ROYAL AUSTRALASIAN COLLEGE OF SURGEONS


# SUBMISSION TO THE MINISTERIAL DRUG AND ALCOHOL FORUM

## National Alcohol Strategy
## 2018-2026

**February 2018**

## INTRODUCTION

Established in 1927, the Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand and across the Indo-Pacific. The College is a not-for-profit organisation representing more than 7,000 surgeons and 1,300 surgical trainees and international medical graduates.

RACS has advocated against the harmful effects of alcohol for many years, not only for the increased risk of complication it poses to surgical patients, but also for the broader ramifications it has on the sustainability of our public health system and society as a whole. Overall, the estimated one in eight hospitalisations relating to alcohol misuse continue to represent a significant and concerning proportion of health system workload.[1]

RACS recognises the importance of the Australian and state and territory governments working collaboratively with non-government agencies and community groups to reduce the social, economic and health costs of alcohol. To this end, we provided input to the 2015 National Alcohol Strategy consultation. Regular updates on the development and implementation of the National Alcohol Strategy 2018-2026 will assist us in providing ongoing expertise.

## KEY ISSUES

RACS recommends the following policy areas for consideration.

### 1. Restrict the physical availability of alcohol (hours and outlets)

There is substantial evidence in Australia and internationally that regulating the physical availability of alcohol, through reduced trading hours and liquor outlet density restrictions, is one of the most effective ways to reduce its negative impacts.[2] [3] [4] [5] Recognising the collaborative approach which the National Alcohol Strategy seeks to achieve, the Commonwealth has a duty as the lead agency in supporting states and territories to reduce the physical availability of alcohol.

### 2. Restrict the economic availability of alcohol (taxes)

Alcohol taxation is another effective policy intervention to reduce harmful alcohol consumption and related problems.[6] Even small increases in the price of alcohol can have a significant impact on consumption and harm, yet taxation as a strategy has been under-utilised in Australia. Economic modelling has shown that replacing the Wine Equalisation Tax and rebate with a ten percent increase to all alcohol excise and a volumetric tax on wine and cider would deliver $2.9 billion revenue and reduce alcohol consumption by 9.4 per cent.[7]

### 3. Reduce exposure

Exposure to alcohol advertisements among Australian adolescents is strongly associated with increased drinking patterns.[8] Alcohol advertisements should be restricted to late evening viewing times, and the loophole that allows alcohol advertisements to be broadcast during televising sporting events should be closed. The Commonwealth should consider comprehensive regulation of alcohol marketing across all platforms to reduce children and young people's exposure.

### 4. Data collection

Government agencies monitor and report incidents of alcohol-related harm and some of the costs associated with alcohol abuse, however agencies do not monitor or report the total costs to the community including trauma and law enforcement. RACS supports mandatory collection of data on whether alcohol use is a factor in emergency department presentations, either by the patient or another individual. All states and territories should also publicly report on alcohol sales data in a nationally consistent manner.

**5. Reduce the influence of alcohol industry in policy considerations**

RACS is concerned about the influence of the alcohol industry in policy development at all levels of government. Alcohol industry representatives should not be allowed to participate in public health policy development, due to vested interests.[9] We urge the Commonwealth Government to better acknowledge and address the influence of industry representatives on the national health policy agenda.

**6. Mandate health warnings on alcohol products**

RACS encourages the Commonwealth Government to consider mandatory health warnings, since voluntary uptake of pregnancy health warnings on alcohol product labels has been slow.[10]

## COMMENTS ON THE NATIONAL ALCOHOL STRATEGY 2018-2026

Australia has been without a National Alcohol Strategy since 2011 and needs a plan that is going to achieve change.

While there are sensible opportunities for action and a summary of recent evidence within the current Consultation Draft, it lacks a tangible program of activity and clearly defined performance measures. It also lacks detail on how objectives will be implemented, timeframes, and accountability mechanisms.

The Consultation Draft does not acknowledge the influence of the alcohol industry which provides significant political donations to both the major parties.[11]

RACS supports the suggestions made by the National Alliance for Action on Alcohol in its joint submission with the Foundation for Alcohol Research and Education to this consultation.

These include adopting the National Road Safety Strategy 2011-2020 model or similar to put meaningful support behind a National Alcohol Strategy, adopting a system of strong accountability measures to monitor progress, and introducing priority actions with timeframes.

### Harm minimisation approach

RACS welcomes the commitment the Commonwealth makes to harm minimisation in its overarching National Drug Strategy, because it acknowledges that while there may be economic implications for industry, there are also social and economic costs to the taxpayer when alcohol, tobacco and illicit drug use are not adequately regulated or addressed.

Above all, governments have a responsibility to ensure that policies prioritise the health and safety of Australians, regardless of industry interests.

It is pleasing to see a greater emphasis on the harm alcohol can cause to those other than the drinker in the Consultation Draft. Australian researchers Collins & Lapsley (2008) and Laslett (2010) have been world leaders in developing two key methodologies to measure the cost of alcohol to the drinker and those around them, and if we want consistent data we need to repeat studies using the same methodologies.

### Targets, data and reporting

Monitoring and publicly reporting on implementation should be an integral part of the Commonwealth's National Alcohol Strategy.

RACS welcomes the introduction of a target to reduce harmful alcohol consumption, as this was a recommendation from our submission to the 2015 National Alcohol Strategy consultation, and demonstrates Australia's commitment to the World Health Organization target of a 10% relative reduction in the harmful use of alcohol by 2025.[12] Some argue that this target is not ambitious enough,

with the Australian Health Policy Collaboration suggesting a 20% reduction in the harmful use of alcohol would be more appropriate.[13]

Regular reporting against this target and other priority areas set out in the Consultation Draft will be critical to the National Alcohol Strategy's success. Further information on how the Reference Group will make information on progress available to stakeholders would be helpful.

National consistency in data collection is important to provide meaningful results. Current data sources that are relevant to measuring any changes in alcohol harms include hospitalisation data, emergency presentation data, ambulance data, and police assault data.

The quality of hospital alcohol harm data is poor and grossly underestimates the real story because primary diagnosis codes are not used properly.

Several organisations such as RACS, the Australasian College for Emergency Medicine and the Australian Health Policy Collaboration have highlighted the need for a more systemic approach to health data, and the Commonwealth Department of Health is well placed to advise whether it would be possible to add alcohol as a flag to the Emergency Department Care National Minimum Dataset, rather than relying on estimations drawn from hospital datasets using the high alcohol hours assault methodology.

**Managing availability, price and promotion**

The Consultation Draft highlights the association between alcohol availability and related problems, yet stops short of committing to greater support for jurisdictions such as New South Wales and Queensland which have reduced trading hours. The Commonwealth needs to outline how it will support governments to reduce the hours alcohol is available, as this will deliver nation-wide reductions in alcohol harm.

RACS supports the objectives outlined in the Consultation Draft on pricing and taxation, and minimising alcohol promotion, but the Commonwealth needs to outline a program of activity to explain how these objectives will be achieved.

**Promoting healthier communities**

RACS agrees with the statements made under Priority 4; in particular the problematic mixed messaging Australians receive via news and public promotion of alcohol. Demand reduction is one of the Government's three pillars of harm minimisation in its National Drug Strategy. Allowing sponsorship of sporting codes by the alcohol industry is illogical in the context of effective health promotion and prevention.

The Commonwealth should be wary of industry-led groups which claim to educate the public about responsible drinking.[14] As per point 5 above, policy development and education campaigns should not involve the alcohol industry or any other vested interests. This was supported by the World Health Organization Director General in 2013 who stated that, 'the alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests.'[15]

It is encouraging to see the role of industry mentioned in the Consultation Draft's Governance section, but the Commonwealth needs to better articulate how it will address industry influence on government policy before the strategy is finalised.

RACS strongly supports implementing readable, impactful health-related warning labels on all alcohol products as this will deliver the dual benefits of reducing alcohol-related harm and preventing obesity. The OECD Obesity Update 2017 includes examples of front-of-pack labels that have been introduced in Australia and internationally to assist people with their food choices.[16] Despite alcohol being a more harmful commodity than food, promotion of alcohol has not been regulated in the same way and in fact industry has been able to market products as healthier alternatives (for example low carbohydrate beers)[17].

RACS also supports ongoing funding of the Prevent Alcohol and Risk Related Trauma in Youth (P.A.R.T.Y.) program in hospitals around Australia.

People aged 16–24 years have the highest rates of injury. They are more likely to drink at risky levels or engage in activities like texting while driving, and this means they are more likely to end up in hospital. The P.A.R.T.Y. program originated in North America and has been running in Australia since 2006. There are more than 100 sites worldwide, and highly effective P.A.R.T.Y. programs are now being run in Western Australia, South Australia, Victoria, New South Wales, the Australian Capital Territory and Queensland.

The Perth program is estimated to cost $1,000 to run each week, while the lifetime cost per incident of paraplegia is estimated to be $5 million per case.[18]

Thank you for the opportunity to provide input to this consultation. For further information, please see our Alcohol Related Harm Position Paper and our Trauma Prevention Position Paper.

[1] Australasian College for Emergency Medicine. One-in-eight patients in emergency departments affected by alcohol. December 2017. Available from: www.acem.org.au. Accessed 7 February 2018.
[2] Menéndez P, Weatherburn D, Kypri K, and Fitzgerald J. Lockouts and Last Drinks. NSW Bureau of Crime Statistics and Research, 2015, School of Medicine & Public Health, University of Newcastle, Australia.
[3] Fulde G, Smith M, Forster SL. Presentations with alcohol-related serious injury to a major Sydney trauma hospital after 2014 changes to liquor laws. MJA. 2 Nov. 2015;203(9):366.e1–5.
[4] Australian Government Department of Health. Technical Report No 3, Preventing alcohol–related harm in Australia: a window of opportunity. Available from: http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/09C94C0F1B9799F5CA2574DD0081E770/$File/alcohol-jul09.doc. Accessed 6 February 2018.
[5] de Goeij M, Veldhuizen E, Buster M, Kunst A. The impact of extended closing times of alcohol outlets on alcohol-related injuries in the nightlife areas of Amsterdam: a controlled before-and-after evaluation. Addiction 2015; 110: 955–64.
[6] Alcohol and Public Policy Group (2010), Alcohol: No Ordinary Commodity – a summary of the second edition. Addiction, 105: 769–779. doi:10.1111/j.1360-0443.2010.02945.x
[7] Foundation for Alcohol Research and Education. Pre-budget submission 2016-17: Submission to Treasury. Canberra: FARE; Feb. 2016.
[8] Jones S, Magee, CA. Exposure to alcohol advertising and alcohol consumption among Australian adolescents. Alcohol and Alcoholism, 2011, 46 (5), 630-637.
[9] Freeman B, MacKenzie R, Daube M. Should tobacco and alcohol companies influence Australia's drug strategy? Public Health Research & Practice April 2017; Vol. 27(2):e2721714. doi: http://dx.doi.org/10.17061/phrp2721714.
[10] Food regulation in Australia and New Zealand. Pregnancy warnings on alcohol labels. Available from: http://www.health.gov.au. Accessed 7 February 2018.
[11] Australian Electoral Commission. Political Party Annual Return – 2016-17. Available from: http://periodicdisclosures.aec.gov.au/Party.aspx. Accessed 7 February 2018.
[12] WHO. About 9 voluntary global targets. World Health Organization. World Health Organization; 2015. Accessed 18 November 2015. Available from: http://www.who.int/nmh/ncd-tools/definition-targets/en/.
[13] Australian Health Policy Collaboration. Targets and indicators for chronic disease prevention in Australia. Technical paper No. 2015-08. November 2015. Available from: www.vu.edu.au. Accessed 7 February 2018.
[14] Hall WD, Room R. Assessing the wisdom of funding DrinkWise. MJA, Vol. 185 Number 11/12, 4/18 December 2006. Available from: www.mja.com.au. Accessed 7 February 2018.
[15] Babor TF, Brown K. Statement of Concern About the Global Alcohol Producers. Journal of Groups in Addiction & Recovery Vol. 8, Iss. 4, 2013.
[16] OECD. Obesity Update 2017. From: http://www.oecd.org/health/health-systems/Obesity-Update-2017.pdf. Accessed 7 February 2018.
[17] VicHealth. Fact Sheet - VicHealth National Community Attitudes Survey: awareness and behaviours of low carb beer drinkers. December 2010. Available from: https://www.vichealth.vic.gov.au. Accessed 7 February 2018.
[18] Access Economics. The cost of traumatic Spinal Cord Injury and Brain Injury in Australia. Report by Access Economics Pty Ltd for The Victorian Neurotrauma Initiative. June 2009. Available from: www.tac.vic.gov.au. Accessed 7 February 2018.