ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SUBMISSION TO HEALTH OUTCOMES INTERNATIONAL

National Alcohol Strategy
2016-2021

November 2015

The Royal Australasian College of Surgeons (RACS) is pleased to be able to offer its advice and support to the Australian Government's development of the National Alcohol Strategy 2016-2021 (NAS). We appreciate the opportunity to be part of this process.

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. Regular updates on how the NAS is developing would assist us in providing ongoing expertise to support the evidence base required.

1.1.1 Please identify, where possible, the basis for the feedback you are providing (e.g. is it supported by evidence and if so what is the source, personal experience etc.).

RACS is the leading advocate for surgical standards, professionalism and surgical education in New Zealand and Australia. RACS is a not-for-profit organisation that represents more than 7,000 surgeons and 1,300 surgical trainees and international medical graduates across New Zealand and Australia. It also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research.

RACS has developed its recommendations on reducing alcohol-related harm drawing on scientific evidence and the expertise of our Fellows in Australia and New Zealand, and other members of the medical profession.

The Chair of RACS Trauma Committee, Dr John Crozier, provided 1.5 hours of expert medical advice via teleconference as part of this consultation on Friday, November 6. This written submission has the endorsement of our Council's executive.

1.1.2 Please identify any organisations/affiliations/experience relevant to the input you are providing (e.g. consumer, service provider, public health advocate, researcher, retailer etc).

RACS has advocated against the harmful effects of alcohol for many years, not only for the increased risk of complication that 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.

Surgeons are dramatically confronted with the effects of alcohol misuse when treating patients with injuries resulting from road traffic trauma, interpersonal violence and personal accidents that are caused by excessive alcohol consumption. Alcohol misuse is also a significant contributor to the total burden of disease, including liver failure, GI bleeding, upper GI and oropharyngeal cancer and infections related to malnutrition.[1]

Overall, hospitalisations relating to alcohol misuse continue to represent a significant and concerning proportion of the surgical workload.

As a Fellowship-based organisation, RACS commits to ensuring the highest standard of safe and comprehensive surgical care for the community. Equally important is the safety of our surgeons. There is no question that excessive alcohol intake increases the risk of all medical professionals being exposed to violent behaviour.

A staff perceptions survey conducted by the Australasian College of Emergency Medicine in 2014 found that of the more than 2,000 Emergency Department clinicians who responded, the vast majority had experienced alcohol-related verbal aggression, physical violence or threats from patients, and felt unsafe as a result.[2] We are committed to working with Government to develop practical solutions to minimise these risks to the health workforce and the public wherever possible.

1.3.1 Is this an appropriate goal for the National Alcohol Strategy (NAS)? If not, what should be the main goal?

The 2014 national Alcohol Policy Scorecard rated the Commonwealth Government as the lowest performing of all jurisdictions in terms of efforts to develop and implement evidence-based alcohol policy. Its score has dropped 20 percentage points since 2013, mainly due to the absence of a whole-of-government strategic plan to address alcohol-related harm.[3]

Funding has ceased for organisations that provided expert advice on ways to reduce the harmful impacts of alcohol, such as the Alcohol and Other Drugs Council of Australia, the Drug and Alcohol Prevention and Treatment Advisory Committee, and the National Indigenous Drug and Alcohol Committee.

We acknowledge that the Government has engaged consultants to drive forward the development of the National Alcohol Strategy, but requests for consultations have come at a very busy time of year, with a short timeframe to provide submissions. RACS is concerned that prior to this, there was little action for the past five years on alcohol taxation, regulation of alcohol advertising, and the labelling of alcohol products, and these issues are still not adequately addressed in the NAS.

The aim of the strategy should be to reduce and stop the harm from alcohol rather than develop a framework. The NAS should include clear objectives, strategies and actions and have measurable targets. It should follow the World Health Organization (WHO) approach in its global strategy to reduce harmful use of alcohol.

At a minimum, the NAS should include a target based on Australia's commitment to the WHO target of a 10 per cent relative reduction in the harmful use of alcohol by 2025.[4]

Stakeholders should have the opportunity to comment on the first draft.

1.3.2 Is a five year timeframe adequate, or should a longer period be considered such as ten years?

We acknowledge the strategic approach the Government seeks to take in relation to reducing alcohol-related harm, however we encourage more regular updates and an annual report that stakeholders can use to measure how we are collectively tracking against the NAS. We do not support a timeframe longer than five years.

1.4.1 Are these principles appropriate? Why / Why Not?

The guiding principles of the NAS should be informed by the WHO Global strategy to reduce harmful use of alcohol.

The principles are:

(a) Public policies and interventions to prevent and reduce alcohol-related harm should be guided and formulated by public health interests and based on clear public health goals and the best available evidence.
(b) Policies should be equitable and sensitive to national, religious and cultural contexts.
(c) All involved parties have the responsibility to act in ways that do not undermine the implementation of public policies and interventions to prevent and reduce harmful use of alcohol.
(d) Public health should be given proper deference in relation to competing interests and approaches that support that direction should be promoted.
(e) Protection of populations at high risk of alcohol-attributable harm and those exposed to the effects of harmful drinking by others should be an integral part of policies addressing the harmful use of alcohol.
(f) Individuals and families affected by the harmful use of alcohol should have access to affordable and effective prevention and care services.

(g) Individuals who choose not to drink alcohol beverages have the right to be supported in their non-drinking behaviour and protected from pressures to drink.
(h) Public policies and interventions to prevent and reduce alcohol-related harm should encompass all alcoholic beverages and surrogate alcohol.[5]

Australian researchers 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. In 2008 Collins & Lapsley used a new methodology to estimate the avoidable costs of alcohol abuse in Australia. In 2010 Laslett developed novel methods for costing different aspects of alcohol's harm to others, and applied these methods to estimate costs to others from the alcohol-related behaviour of heavy drinkers.

1.4.2 Are there other principles that should underpin this NAS? Why?

We support the harm minimisation approach that the Government adopted 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 is not adequately regulated or addressed. Above all, the Government has a responsibility to ensure that wherever possible, its policies prioritise the health and safety of all Australians, regardless of industry interests.

1.5.1 What are the key successes to build on in the new NAS?

The NAS should build on the success of measures designed to reduce availability (such as the measures introduced in Newcastle and parts of Sydney) and demand (such as the alcopops tax, which increased the price of ready-to-drink alcoholic beverages).

The NAS needs to be able to compel governments to adopt key actions to achieve consistent and nation-wide reductions in alcohol harm.

Reduced trading hours

An evaluation by the NSW Bureau of Crime Statistics and Research published in April 2015 showed that since the reduced trading hours were introduced in Sydney, assaults in Kings Cross have declined by 32%. Assaults in the Sydney CBD Entertainment Precinct dropped by 26%, and in the sub-section area of George Street South, by 40%. Reduced trading hours for pre-packaged liquor outlets across NSW have been matched by a 9% decrease across the state.[6] Since reduced trading hours have been shown to reduce assaults in NSW, the Australian Government should encourage other jurisdictions to adopt the same measures.

Effective education programs

RACS 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 and Queensland.

The Perth program is estimated to cost $1,000 to run each week, while the health costs of a quadriplegic are estimated at roughly $8 million for the rest of their shortened life. Program participation was associated with a reduced subsequent risk of committing violence- or traffic-related offences, injuries, and death among juvenile justice offenders. There is huge community support for these programs.

Alcohol interlocks

While all Australian jurisdictions except for Western Australia have implemented offender-based alcohol interlock programs, none currently require the mandatory fitment of alcohol interlocks to any other driver/vehicle group as a preventative program. There is also little evidence that jurisdictions promote the voluntary use of alcohol interlocks.

A 2015 report by Austroads noted that there is a strong case for the fitting of alcohol interlocks to commercial vehicles and vehicles driven by probationary drivers.[7] The report also noted that alcohol interlocks are effective in preventing drink-drive episodes when installed and that the positive effect of alcohol interlocks dissipates once the interlock is removed. To date, no Australasian alcohol interlock program has been evaluated, which limits the ability to provide definitive recommendations in this report.

The authors argue that a harmonised national mandatory approach should be pursued for both existing offender-based programs and non-offender programs as far as possible. This would aid compliance, ensure uniformity of sanctions, improve community acceptability of alcohol interlocks, promote new technological solutions to common problems faced by jurisdictions, promote innovation in the technical specifications of interlocks and reduce the costs of participation and fitment.

RACS supports evaluation of any new technologies which may reduce the prevalence of drink driving.

Outlet density

There is a positive relationship between alcohol outlets (general, on-premise, and packaged) and increased rates of violence. RACS supports limiting the number of outlets where alcohol is sold. The latest research suggests there is a sharp increase in domestic and non-domestic violence where there are more than two hotels and one bottle shop per 1,000 residents.[8] A reduction in the density of liquor outlets may support the Government's efforts to address the prevalence of domestic violence.

1.5.2 What are the key challenges to address going forward in reducing harms from alcohol in the future?

There is currently little cross portfolio discussion on actions needed to reduce alcohol harm and why they are so important for example between Health and Treasury or Health and Communications.

RACS recommends that the Commonwealth consider the following key policy areas to reduce alcohol-related harm.

Taxation

A report from the Parliamentary Budget Office concluded that Australian's system of alcohol taxation is complex. It acknowledged that there are varying exemptions and concessions available to different products. The report clearly notes that Australian taxation of alcohol has not been developed from a set of consistent policy principles. [9]

International scientific evidence consistently shows that rates of alcohol consumption and resultant harm are influenced by price.[10] Alcohol taxation is one of the most effective policy interventions to reduce the level of alcohol consumption and related problems, including mortality rates, crime and traffic accidents. Even small increases in the price of alcohol can have a significant impact on consumption and harm.[11] However, despite its reported effectiveness, taxation as a strategy to reduce alcohol-related harm has been under-utilised in Australia.[12]

When the costs identified in the Collins & Lapsley report and the Laslett report were analysed by one of the authors of the Laslett report in 2010, the total cost of alcohol misuse in Australia was found to be up to $36b.[13] This includes harms to the drinker and those around the drinker. The same year, the Australian Government received an estimated $7.075b in total alcohol tax revenue.[14]

Reducing the significant harms and costs of alcohol should be a key objective of alcohol taxation arrangements. The Wine Equalisation Tax (WET) and its associated rebate are the most problematic and illogical parts of the alcohol taxation system. Under the WET, wine and other fruit-based alcohol

products are taxed based on their wholesale price, rather than alcohol content, which means that cheap wine attracts less tax. This, in turn, creates a price incentive for people to buy, and a profit motive for industry to produce low-cost wines.

The WET is different to other alcohol taxes in that it has no consideration for the alcohol content of the product and instead incentivises the production of cheaper, mass produced wine.

In addition to the WET, a WET rebate exists that provides rebates of up to $500,000 to wine producers, costing Australians $250 million each year. Although it was originally designed to support small producers in rural and remote areas of Australia, the intent of the policy has been undermined by its availability to all producers, with large producers taking advantage of tax loopholes, and New Zealand producers having access to the rebate.

Since the introduction of the WET and the associated rebate, the price of wine has fallen dramatically relative to the consumer price index (CPI).[15] Wine is now more affordable in Australia than it has been in three decades, and its affordability contributes to the way it is consumed and the harms it causes. Depending on the specials available on any particular day, wine is available for around 30 cents per standard drink, compared to beer at $1 and the cheapest spirits at around $1.50 per standard drink.[16]

Evidence shows that low alcohol prices result in higher consumption levels, which in turn lead to increased harms. A 2009 meta-analysis of 112 peer reviewed studies on the effects of alcohol price and taxation levels on alcohol harms showed that there was “overwhelming evidence of the effects of alcohol pricing on drinking”.[17]

Reduce exposure of children to alcohol advertising

Demand reduction is one of the Government’s three pillars of harm minimisation in its National Drug Strategy. This approach requires strategies and actions that prevent the uptake of drug use, delay the first use of drugs, and reduce the harmful use of alcohol, tobacco and other drugs in the community.

Australian studies have shown that exposure to alcohol advertisements among Australian adolescents is strongly associated with increased drinking patterns.[18] The National Health and Medical Research Council recommends that parents of adolescents delay the age of drinking initiation as long as possible to protect the health and wellbeing of young Australians.[19]

New research on children’s exposure to alcohol advertising published in the Drug and Alcohol Review found that current alcohol advertising regulations do not achieve their stated intent, which is to protect children and adolescent’s exposure to alcohol advertising.

- There were 3,544 alcohol advertisements in televised AFL (1,942), cricket (941), and NRL (661), representing 60% of all alcohol advertising in sport TV, and 15% of all categorised alcohol advertisements (23,936) on Australian TV in 2012.
- Sixty percent of all alcohol advertising in sport TV for 2012 was in the AFL, cricket and NRL, and an audience of 26.9 million children and adolescents watched these sports on TV.
- Considered alongside research showing that greater exposure to alcohol advertising in children is associated with earlier initiation and more harmful drinking, the results suggest that this regulatory loophole may lead to more problematic drinking in young Australians.
- Stricter regulation of alcohol advertising has been shown to be associated with lower alcohol consumption in European nations.[20]

RACS supports efforts to reduce young people's exposure to alcohol advertising through policy reforms aimed at reducing the proliferation of alcohol advertising. In particular, RACS encourages the Government to reduce children and young people’s exposure to alcohol advertising on free-to-air commercial television by:

1. Allowing alcohol advertisements to be broadcast only during late evening viewing times.
2. Removing the provision that allows alcohol advertisements to be broadcast during televised sporting events on weekends and public holidays.
3. Removing exclusions under the definition of 'Commercial for alcoholic drinks' that may allow alcohol promotions during hours when children and young people will be watching.

It is illogical that the alcohol industry has been allowed to continue advertising and promoting its products with loopholes that expose children during prime time sporting events, while much heavier regulation of advertising by the tobacco industry has been put in place.

Additional principles should include:

- Use of targets so that success can be measured.
- Adequate and certainty of funding to enable full implementation of strategies and security of funding for services.
- Development of the NAS to be free of involvement by the alcohol industry and any other vested interests in accordance with the WHO view that 'the alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests.'

1.5.3 Are there new stakeholders or industries that should be involved?

None that RACS is aware of.

1.6.1 What areas of focus need to be addressed in evidence-based policy? Why?

The most effective strategies and biggest priorities for action are pricing and taxation, access and availability, and advertising and promotion.

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 through alcohol related trauma and law enforcement, meaning we do not have a complete picture of the harm caused by alcohol in terms of its costs and effects on society.

Screening and Brief Intervention

Despite the evidence supporting the effectiveness of Screening and Brief Intervention (SBI) programs very few patients are asked about their alcohol use in the past year. A structured SBI program is inexpensive, takes little time to implement (5-10 minutes), and can be undertaken by a wide range of health and welfare professionals.

RACS supports further investigation of how a suitable SBI program could be implemented in Australia and New Zealand, in particular the mandatory collection of data on whether alcohol use is a factor in emergency department presentations, either by the patient or another individual.

1.6.2 Are these appropriate in the development of the NAS? Why / Why Not?

Other strategies are needed that address particular behaviours, early intervention and treatment activities such as drink driving, screening and brief interventions, and access to a range of treatment services.

1.7.1 What are the key partnerships needed to underpin implementation of the NAS?

Partnerships are critical to the success of any strategy to reduce alcohol related harm.

Working in partnership includes cross portfolio partnerships for example between Health and Treasury and cross sectoral partnerships such as Health and Social Services.

1.7.2 Are there particular partnerships that need to be established or strengthened?

RACS encourages better engagement with Aboriginal health agencies to allow experts, particularly those with regional experience, to guide policy development.

Identification of relevant partnerships should be informed by a social determinants approach to health. Partnerships are weakened by uncertainty of funding. Building capacity within the health workforce is undermined by lack of and uncertainty about funding

Partnerships must not involve the alcohol industry, other than those relating to the implementation of policies.

1.8.1 Are the identified priority populations appropriate?

The Draft National Drug Strategy 2016-2025 identifies seven priority populations and it could be argued that others should be added. If the NAS only identifies two, there is a risk that this lessens the perceived need to address relevant issues in the priority groups not included.

1.8.2 Are there other population groups that should be prioritised? What evidence supports this?

An alternative could be to adopt a social determinants approach to address the underlying factors that lead to harmful consumption.

1.9.1 Are these priority areas appropriate? Why / Why Not?

The NAS should outline clear priorities for action such as prioritising prevention, and these should be separated from the actions so that they can easily be identified.

Actions identified should be clear and specific. For example RACS recommends that the Australian Government introduce a volumetric tax for all alcohol products. It would also be beneficial if an independent alcohol advertising regulatory regime was established.

1.9.3 What evidence based actions could be undertaken in priority areas?

- Restrict the physical availability of alcohol (Hours and Outlets)
- Restrict the economic availability of alcohol (Taxes)
- Reduce exposure of children to alcohol advertising
- Improve data collection of alcohol-related presentations in Emergency Departments and alcohol sales

1.10.1 Thinking about the priority areas and population groups identified above, or that you have identified, what existing data sources and indicators could be used to provide meaningful and reliable measures of harm reduction? What new data sources require development?

Transparency is important so that the community can have confidence in Government decision making and expenditure.

Monitoring and publicly reporting on implementation should be an integral part of this strategy.

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.

Alcohol sales data is important in examining changes in supply – all states and territories should publicly report on alcohol sales data in a nationally consistent manner in line with the National Alcohol Sales Data Project.

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