



Annual Oration

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Transcript

Alcohol Policy: thinking globally, acting locally

**Professor Robin Room
Director, SoRAD,
Stockholm University**



Turning Point Alcohol & Drug Centre Inc.
54-62 Gertrude Street
Fitzroy, Victoria 3065, Australia

T: +61 3 8413 8413
F: +61 3 9416 3420

www.turningpoint.org.au

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Thank you very much for that very kind introduction. It's a great pleasure to be here and I would like to thank and acknowledge those who have spoken before me and the traditional owners of the land, and really say what a great pleasure it is to be back again in Melbourne.

The title of my oration is *Alcohol Policy: thinking globally, acting locally*. The Parliamentary Secretary for Health, Daniel Andrews, has already talked to you a little bit about the current situation in Australia, which is in fact developing, to some extent and in a positive direction. A fair amount of my talk will be about the international level, but bringing it at the end down to the level at which people actually have to deal with alcohol problems, which is very much at the local level. I want to show you today how I think the international level, as well as the national level, is important when we're thinking of this issue.

Here's the basic argument that I'll be putting forward today. Alcohol imposes a big burden on social and health harm to others as well as to the drinker. Alcohol is not an ordinary commodity, it doesn't fall into the same category as bread or soap. Strategies to hold down or reduce rates of alcohol problems differ in their effectiveness, as I'll show you, and among them the most effective and cost-effective are controls on the availability of alcohol. The alcohol industry is increasingly global and international trade agreements and common markets often undercut alcohol controls at the national, state or local level. At the international level, therefore, a public health convention and a focus on alcohol is needed to enable effective policies at the local level. And at the state and local level, we need to move forward, in terms of evidence-based practice to reduce harm from alcohol—which requires developing the evidence in the first place.

This slide, which is very busy, is drawn from the international study by the World Health Organisation on the global burden of disease. A particular part of it was called the 'comparative risk analysis'. This argues or shows that alcohol imposes a big burden in terms of, even if we think as the WHO was thinking, chronic disorders and injuries. And here the world is divided up into three parts, the one on the left is the high mortality developing countries, the column in the middle is low mortality developing countries, the ones that are doing quite well, and the column on the right is the developed countries. There were 26 different risk factors considered in the comparative risk analysis in terms of the best estimate that could be made of their contribution to the global burden of disease.

As you'll see on the left hand side, alcohol doesn't appear in the first 10 in terms of the high mortality developing countries, there are other risks to people's health that are more important. These are countries that are quite poor and issues like indoor smoke from solid fuels for instance and underweight are especially important, that's the most important cause of loss of life or loss of life years, good life years. These countries include quite a large number of Islamic countries where alcohol consumption is quite low.

On the right hand side, the developed countries, you'll see that alcohol comes in as number three in this kind of ordered list of the risk factors. The surprise to everyone I think was that for the low mortality developing countries, the countries that are doing well, relatively well economically, alcohol actually came in number one in terms of the burden of disease. So this is not a problem only in Australia, it's a problem in a very large part of the world, and particularly in the parts of the world that are doing, relatively speaking, better economically.

This is looking at the data, the same set of data from another direction. In this case, we've actually subdivided to those categories that I was showing you in the previous slide. So if you read across the top, the poor and the poorest of the developing countries are split into two categories in the first two columns, with the very poorest and including many Islamic countries and India on the left. You'll see if you look at the bottom row that the proportion of the global burden is, in that category of developing countries, as low as 1.3%. Then, also subdividing the developed world, Australia actually appears under WPRA, Western Pacific Region A-country, a list of countries that are doing well in terms of both infant mortality and adult mortality. And then Europe B and C, in the column that's the second from the right, is essentially Eastern Europe.

And you'll see that the part of the world that has the highest proportion of its mortality and loss of life years from disability attributed to alcohol is in fact eastern Europe with 12% or so. That and the rest of the developed world, which includes Australia, is about 6.8%, which is well above the international average and, if you look down that column, you'll see where the damage from alcohol has concentrated.

Cardiovascular disease is an area that we could talk about for a long time and there were two different methods that we used in this. The health gained from the protective effects for alcohol were subtracted out (that particularly was applicable in the column in which Australia appears), so you'll see there's a minus there. The two big contributors when you look at it in terms of disability-adjusted life years, which is how this slide has put forward, are mental disorders including alcohol dependence, where alcohol dependence is in fact

the largest single component of that category, and intentional injuries and unintentional injuries. In the world as a whole, about 50% of the DALY lost from alcohol are from injuries.

And even in the column that includes Australia, the percentage is around 27%. So injuries are a very important part of the harm from alcohol. Then there are categories such as other non-communicable diseases, which would include liver cirrhosis, for instance, and cancers, which also accounts for substantial parts of the harm.

So far I've been talking about health harm broadly construed, including injuries, but alcohol is also responsible for social problems, which are not counted in the World Health Organisation's accounting. We don't have as good measures in this area and, in fact, I think it's an important research agenda that some of my colleagues are pursuing to develop that measurement of social harm from alcohol. Here what I've given you is data from just a couple of studies, one from a survey in Canada, which would fairly well represent what one would expect to find in other places like Canada. In the last 12 months at the time of this survey, 7% of the adults who were interviewed reported being pushed or hit or assaulted by someone who had been drinking; 8% reported family problems or marriage difficulties due to someone else's drinking; and 6% said they'd had a friendship break up in the last 12 months because of someone else's drinking.

Another way of going at it is in terms of trying to count the cost of health and social services that are attributable to incidents involving alcohol. The study that was done in Scotland found that of the public service expenditures that were alcohol related, only about 21% were in the health service system; 19% in welfare services; and about 60% in the police and fire services. That is going to vary from one jurisdiction to another, but it gives you some sense of the fact that health problems from alcohol are really only part of the picture.

So, having established that we have a problem in the area of alcohol, that it remains a problem even if it is very familiar to us and something that is part of many people's everyday life, the question is, what about strategies to reduce rates of alcohol problems?

I was part of an effort, it's actually the third effort in this line, which was led by Tom Baber and includes a group of scholars from nine different countries. We produced a book called *Alcohol-No Ordinary Commodity, Research In Public Policy*. I'd actually been part of an effort the year before that produced a book rather like this, but it was aimed at developing countries, and the evidence there, which is of course much more in the way

of case studies than in the terms of the kind of quantitative evidence we were able to draw on in this book.

We looked at the different strategies for reducing alcohol problems from the point of view of the evidence of their effectiveness in terms of the breadth of support for that strategy in the literature, how many studies were there that supported it in one way or another, the extent of cross-cultural testing where all these studies were carried out in one country or two very closely related countries or with a broader range. And then in terms of the cost to implement and sustain was at, relatively speaking, a low or a higher cost. Our basis for that last category was a matter of guesswork. I'll go on and talk about another study that's been published since then that moves it a little bit beyond the basis of guesswork.

We found that some strategies are ineffective in terms of the evidence on them. In some of these areas there isn't much evidence, but there was enough evidence for us to conclude that you had an uphill climb if you were going to claim effectiveness in this area. In a few of the areas, notably alcohol education in schools, there was a great deal of evidence that was able to be drawn on. And fundamentally, even though these are often very popular measures, they're measures in which it's difficult to show effectiveness. Voluntary industry codes, for instance, a bar practice that is not backed up by any kind of regulation or enforcement, is difficult to show effectiveness.

Alcohol education in schools, as I said, it's very difficult to show effects on actual behaviour that lasts over time. This is the most controversial of our findings, the temperance movement doesn't like it, the alcohol industry doesn't like it, there are plenty of folk who find it a very difficult proposition to swallow, but it is indeed at Foxcroft and at Albert with their meta-analysis, a number of studies that have pointed in the same direction. I would say that this is an area where Australia is actually providing some leadership that may be pointing to some more positive stories in the future. Warning labels, public service messages, promoting alternatives, alcohol free activities – that's often a very good thing to be doing in a society that often has other social benefits, but is very difficult to show an affect of promoting alternatives in terms of reducing rates of alcohol problems. And designated drivers and ride services – again something that seems like a good idea, but again something where the evidence does not show effectiveness in reducing the rates of drink driving.

Here, on the other hand, are the 10 best practices, as Tom Baber's called them, based on an evaluation of the literature. A number of these are alcohol-controlled policies, policies that in one way or another limit or restrict or put some kind of boundaries around

the availability of alcohol. One of them is a minimum legal purchase age. Government monopoly of retail sales mostly has its effects through closing hours and numbers at stores. However, the fact that you have restrictions, with government civil servants much more likely to cut off people who are trying to purchase below age, may have an effect through limiting the amount of commercial interest there is influencing the politics of alcohol. Others include restrictions on the hours or days at sale, outlet density restrictions and then last, but by no means least, alcohol taxes.

A number of drink driving counter measures have been shown to be effective. Sobriety checkpoints, for example, is an area obviously in which Australia really played a leading role in the literature. Lower BAC limits, administrative licence suspension, something that brings more or less immediate penalty, and graduated licensing for novice drivers. In addition, there's good evidence that brief intervention for hazardous drinking, particularly in the health service, has effectiveness. There are some other areas that are promising, but you can't really say that there's strong evidence that is conclusive. I'll come back to one of them at the end of the talk.

Moving on beyond that evaluation, which was essentially in terms of effectiveness, a study was done under WHO auspices, which moves onto the question of cost-effectiveness, that is, how much bang do you get for the buck. This study was published at the end of last year by Chisholm et al., and I'm taking here the data in it from Western Pacific Aid, which is the WHO sub-region that includes Australia, Japan, New Zealand, Singapore and Brunei.

This study talks in terms of the cost-effectiveness per DALY, per Disability Adjusted Life Year, which is saved. I've got them here listed in order from the best in terms of the cost-effectiveness, that is the lowest amount of money per year of life that is saved. Taxes come out first. This is the way that economists count it, which is that you don't count the revenue for taxes in the equation at all, it's something separate from that. But even if you don't count the revenue from taxes, which from a government's point of view is after all a consideration, taxes on alcohol can have the strongest effect in terms of cost-effectiveness.

The others include an advertising ban, screening and brief medical advice, a limitation of availability (the example of a weekend closing day was used because it had the best evidence) and random traffic breath tests. Notice that measures like alcohol education in schools were not included because if something is not effective it can't be cost-effective, so they weren't even taken into consideration.

In the list for Western Pacific Aid, there was about a five-fold difference between the most and the least cost-effective. If you combine the top three according to the estimate of Chisholm and his associates, that is taxes, an advertising plan and screening and briefing medical advice, then you'd be estimated to save 983 DALYs per million population and the cost would turn out at about US\$2,528 more or less for a DALY, which is a pretty good rate, and that is quite a conservative estimate.

(Try the right button, and there we go).

Now looking beyond the mechanics of which strategies have been shown to be effective and which have been shown to be ineffective, to the situation we face in terms of alcohol policy at the international level. The alcohol industry is increasingly global and, as you can see in the beer industry, there's an increased consolidation with the four top brewers having interests on every inhabited continent. At this point I think the pecking order is as I show it there: SAB Miller, which is headquartered in the UK, used to be South African breweries but now includes a very large brewery in South America that's headquartered in Colombia; Inbev/Interbrew from Belgium, which has bought a very large brewery in Brazil in the last year or so; Anheuser-Busch in the US and Heineken in the Netherlands. So you can see that there's an increasingly concentrated ownership and the ownership is in the developed world.

Spirits, there's an oligopoly at this point, it's really just, for the international brands, the two biggest players at this point are Diageo which is headquartered in the UK and Pernod Rickard which is headquartered in France. These companies also have interests in other beverage types, particularly wine. The wine area is much more fragmented; the market is still dominated by Europe, in spite of Australia's success in this area. About 71% of world production is in Europe and about 68% of world consumption is in Europe. Basically, this large set of industries is an active voice against any tax increase and any measures that might reduce consumption. Fundamentally, their public position is, in terms of the social aspects of organisations and, directly, in terms of the companies themselves, that they're quite happy to help with reducing alcohol problems but not with any measure that threatens to actually reduce consumption.

In the international arena we have a situation where trade agreements and disputes have been eroding alcohol controls and there's a threat that this will actually become more true in the future. Under the General Agreement on Tariffs and Trade (GATT), which has now been succeeded by the World Trade Organisation's General Agreement on Trade on

Services, there were a series of disputes in the 1980s and 1990s, particularly about beer and wine and the North American market. In Canada, these were known as The Beer Wars. Basically, what you had was the US Federal Government under pressure from the breweries trying to break down the alcohol controls mostly at the provincial level in Canada, and, in retaliation, the Canadian Federal Government trying to put down the alcohol control laws that were at the state level in the US. The US side had considerable success with respect to Canada, however not complete success by any means. Canadian beer controls were, in fact, compromised to a considerable degree by this.

There have been GAP disputes also between the US and Japan and South Korea and between the European Union and Switzerland in the 1990s, all of these resulted in taxes being reduced. The form of these disputes is usually some version of saying that imported spirits are being treated worse in the local market than locally produced spirits and that, of course, is not allowed under the trade rules, but the tendency is that it used to be compromised or sold in the end by reducing the tax on everything, so the disputes were settled by increasing availability. And we can expect this in the ongoing negotiations and the General Agreement on Trade and Services at the World Trade Organisation.

This is very much in the press these days, however, one piece that very rarely appears in the press is that there's a potential impact on several areas of public health, including alcohol control. In the smaller area of the European Union, the single market rules and rulings have been forcing down alcohol taxes in a number of places. Denmark and Finland both reduced their spirit taxes by 40% last year under pressure from the cross-border traffic. In these trade arenas, alcohol is treated as if it were an ordinary commodity most of the time, and that is a big problem.

So, at the international level, as a remedy for this, a public health treaty is needed to enable effective policies around alcohol. The current situation with respect to alcohol is quite anomalous; there are international conventions on psychoactive substances covering nearly everything else at this point. Plant-based drugs are covered by the single convention on narcotic drugs from 1961, psycho-pharmaceuticals are covered by the Vienna convention of 1971. Under the new framework convention on tobacco control, the first public health treaty negotiated under WHO auspices was actually negotiated in 2003 but became effective only with the ratification by the fortieth country this year. Tobacco is going to be increasingly subject to international controls. In the area of sports doping even, the World Anti-Doping Agency was set up in 1999 and last month UNESCO adopted an international convention against doping in sports, which will presumably come into affect some time in the next couple of years. But in alcohol, there is nothing.

There were two agreements among the colonial powers in Africa in the late 19th century that were essentially abandoned by the 1950s. There is no other mention of alcohol in any international agreement from the health perspective.

The argument for an international agreement is that, as I've already pointed out, alcohol is important in the burden of disease and social problems in developed countries. It's particularly important in the better of developing countries. If you look in terms of the developing world's drinking patterns there are many abstainers and, in fact, the amount that is drunk by drinkers doesn't vary internationally, nearly as much as the amount that is drunk per adult—the big variation is how many abstainers there are in the society. There's often a lot of unregistered consumption that isn't measured in the official statistics and often in the developing world in particular the drinking patterns are often hazardous, that is, essentially with the emphasis on intoxication among those who drink. We see also in the data that alcohol consumption tends to increase with affluence and so if things go as we hope and very much with respect to development in the world, alcohol consumption can be expected to increase. That multinationals are there with their marketing, pushing sales, and in their globalising world, local and even national controls are really not sufficient because of the influence of the trade agreements and disputes; then the international agreement is needed as a counter to that.

The precedent for a framework convention on alcohol control would be the tobacco control convention that I already mentioned, which took, if you look at its history (they already had passed a resolution for a feasibility study in 1995) 10 years to get an actual treaty that has come into force. The framework convention, or convention protocol model as it's called in literature, establishes general principals with protocols added as agreements are reached and specific implementing measures added along with them. The framework convention creates an institutionalised forum for cooperation and negotiations, so it has some things specified in it but a lot of it is left for future negotiation.

An alternative solution, one that immediately has people scratching their heads or even wondering if I'm serious, is inclusion in the 1971 convention on psychopharmaceutical substances. There's no question that if you read the international convention, alcohol would qualify, absolutely no question at all. I don't think anyone disagrees with that. If the WHO finds that the substance (I'm reading from the literature, from the language of the convention), has the capacity to produce a state of dependence and central nervous system stimulation or depression, and that its use constitutes a public health and social problem, that's the basic qualification for listing under the convention. But there would be a lot of difficulties with going down this route. The 1971 conference clearly didn't intend to

apply the convention to alcohol but that doesn't stop the WHO from coming along now and overwriting that intention.

The main problem is that if you put a drug under the 1971 convention, then the use and possession of the substance is to be limited to medical and scientific purposes and that's a very substantial problem. One would have to amend the 1971 convention in order to be able to put alcohol under it in any way that, to me at least, would make sense. There are some exceptions in the 1971 convention in terms of... but even then a prescription regime is required and the notion that you would have to go to your doctor to get a prescription for alcohol, this is something that was very common during prohibition and in the US or Finland, but not something that we're likely to return to or look to return to.

If you think about putting alcohol under an international convention, we're talking in terms of a framework convention, a new convention. The interesting thing if you look at the tobacco convention, or for that matter if you look at the other conventions including the drug conventions, is that you would think, naively, they would mostly be about international matters. But they actually spend at least as much energy and time specifying conditions on internal markets. The international agreements, in fact, very often serve as a lever for internal policy change. The delegation comes back from the international meeting and argues to the national government on how we've got to change our laws. They create an expectation of comity, where governments honour the laws of other governments on national territory. This is a very important thing, for instance, in the tobacco area where the idea that smuggling would be discouraged at the source as well as at the place where it ends up.

You also end up with an international structure that serves as a kind of sheepdog, the international narcotics control board is perhaps (I have some mixed feelings about this) an example in this area where it sees itself as the guardian of the conventions.

Very briefly, it's not settled with the tobacco convention, for instance, what happens if there's a conflict with the trade treaties? It seems with the drug conventions, it's been a matter of taboo over the drug companies not being willing to take on some of these issues. But there's an unsolved issue with the tobacco convention. It was discussed in the negotiating sessions, like with the relationship between that convention and the World Trade Organisation. But no agreement was reached essentially.

At the moment we're in a situation where, with respect to alcohol, there's a limited effort at the international level. I mean there's no, as I said, no international treaties and,

therefore, no structure that's created around them. The WHO has been the most involved in alcohol issues at the international level, the International Labour Organisation has produced a few publications but there's virtually nothing else at that kind of inter-governmental level. And in the WHO, I recently updated a 1984 report, it has been a history of ups and downs; often with the downs under quite strong political pressure on WHO.

We're in a period of upswing at the moment, with respect to WHO and alcohol. There was a resolution on health promotion and health lifestyles last year that mentioned alcohol for the first time since 1983, and then this year there was a resolution on public health problems caused by the harmful use of alcohol. This was actually initiated by the Nordic countries, but substantial support came from some Pacific countries, notably Tonga spoke up in the executive board. It requests member states to develop, implement and evaluate effective strategies and programs; it requested a director general of WHO to report back in 2007 on evidence-based strategies and interventions, and with recommendations for effective policies and interventions. In some of the regional offices there's also been an upturn at WHO. WHO Euro, which had a strong program for a period of about five years but went into a period of quiet for about four years, has adopted a framework for alcohol policy for the next five years which gives us hope that they'll be more active again. In the Americas, for the first time in a long time there's substantial efforts with the first Pan American conference on alcohol policies taking place later this month.

In the Western Pacific Region, if you look on the website under alcohol, you'll find it basically says there's nothing going. The discussion document, if you search around a little bit on regional implications of the May 2005 resolution at the World Health Assembly, has a few comments concerning the alcohol resolution which basically said that national strategies and programs do not exist in most of the countries in the region. I know that this is not describing Australia but the region as a whole. The surveillance and recording systems are not well established in many developing countries. Lack of reliable data becomes a major obstacle in developing and implementing appropriate policies and activities.

And when I looked at what discussion there'd been at the regional committee meeting, there was really no discussion beyond what was in this document for that meeting. So at the moment there's a hole on the map that is one you could think about filling.

Turning now more to the state and local level and thinking about how we can move towards evidence-based practice in preventing and reducing rates of alcohol problems. The first thing to say is that it requires developing the evidence. The evidence that we were drawing on in the Babor et al. book is international and based on the limited number of countries, of which Australia is certainly one, and there is always the question of the applicability in the particular national setting of the literature from elsewhere. The most important thing from my point of view, in terms of developing an evidence-based strategy, is that any time we get a chance where there's a change in alcohol policy, there should be provision and funding for evaluation of the effects of that policy change.

If you want to understand policy effects, you need to understand the effects of changes in policy. There's no other way of doing it that really gives you anything like the strength of evidence. They can be planned experiments, called quasi experiments with controls; although there is at least one case in the Nordic countries where there's a true planned experiment and they flip the coin to see which part of Sweden would get Saturday opening and which part of Sweden would not get Saturday opening. So usually we're dealing with natural experiments (what researchers mean by natural experiment is something where the researchers didn't have any control over what was actually done). A good example of that is the Northern Territory's living with alcohol program and there's a recent publication of a real evaluation of that by Tania Chikritzhs and her colleagues. That is a good example in an Australian context of where some important things were learned from evaluating a program that was carried out at the level of the Northern Territory.

One thing, excepting, in the last piece of this, I want to talk specifically about reducing harm from intoxication. As medical people will quickly remind us, it's not the only way that alcohol can have a problem. There are certainly big issues of long-term health consequences of drinking that are not necessarily associated with intoxication. But it is something that is of high political salience and where we are beginning to develop evidence on ways of reducing the harm from intoxication. If we're going to go in that direction, we need to think of the level of the drinkers, the drinking cultures and the level of liquor licensing and enforcement.

From the point of view of the drinkers, the questions that are really not faced in the literature include: What is the meaning of intoxication in different worlds of heavy drinkers? How drunk, for that matter, is drunk? When people talk about being drunk, how many drinks are they talking about and under what circumstances? We need to know more about how drinking groups manage or don't manage intoxication, what are the

realities, within limits laws that Craig McAndrew and Robert Edgerton talked about, which hasn't been well examined.

One of my students is actually presenting a dissertation on this at the beginning of next month using Swedish data: What about the excuse value of intoxication? To what extent does intoxication serve as an excuse in circumstances of violence, sexual violence or, for that matter, in cases of accidents.

Then, in terms of liquor licensing and enforcement, we have a little bit of evidence on the effectiveness of enforcing the idea that those who are already drunk should not be served any more alcohol. This is something which again could be developed and often tends to be quite culture specific in terms of the particular legislation in the state or society. One issue that comes up frequently, you can see it's certainly in the discussions of the situation in Ireland, is that if you give the responsibility only to the general police to enforce the licensing laws, the question is where does it lie on their agenda, how much of a priority does this have and what happens when a police inspector who is particularly interested in this moves onto some other job? This has been a problem, for instance, with the Australian community agreements with respect to alcohol.

So we need to be developing an evidence base for liquor licensing and enforcement. This is not an area that has been regarded up to now as something that people should be operating on the basis of research evidence rather than simply on practical experience.

The third path to look at in terms of routes of reducing or influencing intoxicated harm is through the drinking environment, 'planning the night time economy' it might be called. What are the effects of shifts and zoning, of changes and design requirements, of place and conditions on licensing of one sort or another? One particular thing that we have a chance to be looking at in the next couple of years is what happens to drinking and intoxication when smoking in hotels and restaurants is banned. This is actually an opportunity... I know that Victoria already has some interesting experience with this with respect to banning smoking in gambling places that are also drinking places. But, as far as I know, what happened to the drinking wasn't studied too much. What happened to the smokers may have been.

The fourth way of approaching this is by looking back from the harm, for clues to reduction in terms of the development of the situation, what is sometimes in the old literature called 'multidisciplinary accident investigations'. Police incident reports, domestic violence, drunk driving in terms of the location, the timing, the co-factors... One

thing that's been experimented with in a number of places is a routine recording of where the last drink is... Police often have a good anecdotal knowledge of where trouble starts, but if you start recording it routinely, then it becomes much stronger evidence and, for that matter, ambulance and hospital emergency services are a potential source of routine or repeated monitoring of the role of alcohol and injuries. You can study the context and co-factors if you collect data this way.

Alcohol policy requires thinking and action, at multiple levels and in many arenas. I've talked about the local level and the international level, in fact, the local, the state, the national and the international levels all interconnect and local evidence and action can contribute at the international level. Conversely, what happens at the international level can facilitate or galvanise the local level or, on the other hand, can get in the way and make it very difficult to sort things at a local level.

Alcohol problems at each level reach across departmental and professional boundaries, this is on the one hand a source of inaction and on the other hand is of course an opportunity. Developing the evidence base requires cross-disciplinary work and implementing alcohol policies requires action across departments and services.

So that's it and thank you.