drinkers do so moderately and benefit from a significantly reduced likelihood of chronic disease compared to abstainers or heavy drinkers.

FRESH IDEAS, FUTURE ECONOMY



In both its pre-election policy statements and post-election announcements the Rudd Government clearly signalled that preventative health would be a central focus of its health policy; in particular, the prevention and management of chronic disease.

The proposal for a Preventative Health Strategy was outlined in a speech by the (now) Prime Minister entitled “Fresh ideas for the future economy: Why good health policy is good economic policy”¹ in which the Prime Minister focused on the greatest area of avoidable costs from such a strategy:

“A core challenge of the new century is dealing with the rise in chronic diseases and the management of chronic diseases.

*When I look ten and twenty years ahead, on current trends, more and more of our fellow Australians will suffer from chronic diseases such as **diabetes and cardio-vascular diseases**.*

This will place greater and greater strain on the health budgets of the nation, and more importantly, diminish the horizons for productive and quality lives for all of us. ...

And the cost of providing health care and demand for health care are rising and according to the Commonwealth Treasury this trend will continue.” (emphasis added)

In the same speech the Prime Minister cites estimated costs to the economy prepared by Access Economics for both **cardiovascular disease and obesity**. These were the prime targets of the proposed Preventative Health Strategy.

In 2007, the Labor Party was also very precise on two other points:

1. an understanding that the concern for alcohol was **excessive consumption**, not alcohol use per se; and
2. a commitment to **evidence based** policy:

*“The Strategy will provide a blueprint for tackling the burden of chronic disease currently caused by obesity, tobacco and **excessive consumption** of alcohol.*

*To ensure the Strategy is robust and leads to real change in our health system, its development will be supported by a Taskforce which will provide **evidence-based** advice to government and health providers – both public and private on preventative health programs and strategies.”² (emphasis added)*

¹ Speech presented to the Health Insurance Summit, reproduced as an article in *The Australian* 28/7/08.

² p 27, ‘Fresh Ideas, Future Economy: Preventative Health Care for our economy’ issued by Kevin Rudd, MP and Nicola Roxon MP in June 2007.

OLD IDEAS, TARGET INDUSTRY



Once elected, the Rudd Government established a Preventative Health Taskforce and they, in turn, have issued a discussion paper³ on strategies for prevention against chronic disease arising from tobacco, obesity and alcohol (rather than excessive consumption of alcohol).

Our response is restricted to the alcohol section.

In this discussion paper, the Taskforce:

- Walks away from the commitment to evidenced based policy where either no evidence exists or where it just doesn't agree with it. The discussion paper is a classic example of 'policy based evidence' which misrepresents key research papers which they rely upon;
- Argues that all alcohol consumption is problematic, rather than excessive consumption. The paper argues for reducing per capita consumption, which jeopardises the current prevention dividend from alcohol, rather than reducing high-risk drinking. There are 61 occasions in the paper where the language used describes 'alcohol use' or 'drinking' without any qualification where it would have been appropriate to do so – making their intentions very clear; and
- Ignores the breadth of medical evidence on the benefits of moderate alcohol consumption in preventing some chronic diseases, such as cardiovascular disease and diabetes (even though their own modellers urge them not to) and that research shows that abstainers have poorer health outcomes.

So, the discussion paper junks the three macro-policy starting points set by the Prime Minister in their approach to the issue of alcohol misuse.

If the ambitions of this strategy are implemented as is, they actually risk exacerbating the burden of chronic disease to our community and damaging our future economy.

The Core Proposal

The core proposal in the discussion paper is that the Government should establish an Agency to commission research (including funding 'centres of excellence'), participate in workforce development and be active on the international conference circuit.

It is a broadly similar model to VicHealth (established in 1987) and the Alcohol Education and Rehabilitation Foundation (AERF) (established in 2001) who both claim to do all of these things, including funding centres of excellence: VicHealth funds six and the AERF funds one – the AER Centre for Alcohol Policy Research at the Turning Point Alcohol and Drug Centre.

³ 'Australia: the Healthiest Country by 2020 A Discussion Paper', National Preventative Health Taskforce.

The Australian Government Department of Health and Ageing also currently funds two research centres: the National Drug Research Institute (NDRI) and the National Drug and Alcohol Research Centre (NDARC).

This discussion paper relies very heavily on just a few key documents to support this core proposition:

- **Collins & Lapsley**^{4,5}, for modelling the cost of alcohol abuse and the potential benefits of an effective prevention strategy.

We have supplied (under separate attachment to this submission) two critiques (one prepared on 28 November 2008 and one prepared on 23 December 2008) of this modelling by Access Economics.

- Section V of **Babor et al.**⁶ **Alcohol: No Ordinary Commodity**, for advice on alcohol policy settings.

Babor et al. are materially misrepresented in the Taskforce discussion paper on key points which underpin the draft strategy (see Attachment A).

- An **Options Paper**⁷ for a National Agency commissioned by the National Health and Hospitals Reform Commission (NHHRC), for a review of similar bodies.

The Options Paper rests heavily on commissioned research styled as a 'Rapid Review'. With this reliance, and a call for public comment, we were shocked and disappointed that the Taskforce denied our request for a copy of this research. We also have other concerns (see Attachment B).

The reliance on these few pillars of the research base to inform the proposal represent an extraordinarily narrow base for justifying the creation of an 'Agency' which seeks to have both (a) considerable policy influence and (b) significant, ongoing public funding.

⁴Collins D. & Lapsley H. (2008). *The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05*. Canberra: Department of Health and Ageing.

⁵ Collins D. & Lapsley H. (2008a). *The Avoidable Costs of Alcohol Abuse in Australia and the Potential Benefits of Effective Policies to Reduce the Social Costs of Alcohol*. Canberra: Department of Health and Ageing.

⁶ Babor T, Caetano R, Casswell S, Edwards G, Glesbrecht G, Grube J , et al. (2003). *Alcohol: no Ordinary Commodity*. New York: World Health Organization and Oxford University Press.

⁷ Moodie R, Harper T and Oldenburg B. (2008). *Options Paper for NHHRC: A National Agency for Illness Prevention and Health Promotion*.

SAME OLD...

In our view, it is useful to consider the alcohol policy debate as having two basic streams: strategies or interventions focusing on industry behaviour and on consumer behaviour.

The following table sets out the broad categories from the current debate:

Focus on Industry Behaviour	Focus on Consumer Behaviour
<i>Product integrity & safety (inc. labelling)</i>	<i>Drink driving</i>
<i>Outlet density</i>	Primary health care (inc. GPs)
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<i>Taxation</i>	Pharmacotherapies

All of those issues which focus on industry behaviour, and drink-driving, would be considered general population measures by Babor et al. In Australia they can all be fairly described as being mature debates where the basic policy design parameters have been in place for a considerable period. These are the shaded areas in the table above.

The remaining issues focus on high-risk drinkers and one (pharmacotherapies) on harmful drinkers and involve targeted programs or interventions. These are the unshaded areas in the table above. In relative terms these issues represent ‘greenfield sites’ for public policy in Australia, where the greatest gains could be made, for example:

“In Australia, brief interventions, as yet, are a relative untapped opportunity” (Taskforce Technical Report, p.28)

Babor et al. state that targeting high-risk sub-groups is equally cost effective as general population measures.

Of course, in any mature policy debate there will always be arguments around the edges of the policy (see Attachment C for specific comments). However, on the whole the shaded sections of the table represent settled, successful population-based strategies, which the discussion paper begrudgingly acknowledges on page 29:

“Australia’s international reputation in action on alcohol is among the best in the world. A recent review of alcohol policies in 30 OECD nations rated Australia as fifth overall, ranked behind Norway (1st), Poland, Iceland and Sweden. Another recent comparison of alcohol policies in 18 countries reports that ‘contrary’ to the generally pessimistic reports about alcohol policies, the case of Australia provides cause for optimism.”

However, in the very next paragraph the discussion paper proceeds to narrowly summarise Australia's successful policies as drink-driving legislation and enforcement, compulsory fortification of bakers' flour with thiamine, and liquor licensing in some Aboriginal communities and goes on to say "*these strategies alone are not enough*" as if they were the only policies in place.

This is the pattern of the whole document; no quarter is given to any agreed existing policy setting which may focus on industry behaviour. Generally, the paper rehashes existing arguments for reopening debate in the 'shaded areas' debates and ignores the other 'unshaded area' debates where greater gains can be made for prevention.

The relentless focus on reopening settled debates on industry restrictions and reducing per capita consumption (rather than targeting excessive consumption) in this draft strategy is indicative of an underlying 'command and control' approach.

Stripped to its essence, the proposed model for alcohol is to use the Agency to direct public funds to further research which has clear aims:

- **To increase prices;**
- **To decrease availability; and**
- **To ban or severely restrict marketing.**

Success is to be measured in reduced per capita consumption of alcohol (a largely meaningless measure), rather than a decrease in high-risk drinking (excessive consumption). The fact that the moderate use of alcohol has protective benefits is simply ignored.

The paper argues for a 'groundhog day' strategy. To focus on mature areas of policy and to force politicians back and back to these issues – until they give in.

The Strategy at Work

An example of the strategy at work in the next few years would be in the area of taxation policy:

The Rudd Government has made clear its preference for taxing alcopops at full spirit rates which they believe will stem high-risk consumption by young females.

The Taskforce strategy proposes to model and then campaign for tax changes which they openly concede would reverse this.

On page 26 of the Technical Paper, they set out their preferred tax model (which no OECD country uses) and say "*this model would have a negative impact on some segments... while advantaging other market segments – spirits and spirit-based RTD products.*"

There are similar examples for availability, where research will be aimed at challenging competition policy, and in marketing, where research will be aimed at challenging 'best practice' regulation.

In our view, further research and focus in these shaded areas will provide severely diminishing returns against the prevention criteria when compared to the unshaded areas which are, in relative terms, greenfield sites capable of good returns on any investment of public funds.

We believe that the government should seek to lead the world into these areas of greatest gain – rather than have us all go around the same old bush again and again.

NEW GROUND, GREATER GAINS



We believe that the early initiatives of this government in this area are commendable, focusing on preventing excessive consumption of alcohol by investing in areas previously left in the ‘too-hard basket’ like targeting high-risk behaviour/drinkers and developing and systematising brief interventions.

This consumer focused approach is also consistent with the approach of the National *Binge Drinking Strategy*, released in March 2008.

In announcing the Strategy, the Prime Minister stated:

“Binge drinking among young people is a community wide problem that demands a community wide response, including a new emphasis on young people taking greater personal responsibility for their behaviour.”

The Strategy consisted of three components, all of which would be in the ‘unshaded areas’ of our earlier table:

- \$14.4 million to invest in community led initiatives to confront the culture of binge drinking, particularly in sporting organisations;
- \$19.1 million to intervene earlier to assist young people to ensure that they assume personal responsibility for their binge drinking; and
- \$20 million to fund advertising that confronts young people with the costs and consequences of binge drinking.

It combines brief interventions for young people, advertising targeted at high risk drinkers and support for an ongoing culture change initiative (the *Good Sports* program, which industry has also provided funding for through Drinkwise Australia).

There is a lot of ‘low hanging fruit’ in these areas of policy, often well-researched and positively evaluated, but just as often abandoned after a successful trial due to funding constraints.

The Alcohol Education and Rehabilitation Foundation (AERF) alone has deployed significant public funds into this area, but their constitution constrains them from choosing ‘champions’ for ongoing funding:

“AER[F] has funded more than 850 programs throughout Australia (30% of which are within the Indigenous community) including numerous programs which contribute to shifting community attitudes towards a responsible approach to alcohol consumption.”⁸

The brewing industry has also contributed to projects in these areas:

- We have pioneered work in alcohol education through the development of classroom teaching materials *Rethinking Drinking: you’re in control* which have been in wide use since 1997 (2nd edition 2004) and a web-based resource for parent information nights which was trialled successfully in 2007 (www.rethinkingdrinking.org). *Rethinking Drinking* was based on extensive

⁸ Who we are www.aerf.com.au

research by Melbourne University, is consistent with the Principles for Drug Education in Schools and both programs have been independently evaluated;

- Our members have also been active supporters (and funders) of Drinkwise Australia (www.drinkwise.com.au) which is actively promoting culture change. Drinkwise has invested heavily in baseline research to ensure rigorous evaluation of campaigns and are currently running a campaign entitled ‘*Kids Absorb your Drinking*’ with extensive use of television commercials.
- We have assisted the Australian General Practice Network with funds to produce a *Pregnancy Lifescripts* DVD for general practitioners, which were well received. This is an extension of the *Lifescripts* initiative which has very limited government funding past the design and development stage:

“The Lifescripts initiative aims to make it easier for GPs to encourage patients to tackle lifestyle risk factors (such as smoking, poor nutrition, alcohol misuse, physical inactivity and unhealthy weight). A Lifescripts Resource Kit was produced in mid-2005 and is being disseminated with associated training to general practises through the Division of General Practice (Divisions) network.”⁹

There is considerable research available (much of it funded by the Australian Government Department of Health and Ageing, thus presumably readily available to the Taskforce within that Department) which looks at sub-populations of high-risk drinkers who may be at risk of harm to themselves or others and what may influence their drinking choices.

For example, a report on Parenting Influences on Adolescent Alcohol Use shows that:

“Adolescents reported that they intended to drink to get drunk, and that they put themselves at considerable risk when they drank. Adolescents tend to drink at home, at parties, or at friends’ homes. Finally, it was shown that a considerable proportion of adolescents (up to one half) obtain their alcohol from parents.”¹⁰

At the moment, there is a plethora of smaller initiatives focused on the interaction between parents and teenagers about alcohol; these seek to meet a real need:

- www.drinkingnightmare.com.au – an Australian Government initiative introduced in 2008;
- www.whatareyoudoingtoyourself.com – a NSW Government initiative also introduced in 2008;
- www.rethinkingdrinking.org – a Brewers Association initiative, funded by the AERF (most recently in 2007); and
- ‘*Kids Absorb Your Drinking*’ – a Drinkwise Initiative introduced in 2008, see www.drinkwise.com.au.

The existence of such programs is ignored in the Taskforce discussion paper, as is the existence of the Alcohol Advisory Council of New Zealand (ALAC). It is extraordinary that the Options Paper, which purports to look at models for an Australian Agency and includes New Zealand as one of six nations for review, can comment on a recommendation for a Ministerial Committee on obesity “*sometime in the future*” but ignores ALAC, which has existed for over 30 years:

⁹ p.340, Australia’s Health, 2006

¹⁰ Summary, p.19, Parenting Influences of Adolescent Alcohol Use, prepared by the Australian Institute of Family Studies for the Department of Health and Ageing, 2004

“The Alcohol Advisory Council of New Zealand (ALAC) was established in 1976 by an Act of Parliament, following a report by the Royal Commission of Inquiry into the Sale of Liquor. The Commission recommended establishing a permanent council whose aim was to encourage responsible use and minimise misuse.”¹¹

The ‘greater gains’ argument from a more targeted strategy is common sense, which the paper disagrees with, but notes that the public agrees with:

“...the views of community members tend to be closer to the alcohol beverage industries’ preferred preventative approaches, such as advocating for measures including school-based alcohol education, the responsible service of alcohol training, parent support and information, and education programs for specific target populations on fetal alcohol effects.”¹²

A Clear Choice

The Taskforce discussion paper proposes a population-level, industry-focused approach designed to reduce alcohol consumption by reopening settled policy debates with a primary focus on research.

Governments, industry and consumers seem to instinctively support a more targeted approach, focused on consumer behaviour aimed at reducing high-risk consumption by examining currently overlooked policy debates with a strong preference for implementation.

It really is as black and white as that.

While there are many Australian academics with alcohol policy expertise that recognise industry as legitimate stakeholders (and understand the strong business case for encouraging and promoting moderate consumption) those whose views were relied upon in the Taskforce discussion paper, as a general rule, do not. Nor do they believe in portfolio constraint. They hold view that they, not government, should decide between the competing and complex demands of trade, health, revenue, agriculture and tourism policy. This is a narrowly held but widely cited view (see Attachment D).

Furthermore, they imply that if governments do not let them, it is not simply that they beg to differ or choose to govern, but that they have somehow been ‘got at’ by industry, as this example from the Taskforce shows:

*“...it is acknowledged internationally that ‘alcohol policy is often the product of competing interests, values and ideologies’, and hence is not always based entirely on scientific evidence. More specifically, the cultural significance of alcohol in many societies, along with its economic importance and **the political influence wielded by the global and domestic alcohol beverage industries**, create a hostile environment for public health policies, especially those aimed at reducing consumption overall as a way of preventing and reducing alcohol-related harm.” (emphasis added)*

We reject that view.

¹¹ “Who are we?” www.alac.org.nz

¹² p.42, Technical Paper

Brewing is a legitimate industry that makes a significant contribution to the economy and to social cohesion in the community. Brewers make a product which consumers enjoy in moderation and through which they can accrue both physical and psychological¹³ benefit.

All of our Australian member companies are older than Federation itself. They have always looked to the model of Cabinet government to moderate between the many legitimate but sometimes competing policy objectives which affect our industry.

Brewers have also demonstrated a long term commitment to partnering other stakeholders, including government and primary care providers, in successful prevention programs and this commitment is ongoing.

¹³ Cummins, R.A., Woerner, J., Gibson, A., Lai, L., Weinberg, M., & Collard, J. (2008). *Australian Unity Wellbeing Index: Survey 19 (The Wellbeing of Australians – Links with Exercise, Nicotine and Alcohol)*. Melbourne: Deakin University.

PROTECTING THE PREVENTION DIVIDEND



The Taskforce discussion paper does not comment on the protective benefits of moderate alcohol consumption against some chronic diseases – including the two that were the focus of the Prime Minister’s original announcement as key targets: cardiovascular disease and diabetes. This omission should ring alarm bells in the interested reader, after all, the overarching objective of the Strategy is to discuss the prevention of chronic disease.

Moderate use of alcohol, in and of itself, provides protection against some chronic diseases, notably cardiovascular disease¹⁴:

“There is strong evidence that people who are moderate consumers of beers, wines of spirits have a substantially (30-40%) reduced risk of coronary heart disease when compared to teetotallers and heavy drinkers. Similar results have been shown by many studies throughout the world. The WHO Global Status Report on Alcohol (2004) describes this as the ‘most important health benefit of alcohol’

This reduction in risk (associated with approximately 3 drinks a day) is on par with preventive measures such as the use of aspirin, weight control, and exercise.” (p.12)

We have included a very recent summary of the health benefits of moderate alcohol consumption as a separate attachment to this submission¹⁵.

We accept that Australia’s clinical guidelines do not encourage abstainers to begin drinking alcohol in order to gain a potential benefit. However, it is equally important to accept that any public health campaign which persuades existing moderate drinkers to become abstainers (through a broad brush population-based approach such as that used for tobacco control) may actually exacerbate the problem by reducing the proportion of the population who currently enjoy increased protection from cardiovascular disease compared to abstainers and heavy drinkers.

A United States study published in 2006¹⁶ sought to examine and quantify the protection dividend amongst an ageing population, given that moderate alcohol consumption is associated with lower risks of cardiovascular disease. In an examination of Medicare Part A and B costs over five years involving 4,392 adults over the age of 65 in four US communities, they concluded that **total health costs were lower by approximately \$2,000 per person among consumers of one to six drinks per week compared to abstainers.**

While there is occasional dispute amongst medical professionals about the extent of the benefit, there is no real dispute that alcohol provides protection for moderate drinkers when compared to abstainers.

The current Australian Alcohol Guidelines published by the National Health and Medical Research Council (NHMRC) conclude that:

¹⁴ The Effects of Moderate Beer Consumption, 4th edition, A digest of the current scientific literature, published by The Brewers of Europe

¹⁵ Ibid.

¹⁶ Mukamal, KJ, Lumley, T., Luepker, RV., Lapin, P., Mittleman, MA, McBean, AM., Crum, RM., and Siscovick, DS. (2006). Alcohol Consumption in Older Adults and Medicare Costs. *Health Care Financing Review*, 27, 3, .49-61.

“There is strong evidence that drinking alcohol reduces the risk of heart disease in people from middle age onwards. This protection is achieved by drinking relatively small amounts of alcohol, with no additional benefit from drinking large amounts.”¹⁷

A major Canadian-led global study published in *The Lancet* – the Interheart Study – looked at more than 29,000 people in 52 countries across all inhabited continents and concluded that:

“...the overwhelming majority of heart attack risk may be predicted¹⁸” and “...regular consumption of small amounts of alcohol was found to be modestly protective...”

Despite this, the strategy puts these benefits at risk by a determined population-based approach which aims to indiscriminately reduce consumption:

“...success is to be measured on the basis of any change in rates of overall per capita drinking.” (p.29)

This is in spite of a very specific warning from the Australian Government Department of Health and Ageing’s preferred modellers, Collins and Lapsley, stating in work commissioned for this Taskforce:

“4.3.3. Retaining the protective health benefits of moderate alcohol consumption

It is generally agreed in the literature that the consumption of alcohol in moderation can provide protective effects against certain medical conditions, although in certain risk categories any level of consumption is hazardous or harmful... nevertheless, there is good evidence for the existence of protective effects of moderate alcohol consumption.

It may well be possible to target alcohol interventions in a manner which reduces hazardous and harmful consumption while retaining (and perhaps even augmenting) the protective effects. This would be ideal, and specifically targeted interventions such as more intensive enforcement of random breath testing will probably achieve this objective. However, general, or population, interventions, such as excise tax increases, run the risk of reducing the benefits, as well as the costs, of alcohol consumption.”¹⁹

The same preference for targeted interventions and a focus on patterns of drinking, over a population-based approach, is well understood by ALAC in New Zealand:

“ALAC is an autonomous Crown entity and our statutory primary role is ‘the encouragement and promotion of moderation in the use of liquor, the discouragement and reduction of the misuse of liquor and the minimisation of the personal, social, and economic harm from the misuse of liquor...”

In the past ALAC focused on strategies to reduce total per capita alcohol consumption. We now focus more on patterns of drinking and the way people drink, as this is the area where the most acute harms occur and where the greatest personal economic and social costs are incurred. To change the way people drink we are trying to change the drinking culture.”²⁰

¹⁷ National Health and Medical Research Council (2001) Australian Alcohol Guidelines – Health Risk and Benefits. Canberra: NHMRC.

¹⁸ Global study shows nine factors identify majority of heart attack risk, McMaster University media release, August 30, 2004.

¹⁹ p13, Collins D and Lapsley H. (2008). The avoidable costs of alcohol abuse in Australia and the potential benefits of effective policies to reduce the social costs of alcohol. Canberra: Department of Health and Ageing.

²⁰ Briefing for Incoming Minister, 21 November 2008, ALAC

Care must be taken to avoid unintended consequences. It is alarming that the potential for actually causing harm, and how to avoid doing so, is not canvassed at all in the discussion paper. We believe the prevention strategy should target heavy drinkers and high risk drinking behaviour to protect the existing prevention dividend available to the three quarters of drinkers who currently drink moderately and gain the protective benefits of doing so.

CHANGING BEHAVIOUR



We have argued for more targeted programs which focus directly on changing consumer behaviour. Conversely, the discussion paper believes you can change consumer behaviour via further restrictions on industry.

Typified by the subheading on page 36 (*Reshape consumer demand towards safer drinking...*) which ignores consumer behaviour in the proceeding text to recommend further restrictions on price, availability and marketing. The paper is riddled with such examples.

The discussion paper confuses means and ends in its analysis.

It is wrong to assume that a general decline in consumption per capita will axiomatically lead to a reduction in anti-social behaviour by individuals who engage in high-risk drinking. What people do to get drunk and what they choose to do when drunk have completely different causal factors.

As a study by MacAndrew and Edgerton puts it:

*“... the way people comport themselves when they are drunk is determined not by alcohol’s toxic assault upon the seat of moral judgement, conscience, or the like, but by what their society makes of and imparts to them concerning the state of drunkenness.”*²¹

It is evident that different countries have quite different attitudes to what is usual or acceptable behaviour when drunk and in all of them **this expectation acts as a strong moderator of behaviour.**

A qualitative study in seven countries published in 2008²² found that cultural attitudes to being drunk vary significantly across countries and affect people’s responses when drunk.

A sample of the findings from the focus group study is:

- in Brazil, a culture of viewing drinking as an important part of festivals has “*weakened societal limitations on drinking and related behaviour*”;
- in China, “*people who drink large amounts of alcohol and maintain the appearance of sobriety are greatly admired*”;
- in Italy, drunkenness was strongly criticised; and
- in Scotland, “*drinking regularly and excessively is viewed... as a rite of passage*”.

A recent Australian study, comparing the drinking habits of six migrant communities against the average for NSW²³, reinforces the point about cultural expectation and behaviour. Australia’s own experience with drink-driving shows what can be achieved in this area. Behaviour is primarily influenced by expectation (peers, parents, community), not by price or availability. And, as Babor et al. conclude, targeting programs at high-risk behaviour is very cost effective.

As a bang for buck investment in Australia, targeted culture change initiatives can deliver far greater gains for prevention.

²¹ MacAndrew, C., & Edgerton, R. E. (2003). *Drunken comportment: A Social Explanation*. Clinton Corners, NY: Percheron Press/Eliot Werner Publications.

²² Martinic, M., & Measham, F (eds.) (2008). *Swimming with Crocodiles – The Culture of Extreme Drinking*. Washington DC: ICAP.

²³ A study of six migrant communities conducted by the Drug and Alcohol Multicultural Education Centre (NSW).

ATTACHMENT A – KEY CLAIMS ARE MATERIALLY MISLEADING

The Taskforce discussion paper rests heavily on a book entitled ‘*Alcohol: No Ordinary Commodity*’ by Babor et al. for advice on policy settings.

Clearly, the brewing industry disagrees with some of the views in this highly partisan book. Anyone who is new to the subject would do well to read it in conjunction with ‘*Drinking in Context: Patterns, Interventions and Partnerships*’,²⁴ to get a more balanced view of the ongoing international debate.

Nevertheless, the Discussion Paper relies heavily on Babor et al. **and materially misrepresents its findings to support key recommendations in the Strategy**. This should be of considerable alarm to anyone seeking to rely on the Discussion Paper for policy guidance.

Here are some examples, all from page 37 ‘*Priorities for Action*’.

Example 1: Cost Effectiveness

“Recent reviews of available research evidence show that interventions targeting the whole population generally have higher effectiveness ratings and are cheaper to implement and maintain (on average) than those targeting high-risk groups [Babor et al.]”

Babor et al. define three groups of drinkers (p.272):

1. *The general population of a state or a community;*
2. *High-risk drinkers (e.g. adolescents or pregnant women, though to be particularly vulnerable to the adverse effects of alcohol); and*
3. *Harmful drinkers (i.e., persons already beginning to experience alcohol-related problems)”*

and then proceed to say:

“... interventions directed at the general population and high risk groups tend to be less costly to implement and maintain than interventions with harmful drinkers (average ratings, 2.2, 2.2, and 1.8, respectively.)”

So in fact, measures targeting the general population and high-risk groups are equally cost effective, BUT the discussion paper grossly misrepresents this and argues only for general population measures.

Conclusion: Babor et al. are grossly misrepresented.

²⁴ Stimson G., Grant M., Choquet M., & Garrison P. (2007). *Drinking in Context: Patterns, Interventions, and Partnerships*. New York: Routledge.

Example 2 On the rating of measures and “promising potential”

“Other areas that have very promising potential for effectiveness include:

- Altering the drinking context*
- Regulating promotion*
- Well-funded, sustained public education*

There has not been enough experience to date for programs in these areas to be rated.”

On page 268, Babor et al. set out the following scale of five possible ratings for evidence of effectiveness:

0	<i>Evidence indicates a lack of effectiveness</i>
+	<i>Evidence for limited effectiveness</i>
++	<i>Evidence for moderate effectiveness</i>
+++	<i>Evidence of a high degree of effectiveness</i>
?	<i>No studies have been undertaken or there is insufficient evidence upon which to make a judgement.</i>

So, only if the proposed strategy or intervention has a ‘?’ against it can you report that there has been not enough experience to date. Taking each of the Taskforces claims in turn:

On ‘Altering the Drinking Context’

Table 16.1 in Babor et al. lists six different strategies or interventions under this title. None of which show a ‘?’ against them. The majority rate poorly with a ‘0’ or ‘+’.

Nothing in Babor et al. supports the claim of “*very promising potential*” in this area!

On ‘Regulating Promotion’

Table 16.1 in Babor et al. lists two different categories: ‘advertising content controls’ which is the sole example of a ‘?’ rating for insufficient evidence, and ‘advertising bans’ which is rated ‘+’ for evidence of limited effectiveness.

Nothing in Babor et al. supports the claim of “*very promising potential*” in this area!

On ‘Well Funded, Sustained Public Education’

Table 16.1 in Babor et al. lists four strategies or interventions rated under “education and persuasion”. All four rate a ‘0’, which means there is sufficient evidence, but that evidence shows they don’t work (on warning labels, the comment is “*Raise awareness, but do not change behaviour.*”)!)

Nothing in Babor et al. supports the claim of “*very promising potential*” in this area!

In fact, Babor et al. states the polar opposite, that there is sufficient evidence to reach a view of effectiveness in eleven of the twelve strategies or interventions in the three areas, listed as Priorities for Action in the Taskforce paper: None of which showed “*very promising potential*” at all.

Conclusion: Babor et al. are grossly misrepresented.

ATTACHMENT B – A SURVEY OF MODELS FOR THE AGENCY

The long title of the Options Paper is “*A National Agency for Promoting Health and Preventing Illness*” (R. Moodie, T. Harper and B. Oldenburg).

This paper was commissioned for the National Health and Hospitals Reform Commission as part of the Preventative Health Taskforce process. In turn this paper relies heavily on something called a ‘Rapid Review’²⁵ which is in press and was also commissioned for the Taskforce. A written request by the Brewers Association was made to the Taskforce to obtain a copy of this review and was formally denied so our comments on it can only be limited to the Options paper:

“The paper that you are referring to, as cited in the National Health and Hospitals Reform Commission (NHHRC) paper - 'A National Agency for Promoting Health and Preventing Illness', was prepared for the Preventative Health Taskforce, and as such is not currently available for distribution.”²⁶

We have three concerns regarding the Options Paper:

1. The sometimes odd and limited choice of bodies to which the proposed Agency should be ‘compared and contrasted’;

The proposed Agency is to handle a range of issues e.g. tobacco (7.8% of the disease burden), obesity (7.5%) and excessive consumption of alcohol (3.2%)²⁷.

The comparative bodies were extremely limited in number and one (New Zealand’s on p.14) didn’t even exist – it is just a recommendation.

Here are some examples of other bodies that could have benefited the study and should have been obvious candidates for comparing and contrasting:

- The Canadian Task Force on Preventive Health Care, established in 1976;
- The United States Preventive Services Task Force, established in 1984; and
- Alcohol Advisory Council (ALAC) New Zealand, established in 1976.

2. No evaluation of the performance of any of the examples chosen, i.e. do they actually work?

The Options paper does not consider whether any of the comparative bodies actually delivered any benefit and, if so, how effective that model was. This is despite some hope that it would do so, as the following two quotes illustrate:

²⁵ Fawkes S et al. (2008). *A Rapid Review of Chronic Disease Prevention Strategies in Selected OECD Countries* (in press)

²⁶ Correspondence from Preventative Health Taskforce dated 22nd December, 2008

²⁷ Begg S, Vos T, Barker B, Stevenson C, Stanley L and Lopez A (2007). The burden of disease and injury in Australia 2003, PHE 82. Canberra: Australian Institute of Health and Welfare.

“Part 1, Section 1 Introduction ...

*In Part 2, we present the lessons learned from international experience, and **we critically evaluate models** from Australia and internationally.*

*Part 2, Potential models for the Agency ...The following section considers some models of organisations involved in various aspects of health, as well as one or two operating in other sectors. For the sake of brevity and relevance to this paper, **we have not listed their achievements ...**” (emphasis added)*

3. No survey of local organisations who currently work in the prevention field and whose work may overlap with the proposed Agency.

The paper does not look at the potential overlapping footprint with existing bodies working on prevention in Australia. In the case of alcohol this is particularly relevant to:

- Drinkwise Australia, established in 2005; and
- Alcohol Education and Rehabilitation Foundation, established in 2001.

As well as state based bodies such as the (Victorian) Transport Accident Commission, established in 1986.

Sub-Policies with a Focus on Industry Behaviour

Product integrity and safety (including labelling)

Mandatory requirements are determined by Food Standards Australia New Zealand, who follow rigorous scientific processes for assessing new proposals.

Following a request from the Ministerial Council on Drug Strategy, the brewing industry has rolled out graphical standard drink logos on all beer in Australia.

Outlet density

We leave this to the various retailer-level associations to comment on. Nevertheless, we note that although the discussion paper spotlights the increase in licenses in Victoria (see figure 4.4), less effort is expended on exploring the links between this increase and harm, and the discussion paper also tells us (p.32) that levels of short-term risky/high-risk levels at least monthly for Victoria are 19.4% compared to 18.7% for New South Wales, which has far less liberal licensing laws: a statistically insignificant difference when compared to each other (or the Northern Territory with 28.4%).

Licensing restrictions

Again, we leave this to the various retailer-level associations to comment on. However, we cannot understand why the development of a national (and portable) responsible service of alcohol training regime is taking so long.

Advertising restrictions

The discussion paper misrepresents current regulatory arrangements. The Alcohol Beverage Advertising Code (ABAC) Scheme for regulating alcohol advertising is not a self-regulatory system, nor is it solely administered by industry: guidelines for advertising have been negotiated with government and consumer complaints are handled independently, but all costs are borne by industry.

ABAC is a quasi-regulatory system in line with the strict definitions for self, quasi- and co-regulation issued by the Office of Best Practice Regulation. Both the Australian Government and the Council of Australian Governments are committed to best practice regulation.

No-one from industry makes a subjective judgement on advertising content under The ABAC Scheme: neither pre-vetting advertisements against the agreed standards nor adjudicating complaints. The Chief Adjudicator is Professor the Hon Michael Lavarch. The panel of Adjudicators includes two population health academics: Professor Fran Baum of Flinders University and Professor Richard Mattick of the University of New South Wales.

The ABAC Scheme has been the subject of four major review processes in five years, and made changes in response to all of them, including the review instigated by the Ministerial Council on Drug Strategy, through the National Committee for the Review of Alcohol Advertising (NCRAA).

Given that these facts are well known to the Australian Government Department of Health and Ageing this misrepresentation (spin) in the discussion paper is, at best, mischievous.

Taxation

The discussion paper seeks to collect statistics and commission modelling with a view to a sketchy proposal for alcohol taxation. Essentially, beer, wine and spirits will all pay excise, there will be a 'floor price', some form of 'volumetric' system and incentives for low alcohol beverages.

The debate in Australia is very confused because health groups use the term 'volumetric' almost as a shorthand code for higher taxation, without actually agreeing with the principle. By definition, any variation to the principle of *a single unit of tax for each unit of alcohol* actually renders it non-volumetric (and another term should be used) – a point made to a recent Senate Inquiry by Mr Gordon Broderick of the Distilled Spirits Industry Council of Australia²⁸:

“Senator CAROL BROWN—*Yesterday we received evidence from the National Drug Research Institute that they were in favour of a volumetric tax on all alcohol but wanted to see the price of RTDs maintained at the current level rather than fall.*

Mr Broderick—*That is a contradiction, isn't it, if you are advocating a volumetric tax system but then you are singling out one particular product which just does not fit into the volumetric tax regime?”* (p.C18)

The debate about the status quo, volumetric or a third (health lobby-designed) model is really one about relative harms, and the spirits lobby in Australia has recently opened a debate about whether beer, wine and spirits cause different levels of harm through a very public attack on beer²⁹. This ridiculous claim was easy to refute, using their own statistics (see Attachment C (a)) but it does point to a fundamental issue for the spirits lobby that many in the community share a common belief that 'hard liquor' is different.

As Professor Gordian Fulde, Head of Emergency Department, St Vincent's Hospital stated in a recent report on ABC TV's Four Corners program:

*“I've been the boss here for over a quarter of a century, so I've seen a fair change and the change has been monumental in one, is what people now are drinking. In other words they're drinking spirits, right, the shot glasses are coming in, the hard liquor with mixers have come in. In other words **beer is still there but that isn't what gives us grief, right.** The beer drinkers because obviously to get drunk on beer you've got to drink a fair volume, if you drink a fair volume you often vomit, and that's good, right.”³⁰*

The same point about relative harm is expressed in the Taskforce's Technical Paper when sketching out a possible third model:

“The excise tax could be scaled within different product types to ensure there were strong financial incentives for the production of lower alcohol products (for example, low-strength beer, wine and RTDs), and so that the highest-risk alcohol products (i.e.

²⁸ Standing Committee on Community Affairs (2008). *Committee Hansard: Inquiry into Ready-to-Drink Alcohol Beverages (12 June 2008)*. Canberra: Parliament of Australia.

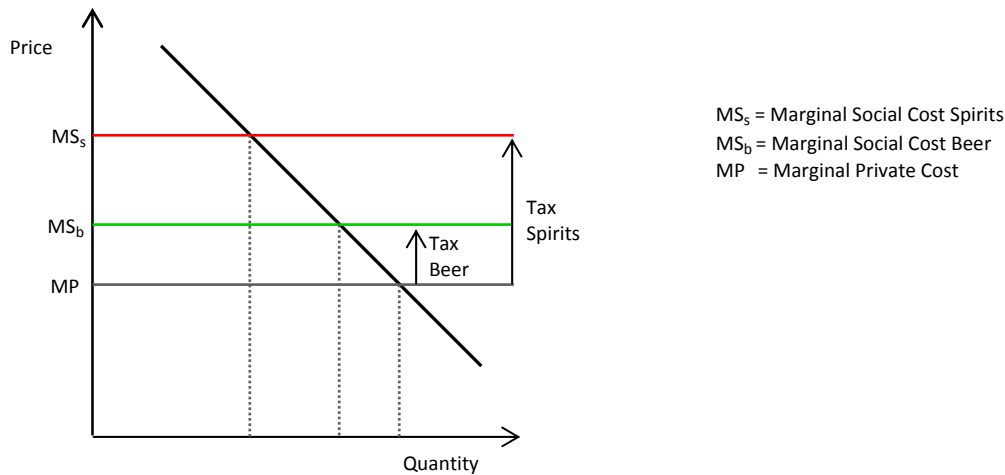
²⁹ DSICA media release 'New Study into Alcohol Abuse Exposes 'Beer-Binge' as Real Problem', 2/6/8

³⁰ ABC Four Corners, Transcript of "On the Piss", broadcast on 9 June 2008.

spirits, *which can more easily cause overdose*) are taxed at an appropriately higher rate.” (p.26) (emphasis added)

An economist would express this sentiment in the following manner:

Figure 2 – Corrective Taxation in the Alcohol Market



In fact, the debate about the relative harms of beer and spirits (and wine) has always been a staple of Australian alcohol policy, as recently described in a speech by Senator the Hon Jan McLucas:

“The NSW corps, who were formed in 1792 to protect the fledgling colony, had a monopoly on the supply and importation of rum, which they exchanged for goods and services at favourable rates, and thus dominated the early political scene. This led many people to refer to them as the “rum corps”.

The prevalence of rum as a form of currency caused a number of social and economic problems to the colony, with workers squandering their wages for the inflated price of rum. By 1793, stills were being imported and distillation of rum was exacerbating the shortage of grain.

The effect of rum consumption on the colony led to the Government actively promoting the brewing of beer. In 1802 Lord Hobart wrote to Governor King –

‘The introduction of beer into the general use among the inhabitants would certainly tend in a great degree to lessen the consumption of spirituous liquors; I have therefore, in conformity with your suggestion taken measures for furnishing the colony with a supply of ten tons of Porter, six bags of hops and two complete sets of brewing utensils.’

It may be a bit of a push to call it a public health measure, but Australia’s first government-owned brewery commenced production in Parramatta in 1804, with a capacity of 1,800 gallons of beer per week, and an eventual capacity of 3,000 gallons.”³¹

Australia is not alone in taxing ‘hard liquor’ differently: No OECD country maintains a uniform tax regime across all alcohol sectors.

³¹ Australian Drug Foundation – Dame Elisabeth Murdoch Oration “The National Hangover – Changing our Drinking Culture”, State Library of Victoria, Melbourne, 9 December 2008

While they do not endorse any specific tax model, the International Center for Alcohol Policies cites a variety of public policy reasons for higher spirits taxation including that different beverages are served in different ways with different patterns of consumption; that production costs per litre of alcohol are significantly higher for beer and wine; and, that government policy steers people to particular beverages to substantially reduce risky or high blood alcohol levels³².

We note that the proposed ‘third model’ sketched out in the Technical Paper (p.26) would have the effect of overturning the present tax policy of the Rudd Government on ready-to-drink products:

“...this model would have a negative impact on some segments... while advantaging other market segments – spirits and spirit-based RTD products.”

Sub-Policies with a Focus on Consumer Behaviour

Drink driving

Australia ranks very highly for our successful drink driving policies. And, various state-based authorities are possible sources of expertise for successful culture change programs which may be undertaken as part of the Preventative Health Strategy.

More could be done with recidivist drink drivers through brief interventions. Tracking recidivist drink drivers would be an efficient means of identifying individuals who will potentially develop into either high-risk or harmful drinkers.

Primary health care (inc. GPs)

See our comments in the main submission at page 12; particularly our support for promoting *Pregnancy Lifescripts* as an effective intervention for pregnant mothers through the Australian General Practice Network.

Other brief interventions

The Taskforce discussion paper briefly canvasses this issue, but mainly in a clinical setting.

Recidivist drink drivers are an obvious target for intervention programs.

On the broad evidence available, Babor et al. rate brief interventions for at-risk drivers as moderately effective and moderate costly with the following proviso: “*Primary care practitioners lack training and time to conduct screening and brief interventions*”. However, there is also research available which shows that brief interventions need not always be delivered by primary care practitioners nor be costly. It seems a large part of their effectiveness for changing behaviour is that ‘someone called them on it’. There have been trials of correspondence- or email-based interventions, for instance.

Further, we would confidently assume considerable community support for a user-pays scheme for brief interventions in this area, where a commitment to a brief intervention was offered as an option for diversion from the criminal justice system or to ‘earn points back’.

³² Table 1, ICAP Report 18 “Alcohol Taxation” May 2006

Such a scheme is already operating in Ontario, Canada and the Victorian Government has recently flagged the possibility of speeding drivers accepting education for the return of demerit points:

“If you are convicted of a drinking and driving related Criminal Code offence, you must take the impaired driving program called Back on Track, delivered by the Centre for Addiction and Mental Health. The three-part program, which is available across the province, involves assessment, education or treatment, and follow-up. You must pay for the program.” (excerpt from the Drivers Handbook, www.mto.gov.on.ca).

“In an Australian first, drivers will be given the chance to wipe off demerit points in a radical deal expected to be offered by the Victorian Government. Tens of thousands of drivers penalised for speeding, red light breaches and other offences could soon trade points in return for undertaking driver education.” (Herald Sun 05/02/08)

The Brewers Association has a Medical Advisor, Professor Ross McCormick who works at Auckland University. Professor McCormick has provided comments on brief interventions at Attachment C (b).

Targeting high-risk sub-groups

See our comments on page 12 relating to parents and teenagers, Drinkwise etc.

Pharmacotherapies

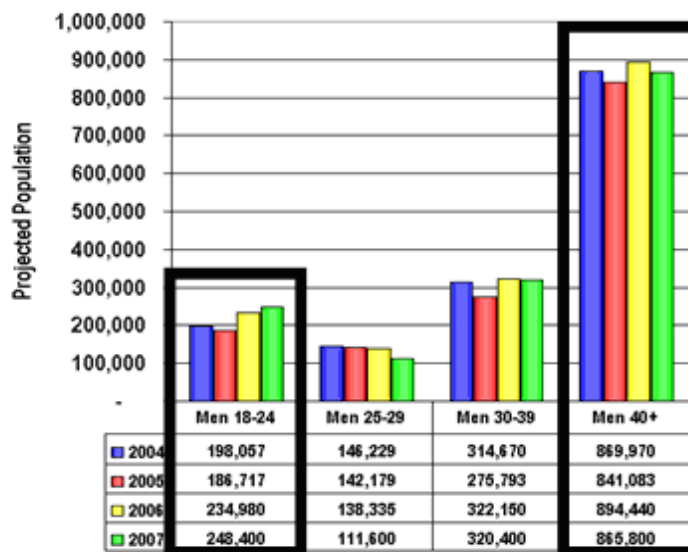
The Taskforce papers give pharmacotherapies just 31 words, summarising a single 2004 study. Attachment C (b) also incorporates a summary of pharmacotherapies prepared by the Brewers Association Medical Advisor, Professor Ross McCormick.

A recent article in *The Australian* entitled “Middle-aged men outdrinking teen tipplers” relied on statistics provided by the spirits lobby to support this headline.

Like many arguments in the alcohol debate this is a misrepresentation which totally distorts the data. This distortion arises from the comparison of absolute numbers of 18-24 year olds (10% of the male population) against absolute numbers of men aged 40 or above (44% of the population).

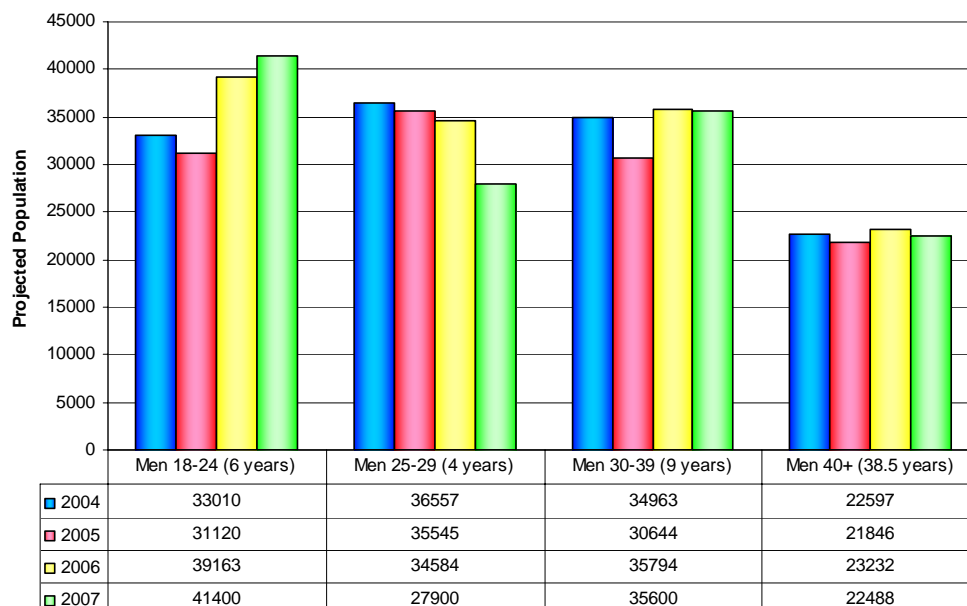
Here are the data for males, as shown on DSICA’s website:

Projected Size of Population Who Consume More Than 100 Drinks in 4 Week Period
 Source: Roy Morgan Single Source, N=2350, 2049, 2334, 1982



Using the same data, if the number of drinkers who drink more than 100 drinks per month is averaged out per year then 40+ males go from the highest to the lowest rung on this measure. This is more in-line with the expectation that drinking behaviour moderates with age:

Projected Size of Population who Consume >100 Drinks in 4-Week Period
 (divided by number of years in each age category)



Emerging Pharmacotherapy for Alcohol Dependency

from

Professor Ross McCormick, PhD, MSc, MBChB, FChAM, FRNZCGP

(Medical Advisor – Brewers Association)

Context: Treatment for alcohol abuse (including dependency) ranges from the well known evidence based(1, 2) brief interventions for those with risky or problematic alcohol abuse (including binge drinking) through to prolonged counselling or residential treatment for those with alcohol abuse syndrome or alcohol dependency. Pharmacotherapy options are limited.

The Preventative Health Taskforce discussion paper states that 84% of Australians are concerned about problem drinking. This high figure could suggest that a considerable percentage of risky and problematic drinkers in Australia are concerned about their fellows' behaviour even if they don't recognise they themselves are problem drinkers. This implies a fertile field for much more aggressive Australian implementation of screening and brief intervention for problem use of alcohol by providers such as practice nurses, general practitioners, dieticians, probation officers, walk in clinics, and other settings where risky and problem drinkers are likely to present.(3-5)

Addiction counselling aims to enable the alcohol abuser to accept they need help and to enable them to explore issues to do with their relationships with others, their relationship to their drinking and their care of themselves. In addition the client is encouraged to join support groups such as Alcoholics Anonymous, to explore risk situations for relapse and to pre-plan how to cope with these. Project Match compared Motivational Enhancement Therapy, Cognitive-Behavioural Therapy and Twelve-Step Facilitation matched to client characteristics such as readiness to change, anger, social networks supportive of drinking, psychiatric co-morbidity and self efficacy. At three year follow-up the reductions in drinking observed in the first year after treatment were sustained: almost 30% of the subjects were totally abstinent in months 37 to 39, whereas those who did report drinking remained abstinent an average of two-thirds of the time. There were few differences among the three treatments, although Twelve-Step Facilitation showed a possible slight advantage.(6)

Pharmacotherapy: In the last 15 years neurobiology of addiction scientists have explored pharmacotherapy for alcohol dependency.(7) This has added to the medications available to addiction specialists to reduce relapse rates in alcohol dependent people and provided a scientific rationale for their use. A systematic review of the literature showed both acamprosate and naltrexone were effective as adjuvant therapies for alcohol dependence in adults.(8) However these drugs are commonly thought to only work in the short term, and irrespective of treatment alcohol dependent people still require follow up support and monitoring to reduce the chance of relapse.

A recent COMBINE study report examined the efficacy of various mixes of naltrexone, acamprosate, placebos, combined behavioural intervention and medical management one year post treatment. The authors stated; "Previous treatment with medical management and either CBI or naltrexone, or both, but not acamprosate, was associated with sustained efficacy beyond discontinuation".(9)

Naltrexone is in use in Australia for alcohol dependency. As an opioid-receptor antagonist its anti alcohol drinking effect is likely to be due to the modulation of the dopaminergic mesolimbic reward pathway which ethanol is believed to activate. A Cochrane review

concluded that “Naltrexone at the dose of 50 mg/day is effective for alcohol dependence in short-term treatment.” Short-term treatment means up to three months of treatment.(10)

Acamprosate is mainly used in Europe. It needs to be taken more than once a day possibly leading to compliance problems. Alcohol affects the glutamine, gamma-aminobutyric acid (GABA), dopamine, and endogenous opioid systems in the brain. It is believed that acamprosate acts as an inhibitor of glutamate, and, to a lesser extent, a modulator of GABA. By blocking the excessive release of glutamate associated with alcohol withdrawal, acamprosate is thought to contribute to a reduction in drinking behaviour.

Disulfiram (antabuse) has a number of unwanted side effects and people stop taking it. It inhibits the metabolism of acetaldehyde, a metabolite of alcohol. After alcohol consumption, the accumulation of acetaldehyde leads to flushing, nausea and vomiting.

Emerging pharmacotherapy: Several other classes of agents have been examined for their efficacy in the treatment of alcohol dependence. Spanagel (11) stated; “Multiple neurochemical pathways are involved in mediating craving and relapse to alcohol. Opioidergic and glutamatergic systems have a key role in alcoholism, as demonstrated by the clinically effective compounds naltrexone and acamprosate acting through these systems. The dopaminergic system has long featured in alcoholism research; hitherto disappointing results from clinical studies could improve following the discovery that dopamine D3 receptor antagonism produces consistent and robust results in preclinical studies. Corticotropin-releasing factor signalling and the endocannabinoid system integrate stress-related events and thereby mediate relapse behaviour. Overall, these new targets have yielded several compounds that are undergoing clinical testing. However, the heterogeneity in treatment response makes it necessary to characterize genetic and protein markers and endophenotypes for individualized pharmacotherapy”.

Other possibilities include antiepileptics and mood-stabilizing agents (e.g. topiramate, oxcarbazepine). These drugs share neurochemical effects with alcohol by inhibiting neuronal excitation through actions at glutamate and GABA receptors. They are sometimes used to treat alcohol withdrawal during acute detoxification. Trials of these types of medications have not produced strong evidence that they are useful to promote safe drinking or long term abstinence from alcohol. For example Olmsted(12) stated; “At this time, data are insufficient to support using topiramate in conjunction with brief weekly compliance counselling as a first-line agent for alcohol dependence”.

Genetic therapy: An interesting but politically fraught possibility is gene therapy. Ocaranza(13) noted that some gene polymorphisms strongly protect against the development of alcoholism. The single intravenous administration into alcohol dependent rats with restricted access to alcohol of an anti-Aldh2 antisense gene carried by an adenoviral vector reduced liver ALDH2 activity by 85% ($p < 0.002$) and inhibited voluntary ethanol intake by 50% (ANOVA $p < 0.005$) for 34 days. He concluded that; “This proof-of-principle study indicates that gene therapy approaches can be employed to achieve a long-term reduction of alcohol intake in alcohol-dependent animals and suggests that gene vectors may be developed as long-lasting therapeutic adjuncts for the treatment of alcoholism”.

Kudzu plant: At a 2007 conference Professor I Diamond University of Chicago described the development of a selective aldehyde dehydrogenase 2 inhibitor called CVT-10216 which appears to act not only by partially reducing the detoxification of acetaldehyde but also to lower the release of noradrenalin in the nucleus accumbens thus reducing the reward from drinking alcohol.(14) A form of this drug is known to the Chinese as an extract of the Kudzu plant(15, 16) and Chinese medicine practitioners claim to have used Kudzu plant extracts to prevent and treat alcoholism for more than 1500 years. Animal testing of CVT-10216 has shown it to reduce drinking and to prevent relapse after binge drinking in alcohol preferring

hamsters and rats without serious side effects. This drug is interesting both because it has a mixed mode of action, and also because its developers are not just trialling a different use for a drug previously developed for another purpose. CVT-10216 will of course have to survive further animal and, (if the trials continue to be positive with minimal side effects), human trials before it is available for use.

Further consultation: If the Preventative Health Taskforce wishes further comment on brief interventions for risky and hazardous alcohol use or further comment about alcohol dependency pharmacotherapy, I suggest they contact Professor James Bell, President of the Chapter of Addiction Medicine, Royal Australasian College of Physicians, or Dr Yvonne Bonomo, President elect.

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12. Olmsted CL, Kockler DR. Topiramate for alcohol dependence. *Ann Pharmacother*. 2008;42(10):1475-80.
13. Ocaranza P, Quintanilla ME, Tampier L, Karahanian E, Sapag A, Israel Y. Gene therapy reduces ethanol intake in an animal model of alcohol dependence. *Alcohol Clin Exp Res*. 2008;32(1):52-7.

14. Diamond I. The development of a selective aldehyde dehydrogenase 2 inhibitor International Medical Advisory Group; 2007; Halifax. 2007.
15. Benhabib E, Baker JI, Keyler DE, Singh AK. Kudzu root extract suppresses voluntary alcohol intake and alcohol withdrawal symptoms in P rats receiving free access to water and alcohol. *J med food*. 2004;7(2):168-79.
16. Lukas SE, Penetar D, Berko J, Vicens L, Palmer C, Mallya G, et al. An extract of the Chinese herbal root kudzu reduces alcohol drinking by heavy drinkers in a naturalistic setting. *Alcohol Clin Exp Res*. 2005;29(5):756-62.

This attachment looks at the underlying ‘command and control’ approach of the draft strategy and the rejection of brewers or industry as legitimate stakeholders (let alone partners) in any proposed strategy. The Taskforce discussion paper and accompanying Technical Report often quote research sources which have had input by Professor Robin Room. It is useful to look at some examples:

1. Babor et al. ‘Alcohol: No Ordinary Commodity’ is heavily relied upon in this Strategy.

It was a project funded by the World Health Organization (WHO) and Robin Room was a contributor: “*During the time of the project, Robin Room was supported as a Visiting Scientist for six months at the National Institute for Alcohol and Drug Research.*”³³

In their conclusions, Babor et al. argue that where potential areas of industry regulation are not well supported by the evidence they are justified in doing it anyway (p.273). These areas include advertising and international trade agreements and they also assert that decision making is “*currently guided too often by economic considerations of the few, rather than public health concerns for the many*”.

2. Professor Room was the rapporteur for a recent WHO committee which made ten recommendations³⁴.

All ten will be very familiar to anyone reading the proposed Australian Preventative Health Strategy. They include the following:

- Recommendation 8 – “*...that WHO strengthen its processes of consultation and collaboration with nongovernmental organizations which are free of potential conflict of interest with the public health interest.*”
- Recommendation 9 – “*...that WHO continue its practice of no collaboration with the various sectors of the alcohol industry.*”
- Recommendation 10 – “*... Recognizing ... that mechanisms should be developed to protect the public health interest concerning alcohol in trade, industrial and agricultural decisions, the Committee recommends that WHO ... seek opportunities to provide an active and continuing presence in trade negotiations and dispute adjudications to represent the public health interest in alcohol trade matters.*”

The World Health Assembly ignored this advice. The Resolution which followed in May 2008³⁵ included ‘economic operators’ among the list of those who should be consulted in developing a strategy.

³³ Babor et al. (2003) p.x.

³⁴ WHO Expert Committee on Problems Related to Alcohol Consumption, second report.

³⁵ WHA6.14

3. Professor Room is an acknowledged contributor to the current Taskforce papers within which:

- No constraint is felt to heed the normal portfolio etiquette expected of other portfolio agencies.

Tax is the classic example here. The Government has made it clear to all and sundry that any taxation policy proposals (including alcohol) are being considered by Treasury, through the ‘Henry Review’. This is given ‘fig leaf’ recognition on page 38 of the Taskforce discussion paper, while the rest of the paper makes it clear that the proposed Agency intends to invest heavily in research on price and taxes and campaign for the implementation of its own proposals, one of which has already been decided and listed as a performance indicator for the strategy: ‘*tax incentives for the production and consumption of low-alcohol products*’ this is a performance indicator for the proposed Agency (table 6.1, p.48).

- The ‘one ring to rule them all’ approach is here, too:

“While we can see that it is politically necessary to have ‘collaborative and cohesive’ alcohol policy where all interested parties are included, this poses significant impediments to the implementation of the most effective preventative interventions.”
(Technical Report p.37); and

“There are some specific challenges that go beyond public understanding and attitudes. These have been raised throughout this paper and include ... The economic and political importance, and thus influence, of the alcohol beverage and related industries.”
(Technical Report p.41)

We are not suggesting that Professor Room, or any other academic, is not entitled to strong views. We are simply saying that we are justly entitled to look to government to moderate the debate.

We also reject the ‘one ring to rule them all’ ambition for health policy over trade, agriculture, tourism, industry and employment policy.

Australia’s brewers are responsible operators, whose products benefit the community when consumed in moderation, including providing some protection against chronic disease.

We do not apologise to anyone for having our own strong views about the proposed Preventative Health Strategy, nor trying to get the debate back on track to focus on excessive consumption targeting high-risk drinkers rather than the diminishing returns of imposing further industry regulation.