Consultation Draft National Alcohol Strategy (2018-2026) - Personal Submission

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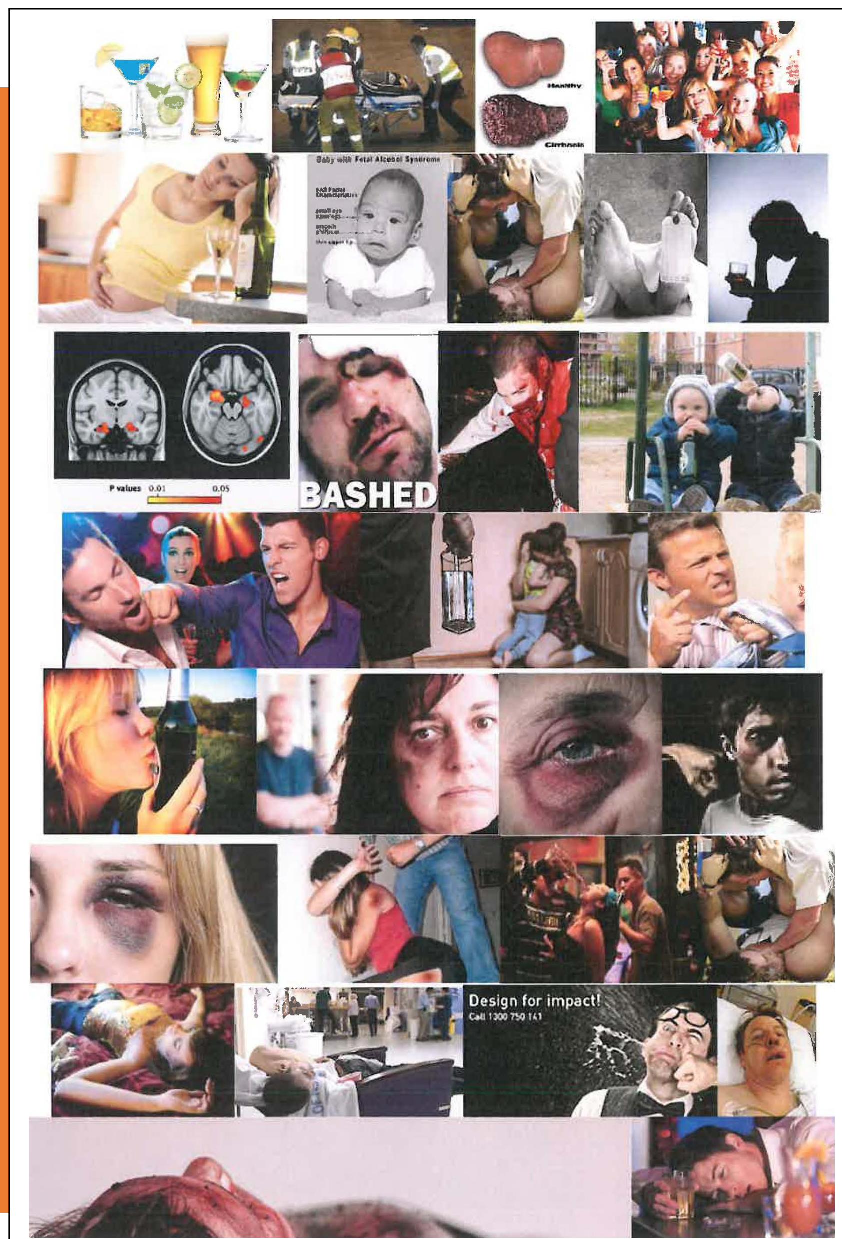

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Consultation Draft National Alcohol Strategy (2018-2026)

- Submission, 18 February 2018

Context of my Response to Draft National Alcohol Strategy

I respond as an Addiction Medicine specialist rather than on behalf of any specific organisation while noting that in terms of my credentials to comment, I hold a number of senior positions that reflect my experience and expertise in the field of addiction medicine and in public health.

Specifically, I am the Clinical Director of Tasmania's Alcohol and Drug Services, current President of the Australasian Chapter of Addiction Medicine, Royal Australasian College of Physicians and I hold an honorary appointment as Clinical Associate Professor, School of Medicine, University of Tasmania. I am a member of the Australia Professional Society on Alcohol and Other Drugs. My qualifications are as follows: MBBS(Melb), BSc(Hons), MPH, FAChAM.

I have worked in the alcohol, tobacco and other drugs field since 1983 and have in the past worked with six agencies of the United Nations system in several dozen countries providing technical and policy advice, teaching and other support to those countries in various roles within the WHO/ WPRO, WHO/ HQ, UNDCP, UNAIDS HQ, UNAIDS-APICT and UNHCR, in the areas of alcohol, tobacco and other drugs; HIV prevention; health promotion, mental health and refugee opioid dependence treatment and resettlement. I acted in the position of Regional Adviser, Health Promotion, Alcohol, Drugs and Tobacco and Mental Health, WHO/ WPRO. All these United Nations professional roles and experiences were on direct invitation from the various UN agencies.

Most importantly, I am a trained doctor who has found it difficult to understand and to come to terms with what I have witnessed through my career arising from the sale and use of this legal drug called alcohol. I have found it difficult accepting that so many who have no relevant training or relevant high-level formal qualifications and no deep content knowledge are so ready to express strong opinions that run counter to the evidence and yet expect their views will dictate public policy. And historically, so often, have they done so.

Introductory Remarks

A new National Alcohol Strategy has been a long time coming. I represented the Royal Australasian College of Physicians (RACP) in my lead RACP policy and advocacy role for all matters related to alcohol, tobacco and other drugs at a meeting organised by the **Intergovernmental Council on Drugs** (IGCD) in Canberra in 19 November 2014, where key stakeholders were brought together from across the country to discuss the scope and direction of this new strategy. The meeting was attended by many members from the alcohol industry and there were significant concerns expressed by experts in the drug and alcohol and related fields about the presence of industry and its attempt to unduly influence the agenda in a way that was contrary to the evidence. That meeting followed a National Alcohol Summit held on 28-29 October 2014 in the Australian Parliament in Canberra, organised by the **Australian Medical Association**. Contrary to the IGCD meeting, ably led

by the then National AMA President and neurosurgeon, Professor Brian Owler, the AMA meeting was provided with a comprehensive overview of the evidence, specific recommendations and the imperatives and clear responsibilities of governments to act upon that evidence. Since that time, our Commonwealth, State and Territory governments have taken little meaningful policy action, while many thousands of Australians have suffered unnecessarily and avoidably or lost their lives.

From national health and broader social well-being perspectives, this draft National Alcohol Strategy (NAS (2018-26) is of immense significance. As a national strategy, it should aim to present a coherent public policy framework, one that is clearly and consistently informed by the best available Australian and international evidence on what works in preventing and substantially reducing ('minimising') alcohol-related harm and one that provides clear direction and signals the strongest possible commitment by Commonwealth, State, Territory and local governments to action in accordance with this evidence. It is important that experts in the field, lead agencies and the Australian public were invited to comment on the draft, though initially, there were great concerns that this consultation was to be very short, too short for meaningful comment.

In this submission, I will 'speak plainly' in reflection of the seriousness of the wide-ranging problems causally associated with this drug, problems that I and my fellow health and human services colleagues witness and do our level best to manage every working day of our professional lives. I have been constantly disappointed by those around and in senior positions around and above me who could and should have done much more over the decades. I ought to have done more too.

In this submission I will discuss areas of the draft where I think the proposed actions are consistent with best available evidence and those areas where I present, they are not and recommend further careful consideration be given. I will pose important questions that arise in relation to this draft National Alcohol Strategy (2018-2026) and I will move through the document, commenting as I go. I will first make some observations about the commercial behaviours of the alcohol industry to lay the foundations for many of my serious concerns, comments and recommendations.

Recommendations

I present my consolidated recommendations first, noting there is some overlap in these given the relevance of what is required across a range of matters that I consider in this submission.

Recommendation 1: that the National Alcohol Strategy (2018 – 2026) provide clear and strong statements about what evidence based policy reforms and actions the various levels of government in Australia will commit to over a specific timeframe with inbuilt mechanisms for monitoring and evaluating progress against specific targets and identified accountabilities, to be reviewed on an annual basis through national governance mechanisms and communicated in a transparent manner to the people of Australia. Alternatively, that governments commit to an operational plan that translates this strategy into specific and accountable actions.

Recommendation 2: that any mention of alcohol and the alcohol industry contributing in a positive way to Australian society be removed from the final NAS (2018-26), including any comment about balancing benefits and harms given the reality that perceived or actual personal or commercial benefits cannot and should never be seen or said to excuse, mitigate or expunge the harms.

Recommendation 3: That the NAS (2018-26) pay careful attention to establishing processes to assess the factors associated with current poor alcohol problems clinical case finding, clinical documentation and ICD-10 coding given the reality that current clinical practices and health systems are leading to substantial under-estimates of the incidence and prevalence of alcohol-related harms and serving to mislead both the Australian public and those who draw upon this data in public policy decision making and health and human sector planning.

Recommendation 4: that the National Alcohol Strategy (2018 – 2026) is adjusted to ensure that it aligns with the WHO's *Global Strategy to Reduce the Harmful use of alcohol (2010)* including specific and strong commitment to implementing the WHO 'best buys'.

Recommendation 5: that the National Alcohol Strategy (2018 – 2026) is adjusted to ensure that it aligns and is consistent in every way with the United Nations Sustainable Development Targets.

Recommendation 6: that the National Alcohol Strategy (2018 – 2026) pays clear attention to the roles and responsibilities of all sectors of the alcohol industry in ensuring that its commercial actions do not harm or in any way glamorise or promote dysfunctional, hazardous and harmful choices to consumers and that it will be held to legal and financial account where it breaches as yet to be determined nationally agreed standards of commercial behaviour, designed to protect public and population health and safety.

Recommendation 7: that the National Alcohol Strategy (2018 – 2026) describe a completely reconceptualised framework for 'responsible server practice' that is based on and in every way consistent with the low risk drinking advisories contained in the next version of the Australian Guidelines to Reduce Health Risk from Drinking Alcohol (NHMRC).

Recommendation 8: that the National Alcohol Strategy (2018 – 2026) make specific reference to a commitment by each of the States and Territories to legislate to prohibit all secondary supply of alcohol to young people under the age of 18 years, buttressed by a sufficiently carefully designed and well-funded social marketing strategy to inform and engage with the people of Australia as to why this is so important.

Recommendation 9: that the National Alcohol Strategy (2018 – 2026) is rewritten to ensure each and every point that is included in the section on managing availability, price and promotion is matched with an appropriate strategy, cross-referenced to the area of government, departments and agencies that are to be held responsible and accountable for implementation, including timelines, continuous monitoring, evaluation, reporting requirements and specific accountabilities. Alternatively, that an accountable operational plan be written to ensure these ends are achieved.

Recommendation 10: that the Indicators of change in drinking behaviours as they relate to school children be reviewed and amended to include more sensitive indicators of risk and therefore concern, including the proportion consuming any alcohol in the last seven days by way of example.

Recommendation 11: that the National Alcohol Strategy (2018 – 2026) be amended to include a commitment to an independent review of the international literature on the effectiveness of various approaches for tightly regulating alcohol promotion, with a view to developing a legislative framework and plan for phasing out all alcohol advertising, promotion and sponsorship.

Recommendation 12: that the National Alcohol Strategy (2018 – 2026) name up a commitment to legislate at an early stage of the life of this strategy so that it becomes unlawful for the alcohol industry to in any way advertise and promote the uptake of drinking, drinking of specific brands and products and increase drinking among female adolescents and women of child bearing age, as a prelude to more comprehensive bans of alcohol advertising and promotion, with monetary penalties that match the seriousness of any breaches.

Recommendation 13: that the National Alcohol Strategy (2018 – 2026) include a commitment to the regulation of alcohol industry political lobbying and political donations with a view to ultimately eliminating these commercial strategies for influencing alcohol policy in Australia.

Recommendation 14: that the National Alcohol Strategy (2018 – 2026) firmly commits Australian National, State and Territory and Local) governments to a review of the contexts, decision making structures, processes and manner in which elected representatives and political parties draw upon relevant high level evidence and expertise to arrive at and commit to policies and strategies that will reduce dysfunctional, hazardous and harmful drinking (as defined by the WHO, 1981) in the Australian community, with all the positive health, social and economic benefits this will bring.

Recommendation 15: That the National Alcohol Strategy (2018 – 2026) commits the Australian, State and Territory governments to substantial increased investments in treatment and a drug and alcohol related sector workforce strategy, utilising the Drug and Alcohol Services Planning (DASP) tool as one among a range of tools, decision making frameworks and methods to assess and address unmet need for treatment.

Recommendation 16: that the National Alcohol Strategy (2018 – 2026) commits the Australian government to an adequately designed, multifaceted and well-funded social marketing campaign and other strategies to ensure the Australian public is made aware of the new NHMRC low risk drinking advisories when released alongside clear explanation of the evidence and reasons for supporting and promoting these new benchmarks, aimed at reducing dysfunctional, hazardous and harmful drinking.

Recommendation 17: that the National Alcohol Strategy (2018 – 26) commits the Australian, State and Territory governments to a balanced mix of targeted and universal prevention strategies with particular attention to the WHO best buy policy reforms, regardless of inevitable industry push back and attempts at manipulating governments to abandon these approaches in their submissions to this national consultation.

Recommendation 18: that the National Alcohol Strategy (2018 – 26) commits the States and Territories to implementing a minimum unit price that is anchored to evidence demonstrating the level per standard drink required to reduce hazardous drinking.

Recommendation 19: that the National Alcohol Strategy (2018 – 26) is not amended in any way that yields to inevitable pressures from the alcohol industry to reinstate commentary about the responsibility of citizens to make healthy choices in terms of alcohol consumption and that the strategy extends its commitment from ensuring that governments and local communities provide a policy environment that 'supports low risk drinking choices and discourages risky drinking', to one that actively addresses industry attempts to block or work around those policy reforms and sought after outcomes.

Recommendation 20: That clear processes be established for monitoring and publicly reporting on progress in the implementation of this national alcohol strategy, aligned to Commonwealth, State and Territory targets and accountabilities, with mechanisms for addressing any perceived or real barriers to progress against the strategy.

Recommendation 21: that the National Alcohol Strategy (2018 – 26) sets a more ambitious target of 30% in the reduction of harmful drinking, by 2026, while adding that a range of more nuanced targets that include reductions in dysfunctional, hazardous and unsanctioned drinking also demand our careful consideration.

Recommendation 22: that the National Alcohol Strategy (2018 – 26) be amended to identify the specific alcohol policy reforms and actions that the Australian, State and Territory governments intend to take with a view to reducing current levels and preventing future dysfunctional, hazardous and harmful drinking in Australia, based on revised methods of engaging governments in policy review, planning and reform.

Recommendation 23: that the Commonwealth Government emulate the structure and processes adopted for the successful Nationally Coordinated Codeine Implementation Working Group (NCCIWG) in bringing together all of the States and Territories, those with relevant expertise and other key stakeholders, to facilitate the planning for and effective and timely implementation of the NAS (2018-26). It would I assume be most appropriately led by the Drug Strategy Branch, Population Health and Sport Division, (Commonwealth) Department of Health.

Recommendation 24: that the National Alcohol Strategy (2018 – 26) be amended so that it signals a clear commitment by the Australian, State and Territory governments to act upon the evidence, rather than framed as a 'menu of options for consideration'.

Recommendation 25: that the final version of the National Alcohol Strategy (2018–26) focusses first and foremost on implementing the WHO 'best buys' and other priorities identified in this submission and only then consider new and 'innovative' policies and strategies to reduce dysfunctional, hazardous, harmful and unsanctioned drinking in Australia.

Recommendation 26: that the National Alcohol Strategy (2018 – 26) commit to research to understand whether and the extent to which current levels and patterns of drinking are diminishing our national cognitive and other high level brain functions at the population level, and how this is impacting on all manner of decision making in governments, in industry and in Australian society more generally, with a view to communicating to the people of Australia why the WHO best buys are so important is we are to address this particular alcohol-related harm, one that has hitherto gone largely unrecognised and unaddressed.

Recommendation 27: that the National Alcohol Strategy (2018 – 26) commit the Australian, State and Territory governments to a far reaching and independent review of Australia's alcohol taxation framework and to implementing recommendations arising from this review, notably, the adoption of a volumetric tax and a floor price on all alcohol products.

Recommendation 28: that the National Alcohol Strategy (2018 – 26) be strengthened to include a commitment to reviewing benchmarks for the composition, structures, processes and objectives of liquor licensing bodies across the nation, so they are genuinely expert in the area of 'alcohol control', so they incorporate relevant external bodies including local government and experts in Public and Population health and in Addiction Medicine, and are given the legislative framework and authority and administrative and political support to make decisions that align with the evidence on what works in minimising current levels and future dysfunctional, hazardous, harmful and unsanctioned drinking in Australia, particularly as this relates to accessibility of alcohol.

Recommendation 29: that the National Alcohol Strategy (2018 – 26) be strengthened to the include a plan to undertake detailed research and analysis of current deficits in data collections and the associated technical and other errors including methods of approach with a view to established refined methods for collecting more detailed data reflecting the wide ranging medical and other conditions associated either directly or indirectly with harmful drinking, so a comprehensive measure of health and other harms can be adduced and communicated to the people of Australia and to governments, monitored and more appropriately responded to in public policy reform and intervention.

Recommendation 30: that the National Alcohol Strategy (2018 – 26) include a commitment to monitor and evaluate the effectiveness of the NAS (2018 - 26) in achieving specific impacts and outcomes and also, the effectiveness of current governance structure and processes in identifying and managing the broad array of strategic, policy and other actions identified as important and necessary in addressing our national alcohol (and other drug) problems.

Recommendation 31: that a genuinely expert committee be established to develop a detailed implementation plan in broad consultation with key health and human service stakeholders; that it be given appropriate authority to closely monitor and evaluate implementation of the NAS (2018-26) against set outcome targets and accountabilities; and report through appropriate channels on a 6 month basis to facilitate and ensure effective implementation of the plan across its 8 year lifetime.

Recommendation 32: that the National Alcohol Strategy (2018–26) signal an intention to strengthen the technical capability of the Drug Strategy Branch by establishing a senior position of Medical Adviser, Alcohol, Tobacco and Other Drugs (or similar), with a requirement that that position holds a Fellowship in Addiction Medicine and/ or in Public Health and extensive expertise and experience working in the drug and alcohol field.

Recommendation 33: that the National Alcohol Strategy (2018–26) signal a commitment to broaden the framework for addressing the upstream macro-environmental (economic, cultural, social, commercial and physical) and structural determinants of dysfunctional, hazardous, harmful and unsanctioned alcohol (and other drug) use beyond the current conceptually limited, limiting and now dated supply/ demand/ harm reduction framework.

Regulation 'Red Tape' Advocacy by Commercial Interests

How often do we read erroneous statements, attributing alcohol consumption in Australia to cultural and social factors but omitting the important contribution made to this 'culture' by the policy environment, mainstream media, social media, entertainment industry (especially the television and movie industry) and most importantly by the alcohol industry itself in shaping the social narrative, beliefs and drinking behaviours of the Australian people. The evidence is very clear that governments cannot rely on corporate industry to self-regulate and do the right thing nor on the health literacy of citizens in isolation of supportive policy environments, to behave in accordance with what we know about 'healthy lifestyles'. The evidence-informed regulatory approaches adopted in effective tobacco control provide a sound basis for alcohol control and what works.

It is relevant to note that at the Intergovernmental Committee of Drugs **(IGCD) hosted meeting** held in Canberra in December 2014, alcohol industry representatives quite brazenly stated that:

"We have been talking about price increases through taxation, access controls and controls on advertising and promotion for the last 20 years. Why don't we try something new … to address alcohol-related harm that is the problem of a small minority of Australians."

…or similar. Of course, industry would say that.

Content experts in the room at that IGCD meeting mentioned above, naturally reacted quite strongly to the thinly veiled attempt by the alcohol industry to influence government to move away from the evidence and consider only those strategies that protect the alcohol industry's future bottom line. Concerns were voiced about the way this was handled. Several expert panel members expressed their strong rejection of this industry message.

So, while it is a mother's milk observation that '**innovation'** is always to be welcomed, I do not support the idea of 'innovation' unless the final NAS (2018-26) states very clearly that such new ideas will only be considered in addition to a commitment by governments to implement what the evidence shows (and has shown for nearly 50 years), works best in reducing alcohol consumption and alcohol related harm. Any suggestion by any entity with a commercial or other vested interest that we should move away from time-honoured evidence for which the evidence has only consolidated over the past five decades, must be ignored. I speak in particular about taxation as a means of impacting on the affordability of alcohol and associated minimum price to prevent the industry from undermining taxation policy (though it is industry that may initially benefit financially from a minimum price not government), advertising, product placement, sponsorship and other forms of marketing to promote alcohol consumption, and the availability and accessibility of alcohol.

Note by way of example, the following observations in the literature in relation to these matters:

All three reviews (Booth et al., 2008; Elder et al., 2010; Wagenaar et al., 2010) conclude that there is clear and consistent evidence that increasing alcohol price or taxation reduces overall consumption and related harm. Wagenaar et al. (2010) calculated a Cohen's d (standard mean difference) of −0.70 for alcohol morbidity and mortality, consistent with a large effect size, and d = −0.22 for traffic crash outcomes, a medium effect size. Other outcomes showing smaller but significant inverse associations with alcohol taxation included crime, violence and sexually-transmitted disease rates (Martineau et al, 2013).

Jackson et al (2010) reported similar results, with studies indicating that a 10% increase in alcohol prices would lead to a 3–10% decrease in societal alcohol consumption (Martineau et al, 2013).

Evidence supports reducing the affordability of alcohol as the single strongest intervention to have been evaluated for the reduction of population levels of alcohol related harm …. They concluded that a 10% increase in price led to an average 4.4% reduction in total population consumption (Gilmour et al, 2016).

Reviews and meta-analyses report that an increase in alcohol price is consistently associated with a decrease in its consumption, with a 10% price increase associated with a 5% decrease in consumption, on average [price elasticity] (Burton et al, 2017).

While these policies vary in their effectiveness and cost-effectiveness, evidence supports those that reduce the affordability of alcohol as the most effective and cost-effective approach to prevention and health improvement. Increases in taxation, for example, increase government revenue and deliver substantial health and social returns (various references in Burton et al, 2017).

Moderate drinkers may be more sensitive to price changes than heavy drinkers; however, in absolute terms, the reduction in consumption among heavy drinkers is considerably higher than among moderate drinkers. Within the UK, heavy drinkers are more price sensitive than moderate drinkers for most products, although they tend to switch to cheaper products when the price of their preferred product increases [cross-price elasticity] (Burton et al, 2017).

Consumers increase their demand for one product following a rise in the price of the other. A tax increase can lead to significant improvements in health. A meta-analysis reported that doubling tax rates decreases alcohol-related mortality by an average of 35%, with further reductions in violence, crime, road fatalities, and sexually transmitted infections (Burton et al, 2017).

A potential concern regarding tax increases is that they may have a greater financial impact on less affluent people who tend to spend a larger proportion of their income on alcohol. However, on average, less affluent households consume less alcohol than high-income consumers and are more likely to be abstainers. As such, they are less likely to be financially impacted by changes in taxation.

Analyses suggest that an increase in alcohol taxation is progressive when considering all households, but regressive when considering only those who consume alcohol. However, to the extent that less affluent groups are more likely to suffer the harms associated with alcohol consumption, increasing the price of alcohol through tax has the potential to

reduce health inequalities, however strategic behaviour of manufacturers and retailers may moderate the effect (Burton et al, 2017).

Dozens of studies, including a growing number in developing countries, have demonstrated that increased alcohol prices reduce the level of alcohol consumption. The evidence suggests that the effects of pricing apply to all groups of drinkers, including young people and heavy or problem drinkers, who are often the focus of government attention. (Burton et al, 2017).

Despite its apparent effectiveness, taxation as a method of reducing harm from drinking appears to have been under-used. In recent decades, the real price of alcoholic beverages has decreased in many countries, at a time when other alcohol control measures have been liberalized or abandoned completely (Burton et al, 2017).

However, in contrast to education and persuasion strategies, across-the-board alcohol pricing and tax increases are among the most unpopular policy options with the general public and are more unpopular in heavier drinking populations (Gilmour et al, 2016).

While many respondents can correctly identify liver disease as a potential harm caused by alcohol, fewer are able to freely recall other harms such as cancer …People who are aware that alcohol is a risk factor for cancer are more likely to support alcohol control policies, including increases in taxation and strict marketing regulations, consumers have a right to understand the risks associated with alcohol consumption, and policies in this area reflect this right…Particularly for the links between alcohol consumption and cancer. Industry-sponsored messages and campaigns are reported to be ineffective (Burton et al, 2017).

Alcohol education programmes in schools and higher education settings are a popular intervention, but their effectiveness is poorly supported by the evidence, so are not cost-effective (Burton et al, 2017).

Education and persuasion strategies are among the most popular approaches to the prevention of alcohol-related problems. Some school-based alcohol education programmes have been found to increase knowledge and change attitudes toward alcohol, but drinking behaviour often remains unaffected… Scientific evaluations of these programmes have produced mixed results, with generally modest effects that are short-lived unless accompanied by booster sessions.

Some programmes include both individual-level education and family- or community-level interventions. Evaluations suggest that even these comprehensive programmes may not be sufficient to delay the initiation of drinking, or to sustain a small reduction in drinking beyond the operation of the programme (Babor et al, 2010).

I will now make a series of observations and comment on alcohol industry commercial behaviours that I present provide reason for serious concern.

Alcohol industry Exploitation of People & Governments

The challenge for industry as it sees it is to exploit markets, especially in countries with low and middle incomes, and to increase profits (Beaglehole and Bonita, 2009). As so many point out, it is

evident that the alcohol industry will continue to affect policy by encouraging ineffective policies and so the potential for increased harm from alcohol will remain high, facilitated by the common predatory commercial practices of the alcohol industry encouraging excessive and routinely unsafe consumption (outside NHMRC, 2009). It is salient to note that young people bear a disproportionate proportion of this burden, with high associated rates of morbidity and mortality arising from commonly drinking to deep intoxication.

Considering the strong link between purchasing power, per-capita consumption and aggressive marketing by the alcohol industry (Beaglehole and Bonita, 2009), current consumption levels and patterns and associated harm are likely to be maintained and even increase, in the future. That is, unless those who are the victims and health and human service professionals who witness or whose daily work involves managing the health, social and other harms associated with drinking, demand of governments that they respond in policy reform in more appropriate, evidence based and socially responsible ways.

Industry Making, Offering & Encouraging Very Poor 'Choices'

While the alcohol industry makes the case for its products and services promoting positive social interaction and enjoyment, I observe as a medical practitioner that alcohol is the single most common and important factor causing or contributing to wide ranging and serious anti-social behaviour in Australian society.

Contrary to the apparent beliefs and presentations of the industry, our legal framework does not excuse or ignore serious anti-social behaviour on the basis of some mythical balancing of the 'enjoyment' of some with the serious health and social harms commonly incurred by 'innocent bystanders' and indeed, by the drinker at some time in their lives.

Every day across our nation, all forms of media report on **dysfunctional** (leading to impaired psychological or social functioning), **hazardous** (drinking that will probably lead to harmful consequences), **harmful** (known to have caused tissue damage or mental illness in the particular person), and **unsanctioned** (not approved by a society, or a group within that society) behaviour in association with drinking (WHO, 1981) while the industry continues with its external attribution of blame and denial of any responsibility, declining to acknowledge the causal and contributory relationship of its products and services and stating it is the drinkers fault and not uncommonly, due to other substance use ('drugs'). In drug related deaths where there are multiple substances found at post mortem, equal weighting may be given to each substance present where differential weightings cannot be applied and where it is known that at above certain blood levels, the drugs that are present (including alcohol) cause impairment – including psychomotor impairment and synergistic drug induced ventilatory impairment and respiratory arrest, by way of example.

Emergency Department physicians are understandably unimpressed by common industry claims that individuals who come into the care of Emergency Departments are there because of 'other drugs' and not alcohol, as am I, having spent a great deal of time in the past providing consultation services to hospital Emergency Departments as an Addiction Medicine specialist.

In alignment with the clear guidance provided by the WHO, it is my presentation that industry should not be accorded legal or social license to freely, actively and knowingly adopt commercial practices designed to

persuade or seduce citizens to make highly unhealthy, unsafe and ultimately health harming and life shortening decisions.

Nor should Australian society or its governments accept or allow nonsensical *'social benefit'* or *'convenience in a modern society'* arguments in support of its present commercial practices, which would not be allowable in any other legal defence of serious individual citizen or industry induced harm. In any case, any honest and erudite analysis of net social benefit versus health and social harm associated with alcohol would always be highly unfavourable. Beneficence and non-maleficence-for-all ought to guide public policy that regulates any unhealthy commodity industry where that industry demonstrates it is unable to self-regulate in the interests of the public health and public safety.

Understanding 'Nanny State' Pushback

Whenever there is a discussion on regulating industry, it is common to hear some individuals in the community complaining about the 'nanny state' as it suits their own personal values, beliefs, wants and needs and yet, I imagine these very same people would be quick to assert the responsibility of government and others to protect or at least not harm them or their family in other circumstances, once again as it suits their vested interests and personal or family needs.

'No man is an island entire of itself' (Donne, 1624)

We should as a nation aspire to develop as a kind, caring, thoughtful, and intelligent civil society that behaves in pro-social ways. In such a society, citizens would not selectively cherry pick which civil protections are supported by governments - and demand others not be protected as suits their own lifestyles and personal ideology, wants and interests. They should not engage in ad hominem attacks on content experts who seek to protect the entire population based on best evidence in their advice, teaching and communications. Where they do so, Australian society should be quick to place the public spotlight on such individuals and call them to account.

It is lamentable that we so commonly witness such industry behaviour. It is lamentable that health professionals are sometimes criticised by those representing industry, for speaking up in the best interests of public health and safety. It reveals the character of those who do so.

We have constructed civil society with governance structures and processes that include the 'rule of law' that is underpinned by **public policies, laws and regulations** to guide or direct, allow and enable or restrict or prohibit a vast array of products, services and human behaviours, based on a common understanding and commitment to ways of behaving for the mutual benefit, mutual protection, human development and maximisation of flourishing of all citizens. By way of example, we regulate for building standards, disease control, toy standards, clean air, safe water, safe food, safe roads, drug scheduling for the quality use of medicines, minimum legal drinking age, swimming pool skimmer box safety, fire safety, building regulations, asbestos building control, air bags in cars, bans on public spitting, urination, defecation, the list goes on.

I present that commercial industry should be held to the same standards as individuals in Australian society and should never wittingly do harm to citizens, whether by commission or omission. I present that the same legal

accountabilities should kick into play when industry products and services disempower citizens in their 'health behaviours' and when they are causally associated with serious harm. Demonstrably, that is so often not the case at present.

To paraphrase a colleague (Professor Rob Moodie, APSAD conference, 2011), those who would complain about industry regulation and the 'nanny state' ought to consider which nanny they would prefer – the *'fairy godmother'* or the *'wicked witch'* – a health professional's best advice to their patient and to government in the interests of patient or population health or the advice of an uncaring, self-interested industry that is motivated by the need to maximise profit margins?

Alcohol Industry Healthy Policy Blocking

The alcohol industry has hitherto effectively 'vetoed' and scuttled healthy public policy reform and governments of all persuasions have in effect, allowed this to occur. So too has the community and those who are potentially good leaders but who remain silent. Of course, big industry plays the game of **good corporate citizen** and is only too ready to fund and promote ineffective strategies such as education and interventions targeting only those with established problems (e.g. drinking, gambling) and …

…to promote the idea that the individual has primary responsibility for making the healthy choices, even young people whose brains are far from fully developed, who have limited life experience to draw upon, who generally have poor health literacy and health policy literacy, who are vulnerable to peer and industry influence, who are exposed to potential harm by child-adult power imbalances, and who are attracted by risk.

I will make further comment on these matters in relation to secondary supply.

Of course, once socialised into regular drinking or even when alcohol dependence is established, true choice is axiomatically further constrained or removed.

Understanding this evidence base is critical given the propensity for alcohol industry bodies to cite a weak evidence base when challenging policy implementation (Babor and Robaina, 2012).

I will now turn my attention to the draft NAS (2018-26) more specifically.

Comment of Strategic-ness of this Consultation Draft Strategy

Q. Is this a genuine 'National Drug Strategy', one that is likely to achieve significant advances in the very important goal of preventing and reducing alcohol-related harm in Australia?

My first and overarching comment on the Consultation Draft National Alcohol Strategy (2017 – 2026) is that that it is not a true strategy and in its current form, cannot be properly called a 'strategy'. This document provides insufficient direction to what Australia specifically intends to do

to address its serious and wide-ranging alcohol problems. There is no stated commitment to anything in particular. This echoes the history of alcohol policy in our nation for over 50 years, noting that 41 years ago, a 1977 Report by a Senate Standing Committee that was chaired by **Senator Peter Baume** (*"Drug Problems in Australia - an intoxicated society"*) made a raft of recommendations that were based on sound evidence (e.g. from WHO Reports). However, the key recommendations related to pricing, product access and advertising and promotion were never acted upon, even in the context of three further national alcohol strategies spanning 1989 to 2009. The key (most effective based on evidence) recommendations of that historically important report are yet to see the light of day notwithstanding the reality that those recommendations and the supporting evidence has stood the test of time and have been further strengthened. I say this is to our national embarrassment and shame.

> ***"Because alcohol is no ordinary commodity, the public has a right to expect a more enlightened approach to alcohol policy"***
>
> - *Babor et al, 2010*

The current iteration of the draft NAS (2018-26) is substantially improved on a previous draft which I read late last year, and which failed to heed the international evidence on what works and what does not work in preventing and addressing alcohol-related harm. The current version does mention key strategies that would make a difference if implemented. However, the current draft remains less than exemplary in its non-commitment to action and in the absence of named up accountabilities and timelines. It is for this reason that I am taking a different approach in my feedback to the approach that I and my colleagues might previously have adopted.

The public health, public safety and indeed, well-being of the people of Australia are so adversely affected by alcohol that I feel compelled to speak as an individual in the most honest and forthright manner possible, so there can be no doubt about what an experienced doctor practising in the area of Addiction Medicine and who alongside his colleagues, sees and attempts to pick up the pieces every day of his working life, identifies as being necessary to address our nation's serious alcohol problems, meaningfully and effectively.

A common dictionary definition of *strategy* is "a plan of action designed to achieve a long-term or overall aim".

The overall aim ought to be: ***"to reduce dysfunctional, hazardous, harmful and unsanctioned drinking in order to prevent and minimise alcohol-related harm among the Australian population",*** *or similar.*

I reference the WHO definitions of dysfunctional, hazardous, harmful and unsanctioned use as a suitable source for this terminology

- WHO, 1981

A subtext to this aim might be ***"to implement alcohol control policies, regulations, programs and activities aimed at maximising an equitable distribution of health and equitable distribution of 'flourishing' across Australian society, in so far as alcohol harms health, in so far as alcohol problems impede equitable distribution of health and in so far as health is necessary for an individual to flourish as a human being"***

- *Extending the thinking of Culyer and Wagstaff, 1993*

Traditionally, strategies identify a range of component policies and actions that together, are considered likely to facilitate achievement of the desired outcome(s). In addition, strategic planning requires the identification of specific accountabilities and timelines for completion of each task as well as collaboration, logical sequencing, integration and coordination. The question arises – who will do what specifically, in partnership or consultation with what other persons and bodies, how, by when and to whom will they be accountable to for completion and through what particular governance process? And will the plan of action be carefully costed and fully funded, as opposed to a quantum of money being allocated with no attention to the detail of what is actually required. This is a common government funding practice, one that would not be acceptable in any capital works project (a half-built bridge cannot carry anything) so we must ask the question, why is it acceptable when investing in human capital?

As it stands, this Consultation Draft NAS (2018-26) gives each jurisdiction 'licence' to do what they will (or nothing much at all) in their own time according to their own political leanings, priorities and resources with no commitment to invest in policy reform or resources, expertise and time required to ensure a meaningful, coordinated, integrated and committed response.

We have seen this all too commonly, for example, following the completion of the *National Pharmaceutical Drugs Misuse Framework for Action (2012).* This does not augur well for delivering on an integrated, coordinated and effective national alcohol strategy, which is essential if such a national document is to have teeth and have the intended effect. Too often do we witness one or more of the States or Territories doing their own thing, not uncommonly against the direction supported by good evidence.

Anything that provides a 'get out of gaol' card for governments more committed to supporting the unhealthy commodity industries including the alcohol industry - perhaps because they believe or assert it creates jobs that cannot otherwise be created or because they believe in 'market freedom' without nuance - than acting upstream in the causal chain of prevention, is lamentable and must change…

*… if we are to avoid entering yet another National Alcohol Strategy **Groundhog Day**.*

The draft NAS (2018-26) has attracted significant discussion among colleagues working in the drug and alcohol field and in the field of public health more generally and there is agreement that this document does NOT provide adequate direction. Indeed, concerns are commonly expressed that the document lacks detail and the language reads like a menu of options for further consideration with no commitment to action by anyone in particular including most importantly, the three levels of government in Australia.

The language used is often vague, weak and indecisive rather than action oriented with the use of words such as 'regulate', 'legislate', 'require' and 'mandate' and as such, once again fails the test of providing clear and committed strategic direction.

In this, the document repeats the errors of the past 50 years of key, 'best buy' policy inaction in Australia.

It is of grave concern to note that the Consultation Draft NAS (2018-26) mentions legislation only twice, once in relation to improving awareness of secondary supply laws (p.18) and once 'to achieve legislative and broader policy consistency where possible' (p.24). In this, the Consultation Draft NAS (2018-26) fails fatally.

<u>Recommendation 1:</u> that the National Alcohol Strategy (2018 – 2026) provide clear and strong statements about what evidence based policy reforms and actions the various levels of government in Australia will commit to over a specific timeframe with inbuilt mechanisms for monitoring and evaluating progress against specific targets and identified accountabilities, to be reviewed on an annual basis through national governance mechanisms and communicated in a transparent manner to the people of Australia. Alternatively, that governments commit to an operational plan that translates this strategy into specific and accountable actions.

Comment on the Structure & Thrust of this Consultation Draft NAS

The next observation I make is to question the **duration** of this proposed NAS (2018-26). It would have been close to ten years originally but now we are down to eight years, which means the strategy will span at least three Federal, State and Territory governments. Unless there is clear multi-partisan support and commitment from the outset, and we have never achieved that as a nation in relation to public policy in regulating the unhealthy commodity industries in Australia, the risks in this are obvious. The NAS (2018-26) could easily sit and gather dust like so many other national strategies and plans with or without perfunctory reporting but no meaningful outcomes. The Consultation Draft NAS (2018-26) does speak of coordination and integration and makes claims that are difficult to demonstrate, including comment on how well we have performed as a nation in this regard, but it says nothing about transparency and accountability. One can readily imagine elected representatives saying something like, '*economic times are too difficult to consider these options right now and we will leave it to the next government*' (see Recommendations 28-30).

Those comments would be rendered less plausible when the public sees elected representatives enthusiastically engaging in **photo opportunities** with representatives and advocates for the unhealthy commodity industries (e.g. alcohol, tobacco, gambling and ultra-processed food) and supporting their **specious** arguments about not restricting or removing people's 'free choices', seeing the 'big picture' and looking after the jobs and the families of members of those industries. I will deal with these false and misleading arguments elsewhere in this submission.

Rarely if ever do elected representatives appear in the media with and send a clear message of supporting public health experts and their messages aimed at improving the health, safety and well-being of the Australian people, as well as the economic bottom line.

Under the **Purpose of a National Alcohol Strategy**, **page 4**, there is indeed a get out of gaol sentence of a different nature, which states that '*the aims of the national alcohol strategy cannot be achieved by governments alone'.* While there may be some truth in this statement, the evidence shows that it is *public regulation and market intervention* that work in preventing unhealthy commodity driven health and social problems in the community. This means that essentially, government must accept primary responsibility for leading actions to prevent and address these health and social harms, not citizens acting in isolation.

As alluded to above, there is claim on **page 4** that 'a key strength of the Australian approach to reducing alcohol-related harm has been its **strong and enduring partnerships'**. What exactly is meant by this, the reader may well ask? Certainly, Police and Health officials did work quite well together though the previous IGCD and MCDS and perhaps they do so now through the Ministerial Drug and Alcohol Forum (MDAF) and related processes but what have the outputs and outcomes been when compared to the evidence on what works best in addressing alcohol-related harm? In the absence of evidence-based public regulation and market intervention, partnerships are in any case meaningless and ineffective.

*Apart from important drink **driving measures** and some less potent policy adjustments, nothing of substance has been achieved in alcohol control over the past 40 years.*

I will comment further on this critical consideration later in this submission.

By 'partnerships' do we mean funding Non-Government Organisations (NGOs) to do certain things that aren't necessarily evidence-based or likely to make a difference? That is certainly also our history to some extent. The ***National Binge Drinking Strategy*** in 2011 was an example of a wasted opportunity to intervene effectively. So too was the ***alcopops tax*** (Chikritzhs, et al, 2009) which while effective in reducing overall consumption in the short term, in isolation and over time, made little sense and provided further evidence of the need for volumetric tax applied to all alcohol products and buttressed by a policy on a minimum unit price.

Under **priority 3 on page 21**, there is again reference to:

*"**Strengthen partnerships** and communication between services to support early identification of problems and ensure treatment and ongoing care, including between:*

- alcohol treatment, child protection and family violence services; and detoxification and rehabilitation and aftercare services."

One assumes from this statement that these partnerships are **currently weak** as is communication between services and of course that is often true.

On **page 5**, there is mention that:

*"the alcohol manufacturing **industry**, wider retail and hospitality industries, advertising, broadcasting and sporting industries play a **significant role** in Australia's economy and social fabric. These industries also have a **responsibility** in supporting and taking appropriate action to prevent and minimise alcohol-related harms through the lawful, responsible supply of alcohol and their ability to influence drinking behaviours."*

While the latter part of this paragraph has salience and is supported ('if only'), it is important to recognise that the **alcohol industry** makes a substantial contribution to losses in educational and employment prospects and employment. I am operationally **defining** the alcohol industry as comprising those engaging in the production, supply and sale of alcohol, from the farm through to the supermarket and other on or off-licence liquor outlets, as well as those profiting from advertising and promotion of alcohol products and services including the print and broadcasting media and public personalities.

Alcohol dependence is axiomatically accompanied by reduced life choices, reduced life opportunities, reduced life chances and increased disparities in health, social and economic well-being.

The alcohol industry never makes mention of this but surprisingly, neither do we hear other interested parties including our elected representatives acknowledging this reality.

A reduction in consumption and sales and a reduction in 'dysfunctional, risky or hazardous drinking' (i.e. more than a reduction in 'harmful drinking') among vulnerable sub-populations and in high risk social contexts will force the industry to reconsider its **business models**, as it must. There are always new, pro-social and better ways of succeeding in business.

A reduction in dysfunctional, hazardous and harmful drinking will create new opportunities for new products and services that are more healthful or at least not dangerous and new job opportunities. Reduced expenditures on excessive alcohol consumption will not disappear into thin air, rather, this money will become available for alternative expenditures, which the 'free market' can compete for.

*We should **stop stating** in national documents like this one that the alcohol **industry contributes positively** to Australian society because in the net, it clearly does not.*

Even in cold hard economic terms, the costs associated with alcohol, estimated at between $15B and $36B per annum (Collins and Lapsley, 2008; Laslett et al, 2010), are far in excess of taxation receipts that are estimated to be about $6.5B per annum according to the Parliament of Australia, Parliamentary Budget office, Alcohol taxation in Australia, Report no. 03/2015.

In any case, the harms caused by alcohol cannot in any way be ignored, excused or downgraded by the pleasure reported by drinkers or by the profits earned by industry. That is not how legal or social justice works.

Even if the population level 'benefit/ harm calculus was not a net negative (it clearly is), alcohol related harm and loss of life enjoyment and flourishing cannot be traded off against perceived or actual benefits including 'enjoyment of the taste' or enjoyment of being alcohol 'affected' or intoxicated, for positive or negative utilitarian purposes or commercial profit.

If anyone should wish to **deny or challenge** this analysis of net tragic though substantially preventable harm rather than net benefit to the health and very fabric of Australian life, I suggest they spend a week in each of the following health and human services, just to name a few examples:

- *General practice*
- *Hospital EDs*
- *Intensive care units*
- *Neurology Units*
- *Coronary care Units*
- *Acute pain services*
- *Chronic non-cancer pain services*
- *Plastic surgery*
- *General surgery*
- *Vascular surgery*
- *Neurosurgical wards*
- *Trauma surgery units*
- *Orthopaedic wards*
- *Hospital outpatients*
- *ATODS*
- *Relationships Australia*
- *Centrelink*
- *Child & Family*
- *Youth Justice*
- *Child Protection*
- *Youth Justice*
- *Juvenile prisons*
- *Adult prisons*

- *Palliative care wards*
- *Oncology services*
- *Mental health services*
- *Obstetrics*
- *Churches*

I also suggest they speak with:

- *Addiction Medicine specialists*
- *Emergency physicians*
- *Psychiatrists*
- *Public health physicians*
- *Pain medicine physicians*
- *Cardiologists*
- *Gastroenterologists*
- *Pathologists … AND…*
- *Nurses*
- *Paramedics*
- *Hospital clergy*
- *Ambulance officers*
- *Psychologists*
- *Social workers*
- *Occupational therapists*
- *Coroners*
- *Medical examiners*
- *Staff in hospital morgues*
- *Families of patients suffering or dying from one or more of the 200+ ICD-10 coded alcohol-related medical conditions*
- *Community Clergy who counsel and console those affected and their loved ones*
- *Staff in clubs and pubs who deal with the irrational, unsafe and dangerous behaviours*
- *Uniformed prison officers*
- *Prison inmates imprisoned as a consequence of alcohol-related violence or other anti-social behaviour*
- *Police officers*
- *Security guards*

Sadly, they will all say the same or similar things to me in relating their routine professional and personal experiences observing and responding to the harms arising from drinking.

Recommendation 2: that any mention of alcohol and the alcohol industry contributing in a positive way to Australian society be removed from the final NAS (2018-26), including any comment about balancing benefits and harms given the reality that perceived or actual personal or commercial benefits cannot and should never be seen or said to excuse, mitigate or expunge the harms.

Hospital Alcohol Data is Low Quality, Unreliable & Misleading

Hospital and other health expenditure arising from alcohol and other substance use and related health harms in Australia is under-identified by large quantum, as are our national and local health and social policy and health system responses.

To provide but one example of the impact and to demonstrate the need for much better data to inform policy and planning, based on current data, it is estimated that there are **430 admissions** to **1,322 public and private Australian hospitals** each day because of alcohol consumption (FARE, Alcohol-Burden-of-disease Report, 2014). To some this will seem a lot while to others, it will seem like a small price (for 'others, not me') to pay for the pleasure they report that drinking brings them.

This estimate suggests one patient is admitted to every Australian hospital every three days. This is of course a highly implausible low estimate, standing at stark odds with a range of studies suggesting that 20% or more of patients admitted to Australian hospitals have an alcohol-related health problem which has caused or contributed to the hospital admission and requires skilful clinical intervention (Foy and Kay, 1995; Ling and Chikritzhs, 2011; Bonomo et al, 2017). In a survey

of 180 emergency department across the nation, Chikritzhs and colleagues (2011) reported that 28% of all injury presentations are alcohol-related. A 'snap shot' survey on at 2.00 am Saturday 14th December 2013 of emergency departments in 106 Australian and New Zealand hospitals revealed one in seven presentations were alcohol-related, while in some EDs, more than one third of presentations were alcohol-related. (Egerton-Warburton et al., 2014).

So, in truth, the real number of alcohol-related presentations to Australian hospitals is likely to be more than an order of magnitude higher. Saunders (2015) estimates that thirty to forty percent of patients in a public hospital are using alcohol at hazardous and harmful levels. Add tobacco, illicit and prescription drug related problems to this estimate and we can readily see the significance of the substance use-induced and substance-related hospital and broader health burden and its impact on healthcare resources and other expenditures in Australia.

This highlights the reality that the doctors working in Australian hospitals have not been adequately trained and prepared to assess and manage substance use problems (though we are improving on this now in some jurisdictions including Tasmania), are extraordinarily busy in the hospital environment, and are not reliably case finding or writing down adequate clinical case notes to allow hospital coders to reliably record presentations related even to the most common alcohol-related diseases and illnesses yet alone the **200+ ICD-10 alcohol harm related codes**. My many discussions with hospital coders confirm this assessment.

Indeed, hospital coders identify that there are often little or no alcohol-related (or smoking) clinical comment made in hospital file clinical notation, clinical linkage and therefore in ICD-10 coding.

Common examples where there is poor alcohol-related **case finding**, clinical notation and coding include:

- Cardiac failure
- Foetal alcohol spectrum disorder
- Wernicke-Korsakoff syndrome
- Cancer - very few among a range of cancers (e.g. nil with breast cancer at the RHH) known to be causally associated with drinking are noted and linked in clinical documentation (this is of considerable concern given that cancer is responsible for an estimated 36% (2,106) of alcohol-related deaths in Australia each year) (Lensvelt et al, 2018)
- Mental health problems, including depression linked to drinking
- Anxiety
- Aggression and violence secondary to alcohol or other substance use leading to harm to others is also unreliably identified in clinical notation, as is linkage and ICD 10 coding
- Drink-driving and related MVAs which are also unreliably coded, though any legal problem is treated the same as falls and if there is notation of alcohol-related intoxication then there may be a diagnostic linkage which allows ICD-10 coding.

I am advised that if alcohol -dependence or intoxication is mentioned in the clinical notes then falls related to intoxication will be coded, reflecting there was a fall related to alcohol intoxication. However, I am also advised coders rarely if ever see clinical notations linking **smoking plus drinking** with cancer, where we know there is a **multiplier effect** in relative risk.

For some cancers, the combined effects of drinking alcohol and smoking tobacco greatly exceed the risk from either factor alone. Smoking and alcohol together have a synergistic

effect on upper gastrointestinal and aerodigestive tract cancer risk. Compared with non-smoking non-drinkers, the approximate relative risks for developing mouth and throat cancers are up to seven times greater for people who smoke tobacco, up to six times greater for those who drink alcohol, but more than 35 times greater for those who are regular heavy users of both substances (consuming more than four alcoholic drinks and smoking 40 or more cigarettes daily). The synergistic effect of alcohol and smoking has been estimated to be responsible for more than 75% of cancers of the upper aerodigestive tract in developed countries (Winstanley et al, 2011).

Even the relationship between smoking and lung cancer is often unclear from the clinical notation and hence the ICD-10 coding may not capture such events reliably. Coders advise they can often link lung cancer with smoking status, but of course smoking status is not reliably recorded as the data shows. There is no reliable clinical notation leading to coding demonstrating the extent of **family** and **social disruption** and other social problems related to alcohol and other drug use, though we do have national estimates (e.g. Laslett et al, 2010). By way of example, there is no reliable clinical notation and thus data linking alcohol use with **child-abuse**. We await the release of **ICD-11** which promises to simplify the diagnosis of alcohol and other substance dependence.

Of course, our national estimates are equally dependent on the research methodologies used to derive estimates of alcohol induced (directly attributable to) and drug related (contributory to) morbidity and mortality – methods for developing and applying an alcohol attributable fraction to hospital admissions with a particular ICD-10 code, for example, 47% for the assault ICD code (X85-Y09) (English et al., 1995; Gao et al, 2014). Colleagues with expertise in epidemiology and biostatics advise this is an area that demands our more careful and concerted attention into the future, both in terms of refining methodology and alcohol problems (e.g. domestic violence) area coverage.

As I learned from my own clinical experience when providing consultation-liaison services to a major Tasmanian hospital, ischaemic digits or limbs leading to amputation are also not reliably coded for even when my clinical notes have been very clear about the primary cause of the presentation and admission to hospital (injecting drug use), so the problem appears to extend deeper than just training doctors to reliably case find and document the primary causal or contributory factors for admission. There are broader structural errors in our data collection and coding systems.

Most importantly, no data is going to government that accurately and reliably reflects the true picture of health problems related to substance use and there is no meaningful analysis that allows reliable identification of the contributory or causal relationship.

We can add to this the above considerations, an estimated **5,554 Australians** older than 15 years died from alcohol-attributable disease and injury in 2010 (FARE, 2014), an increase of 62% on the estimate derived from a similar study a decade before. Latest unpublished data indicates an estimated **5,797 Australians** died from alcohol-attributable disease and injury in 2015. Moreover, one third of these deaths were caused by cancer, a relationship that is poorly understood by the Australian public.

Recommendation 3: That the NAS (2018-26) pay careful attention to establishing processes to assess the factors associated with current poor alcohol problems clinical case finding, clinical documentation and ICD-10 coding given the reality that current clinical practices and health systems are leading to substantial under-estimates of the incidence and prevalence of alcohol-

related harms and serving to mislead both the Australian public and those who draw upon this data in public policy decision making and health and human sector planning.

What Inferences are to be drawn from this Information?

If any pharmaceutical were to be found to have anything close to the significance and incidence of serious adverse events associated with the use of alcohol, its availability and context of use in the market place would come under intense scrutiny. It would likely be removed from the market. Why do we treat alcohol differently and not regulate it more tightly? There is no credible answer, apart from the influence of vested commercial interests and the reality that people enjoy using substances that alter their consciousness and the way they think, feel and behave, regardless of associated risk and harm, and argue strongly to have unfettered access to these substances even when this is not in theirs or the community's best health and social interests.

> *The alcohol industry has been very effective in persuading elected representatives that policies aimed at controlling promotion, access and consumption and consequentially contracting the alcohol business component of licensed venues, would 'not be in the industry's best interests and therefore not in Australia's national best interests.'*

The final NAS (2018-26) must be anchored not only in evidence informed targeted approaches but also in population-wide prevention strategies that we know are the '**best policy buys'**, specifically, those related to pricing and taxation, access and availability, and advertising, sponsorship and promotion. It must be consistent with the ***WHO's Global strategy to reduce the harmful use of alcohol (2010)*** and with the ***United Nations Sustainable Development Targets*** to which Australia is signatory and that include targets (3.5.2) related to the "harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol".

Recommendation 4: that the National Alcohol Strategy (2018 – 2026) is adjusted to ensure that it aligns with the WHO's *Global strategy to reduce the harmful use of alcohol (2010)* including specific and strong commitment to implementing the WHO 'best buys.'

UNSDT Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

- **Indicator 3.5.2:** Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol

It is pleasing to see that following feedback, the most recent draft has referenced these two key guiding frameworks for member states, particularly since Australia is not on track to meet the United Nations Sustainable Development Targets nor to implement the key elements of the WHO Global Alcohol Strategy (2010). In fact, it is nowhere close to doing so and as it stands, this draft NAS (2018-26) offers little hope that this situation will change for the better over its lifetime.

Recommendation 5: that the National Alcohol Strategy (2018 – 2026) is adjusted to ensure that it aligns and is consistent in every way with the United Nations Sustainable Development Targets.

Coordination & Integration across Three Levels of Government

There is comment on **page 11** that *"this Strategy provides a guide to inform ongoing development, promotion and coordination of national and locally delivered evidence-based and practice-informed responses to agreed priorities".*

This is indeed a critical challenge for Australian governments if committed to reducing alcohol-related harms. As others have pointed out, **strong political leadership** will be required with effective **coordination and integration** across the Commonwealth, States and Territories and across and relevant departments and agencies. In relation to evidence informed alcohol policy, this is something we have not yet witnessed in Australia, notwithstanding the various governance structures and processes that have been implemented including the Ministerial Council on Drug Strategy (MCDS), the Intergovernmental Committee on Drugs and the Ministerial Drug and Alcohol Forum and now the Ministerial Drug and Alcohol Forum (MDAF).

> *As has also been reiterated by others, a comprehensive package of measures must be implemented that includes both national - and jurisdiction-level* ***evidence-driven strategies****,* ***strong legislation*** *with* ***effective enforcement*** *(which we do not have at present), and adequately funded,* ***hard-hitting public awareness*** *campaigns (FARE, 2018).*

If governments now choose one or several low hanging fruit options in order to appear responsive to the concerns expressed rather than adopt and implement comprehensive policy reform, they can expect no plaudits from clinicians and public health experts.

> *Genuine coordination and integration in the planning for and delivery of a comprehensive package of measures to address alcohol-related harm requires good governance across our Commonwealth of Federal, State and Territory governments, something we do not enjoy to a level required, at present.*

I will return to this matter later in this submission.

Priorities for Action

The Identified four priority actions in the draft strategy, outlined in a diagram on **pages 12** and **13** represent the most important section of this draft strategy. The first point I make here is to recommend that Priority 2 should be re-ordered as priority 1 as this priority is where the best buys are to be found and therefore, most important.

On **page 12** under *Opportunities for Action* there is comment:

> *The Strategy highlights a number of opportunities for action under each of the priority areas of focus. These opportunities are examples of activities or initiatives that* ***could be considered*** *at either local, jurisdictional (state and territory) or national levels, including a mix of broad population approaches and targeted approaches. The Strategy also provides relevant* ***examples*** *of evidence-based and practice–informed approaches*

*outlined in the NAS (2018-26) at Appendix B that **may contribute** to progress against these priorities.*

So, according to this element of the draft NAS (2018-26), governments can **choose to act** on this plan or not at all, just as they have opted not to act on previous national alcohol strategies (for all of their limitations) and a raft of other recent national strategies, for example, the *National Pain Strategy (2010)* and the *National Pharmaceutical Drugs Misuse Framework for Action (2012).*

To put it in the most diplomatic way from a health professional perspective, this is highly puzzling and disappointing, given the extent and seriousness of alcohol-related harms in Australia. It is unacceptable to the medical and other health professionals of Australia as I'm sure it is to those working in the human services sector (including Police) where the harms, suffering and personal risk not only to the individuals concerned but also to others consequential to the use of this drug is so evident in their everyday work.

Once again, in adopting a menu of voluntary options, the Consultation Draft NAS (2018-26) fails fatally.

To drive the point home, I ask the reader of this submission to consider, what has history in Australian health policy revealed when considering similar documents and processes? How effective have they been, and have they even been evaluated in terms of the extent to which they have been implemented and given clear direction to and driven meaningful responses from all three levels of government?

Furthermore, is the very process of writing a national strategy independent of the engagement of key policy and planning decision-makers (including most importantly, elected representatives) likely to bear fruit today or into the future? Has it borne fruit in the past? Why can't we change this? I say there is no option other than to make fundamental changes to the way we behave as a nation, particularly in the context of our governance structures and processes. I will return to these important questions later in this submission when I address the critical subject of 'good governance'.

Priority 1: improving community safety and amenity

Priority one: improving community safety and amenity does not pay sufficient attention to the role and commercial responsibilities of industry to protect rather than harm citizens. That I should identify this as a priority signals the impact of the alcohol industry's unfettered and often poorly judged commercial decisions and practices on the drinker and innocent others. That we enclose drinkers behind wire fences at some community events where sale and drinking is allowed, tells us something very important about this drug called alcohol **impact** on human **cognition, affect** and **behaviour** and on **public amenity** and **public safety**. It and its signals the common and high level of **danger** and **anti-social behaviour** associated with its consumption as referenced in the draft NAS (2018-26) to "supporting greater and more efficient enforcement of liquor licensing and *public conduct laws*" as does the comment about the need to *police the behaviours* that are consequential to the sale and supply of this drug.

We need to think very carefully about what we're saying here about community safety, why and what it means. Sound inductive reasoning (putting all the information together) should lead us to conclude that this drug is associated with unacceptable harm to drinkers and to innocent bystanders under current alcohol industry behaviour and alcohol control circumstances in Australia. The question then arises – does this draft NAS (2018-26) provide appropriate and sufficient roadmap

responses like no other preceding strategy and does it signal that we serious as a nation about implementation? Sadly, the answer is no to both parts of this question, it does not.

<u>Recommendation 6:</u> that the National Alcohol Strategy (2018 – 2026) pays clear attention to the roles and responsibilities of all sectors of the alcohol industry in ensuring that its commercial actions do not harm or in any way glamorise or promote dysfunctional, hazardous and harmful choices to consumers and that it will be held to legal and financial account where it breaches as yet to be determined nationally agreed standards of commercial behaviour, designed to protect public and population health and safety.

'Responsible Server Practice'

I note with concern the Draft NAS (2018-26) provides no meaningful analysis or informed strategies in relation to the concept of '**responsible service of alcohol'** (RSA). The reference to RSA and monitoring and supporting compliance with service standards fails to address the reality of commercial behaviour as we commonly see it in pubs, clubs and other licensed venues.

> *Most importantly, I present that the responsible server practices framework, as appealing as it has been to industry as a means of **corporate capture** of the **harm minimisation** paradigm over many decades, is a conceptually flawed and ultimately, a failed strategy, one that is not in any case taken seriously by the alcohol industry.*

I further present that the RSA framework no longer holds up when placed under careful scrutiny and needs to be completely rethought.

> *The amount of evidence on the effects of altering the drinking context has been growing, and we now think that strategies in this area can have modest effects. The fact that these strategies are applicable primarily to on-premises drinking in bars and restaurants somewhat limits their public health significance, as a high proportion of alcohol is purchased more cheaply for consumption elsewhere. … However, responsible beverage service is only effective if accompanied by enforcement. Enhanced enforcement of laws and regulations by police, liquor licensing, municipal authorities and other methods is likely to have impact through situational deterrents, in particular the threat of suspending or revoking the licence to sell in cases of irresponsible selling and, where laws permit, through holding servers and owners liable for the harms resulting from over-service (Babor et al, 2010).*
>
> *Four reviews (Bolier et al., 2011; Brennan et al., 2011; Jones et al., 2011; Ker and Chinnock, 2008) reported mixed results for studies investigating server training. Some studies showed significantly beneficial effects on patron alcohol consumption, night-time vehicle crashes and on-premises violence; others demonstrated no significant effects.*
>
> *Rammohan et al. (2011) found that dram shop liability – holding a shop culpable for serving someone underage or visibly intoxicated who is subsequently injured or causes injury – can reduce vehicle crash deaths. The authors emphasise, however, that litigation may not be cost-effective or a feasible intervention in all contexts.*
>
> *Server training educates servers of alcohol about the harms of serving alcohol to people who are underage or intoxicated, and while based on solid principle, no strong evidence*

has emerged of their effectiveness. Larger beneficial effects are reported for server liability, which holds servers legally responsible for harm (in Burton et al, 2017).

At best, interventions enacted in and around the drinking environment lead to small reductions in acute alcohol-related harm. But their implementation is resource intensive and many of their benefits could be achieved by wider environmental policies (Burton et al, 2017).

In any case, from a medical practitioner's perspective serving 6, 10, 20, 30 or more drinks in a sitting to any individual or to the point of clear intoxication and/or behavioural disorder in the server's assessment is hardly responsible server practice. Rather, these metrics can only be described as ill-conceived and irrelevant to the harms incurred.

Serving to the point of intoxication means the customer is likely to be emotional labile and substantially impaired in their conscious state, perception, behavioural control, cognitive and motor functions (including impairment of coordination). It means the commercial enterprise is wittingly selling or serving an intoxicant that damages human cells throughout the body, damages and impairs brain function regardless of the patron's level of tolerance and visible intoxication; and regardless of their wish to be intoxicated. Such sever behaviour places the drinker at significant increased risk of falls, motor vehicle and other accidents; domestic and other violence including homicide, suicidal ideation and completed suicide; sudden death from alcohol-related medical causes including cardiac arrhythmia; alcohol-depressant drug ventilatory impairment leading to respiratory arrest; and exacerbation of low mood or depression. In plain speaking terms, when serving far in excess of the NHMRC (2009) low risk advisories yet alone to the point of visible 'intoxication' or 'behavioural disorder', a licensee and his/ her staff are making **commercial choices** that physically harm the customer and potentially sets them up to 'fail in their lives' or to harm others, sometimes in a minor way and sometimes in a major way. All these outcomes are as tragic as they are often hidden but also clearly visible in Australian society to those who care to look and to 'see'.

To illustrate the disconnection between evidence and contemporary public policy, one jurisdiction has legislated *'to ban troublemakers in and around licensed premises to reduce alcohol-related problems'*. We need to think firstly, what is happening here and what does this say about this drug called alcohol and our societal responses. Well, we are identifying that it is a drug that creates immense danger, sufficient for our society to say we need liquor licensing and other laws to protect people (after the fact) from the behaviours that arise because of its use. That some persons may be more vulnerable to such dangerous behaviour is immaterial to the upstream cause or trigger, the sale or serving of large quantities of alcohol, at levels that are staggeringly more than our national (NHMRC, 2009) low risk drinking advisories and without any serious attempt to monitor and respond until there is clear evidence of intoxication or behavioural disturbance. The 'logic' behind such claimed 'responsible server practice' beggar's belief.

So, the question arises: does this legal reform (banning 'troublemakers') target the right persons? It targets the customer rather than the Licensee who is willing to serve or supply the customer so much alcohol that their perception, consciousness, cognition, affect, motor function and behaviour are adversely affected and likely to make a significant contribution to their decision making and to their behaviour which can be unruly, present significant dangerous to self and others and not uncommonly, trigger or fuel violent behaviour? Is the Licensee not making a profit at these citizen's health and safety expense and then blaming, stigmatizing and further punishing the citizen, as if they haven't harmed them enough already? I ask, how can this be described as 'responsible server practice'? How can our response be described as a morally and intellectually defensible public

policy stance? How is it that we continue to stumble as a nation in our public policy decision making in such matters? I will return to this issue when I discuss the key issue of governance.

Indeed, crime statistics reveal that while many customers incur legal sanctions for alcohol-related 'behavioural disturbance', licensees are hardly ever prosecuted for serving patrons who are 'drunk'. They are not losing their licenses based on what I will call, 'permissive and unsafe server practice', in ways and to the extent that could act as a more effective deterrent (Babor et al, 2010).

Any erudite assessment would reveal wide scale unsafe server practices across the nation. The law as it stands is not being commonly enforced and even when it is, licensees are likely to hire a lawyer who will set about trying to prove 'it was other drugs', not the 'Licensee's drug' that were responsible for the harms arising and, in any case, 'the customer chose to drink the licensee's alcohol'.

In Victoria in 2015, over **13,000 persons** were arrested for **public drunkenness**, not all of these on premises, but only **one licensee** received an infringement notice for serving an intoxicated person, between **2012 and 2015** (Victorian Police – ref). If this doesn't demonstrate the failure and injustice of the responsible server practice framework, I really don't know what would. In my assessment, this is the nail in the coffin of responsible server practice as it is currently conceived and implemented.

> *Notwithstanding the clear **commercial choices that I describe**, primary responsibility for any of these tragic outcomes is always sheeted home to the 'choices' of the drinker, even when the drinker's decision making may already be impaired and their **human agency diminished** by their excessive drinking and alcohol dependence, promoted and enabled in no small part by the alcohol industry's glamorisation and socialisation of drinking, rendered even less competent by acute and increasing intoxication.*

I am not a lawyer, so I express a lay view, not an expert legal view in the following legal matter, noting however that the law ought to support a principle of justice for all that is based on contemporary scientific evidence and analysis (what we know and what we understand) as well as social values of protecting and promoting beneficence and non-maleficence as the bedrock for how we behave and how we treat each other in Australian society.

High Court of Australia Adopts Position in Favour of Industry

That primary responsibility belongs to the drinker where drinking causes or contributes to serious harm was upheld by the High Court of Australia in overriding the Supreme Court of Tasmania no less *(C.A.L. No l4 Pty Ltd v Motor Accidents Insurance Board; C.A.L. No 14 Pty Ltd v Scott [2009] HCA 47 (10 November 2009),* which found (by broader inference beyond handing back the motor cycle keys to an intoxicated individual), that a commercial enterprise bears no legal responsibility for the consequences experienced by the drinker as a result of the choices the enterprise offers to its customers and its server practices, nor by logical extension of this kind of argument, its active engagement in all manner of commercial manipulations to promote and supply alcohol in ways that facilitate excessive drinking – advertising, two for one drinks and other promotions, price discounting, shopper dockets and the list goes on. It is not difficult for the well informed to challenge the evidence presented and legal arguments provided in that High Court decision, but there it is.

I observe that in the above-mentioned legal case, the High Court delivered a legal decision that signalled its apparent lack of in depth understanding or failure to take into adequate account, relevant scientific knowledge. I reference in this regard the cognitive, behavioural, coordination (critical for safe riding a motorcycle) and affective impacts of alcohol as well as the influence of alcohol dependence where present, in any social interaction related to the supply and use of alcohol. I also reference the Court's unusual understanding of the concepts of 'duty of care' ('a side wind blowing from the law of negligence') and of 'autonomy'; and its apparent neoliberal ideological underpinnings which selectively focus on the choices and therefore the responsibility of the individual customer making those 'choices' and impacts of those 'choices' while ignoring or discounting the choices and impacts of industry and its civil responsibilities to not wittingly and avoidably harm others. The court stated that it is "a matter of personal decision and individual responsibility" and "a matter more fairly placed on the drinker than the seller of drink". The Court could not support what it termed, "interfering paternalism on the part of those who run the hotels and restaurants", which is of course, a hallmark of neoliberal thinking.

The High Court argued that certain matters were not relevant to its considerations. By way of example, the High Court assessed that the Licensee was unaware of the plaintiff's intoxicated condition and so a Canadian decision regarding duty of care was 'distinguishable' (not applicable to this case), to which I beg the question, really? How thoroughly was this assumption tested? It also argued that the Licensee could not have known the customer would change his mind and insist on taking the keys to his motorcycle to attempt to ride home, to which I again ask the question, really? Licensees are in the business of selling and serving alcohol, often in quantities that are five, ten or twenty times more than the NHMRC (2009) 'low risk drinking advisories' and they will know the effects on affect, cognition and behaviour.

The Court chose to apply a high and I say unreasonable standard of expected knowledge, understanding and behaviour in the drinker while at the same time applying a low standard of expected knowledge, understanding and application of that understanding in commercial practice. The Court did not assess it reasonable that the Licensee should know and anticipate the common adverse effects of alcohol on judgement, lability of decision making and unsafe and unwise behaviour in the face of a customer's previously stated resolve to behave otherwise. Even though the Court did make mention of 'serving intoxicating beverages' leading to 'diminished capacity to make sensible judgements', it failed to apply that apparent insight in its judgement.

In the matter of duty of care, the Court argued a 'lack of coherence with other torts' such as the potential for assault and battery and false imprisonment (*to conclude that the law of negligence creates a duty in the present circumstances "would subvert many other principles of law and statutory provisions, which strike a balance of rights and obligations, duties and freedoms").* It did not consider the sale of a large quantity of alcohol to constitute an assault on health and safety (for which I make the general case elsewhere in this submission).

The Court argued against a duty of care to monitor drinkers based on 'impracticability' and also, that it would destroy peaceful relations. Firstly, I find it quite extraordinary that any court of law would so readily dismiss a most basic responsibility of any commercial operator willing to profit from the sale of a good that is potentially so dangerous when consumed in excess of the low risk drinking advisories. Such checks are the very least society should expect of them. Secondly, continuing to serve alcohol to a customer is most certainly likely to 'destroy peaceful relations'. The primary problem is serving too much alcohol and in a highly hazardous context. As the Court should know, unsafe even highly dangerous behaviour is a most common consequence of drinking alcohol. Indeed, to draw an analogy, one of the reasons we now have serious prescription drug problems in Australia is a reluctance among some medical practitioners to appropriately manage and say 'no' to requests

or demands to prescribe these drugs out of fear of 'destroying peaceful relations'. Would the High Court propose that the medical profession continue to prescribe inappropriately for this reason? I trust that it would not.

The High Court adopted the common defence of the alcohol industry in stating that *"expressions like 'intoxication', 'inebriation' and 'drunkenness' are difficult both to define and to apply*. Variables such as tolerance make it *"difficult for the observer to assess whether a drinker has reached the point denoted by these expressions",* implying that it is not possible to apply the principles of responsible server practice, save in "*exceptional cases' where a person is intoxicated as to be completely incapable of any rational judgment or of looking after himself or herself, and the intoxication results from alcohol knowingly supplied by an innkeeper to that person for consumption on the premises affected".* In this judgement, the High Court inexplicably defended industry claims of difficulty assessing impairment and refusing supply and the often-unsafe commercial practices of Licensees across the nation in continuing to sell alcohol well beyond the point where such impairment is patently obvious to others.

Furthermore, the High Court observed there is no workable basis for enforcing responsible server practices based on the introduction of a civil duty of care defined by reference to those expressions. *"Outside exceptional cases…the Proprietor and the Licensee…owe no general duty of care at common law to customers which requires them to monitor and minimise the service of alcohol or to protect customers from the consequences of the alcohol they choose to consume".*

While the High Court judgement may in its eyes have been a defensible analysis of present law, from a medical perspective I assess the ruling and legal arguments to contain many illogical, non-sequitur and incorrect conclusions that might well be difficult to defend elsewhere in Australian society, based on contemporary scientific knowledge and sound inductive reasoning. I also assess the legal argument and associated logic to be ethically problematic because the argument was in my lay observation, applied unequally and inequitably, protecting the unsafe commercial practices of industry while disadvantaging and placing the vulnerable community at further risk because of the ruling's potential undermining of health protection based public policy reform (while noting the Courts may say this is none of their concern, they just interpret and apply the law).

If a health professional were to adopt a similar line of argument and actions in clinical practice, they might well be found to be negligent in the event of a serious adverse patient outcome. This is indeed what we are likely to see more commonly in Coroner reports following the findings of Tasmanian Coroner Stephen Carey in relation to the overdose death of *Dearne Barnes* (Signed on 25 May 2016), where by implication, a medical practitioner is in future found to be at fault in prescribing excessive doses and quantities of opioid medicines leading to death and where those deaths are assessed as in the Barnes case, to be *"likely and avoidable"* (Carey, 2016).

There is nothing exceptional about placing limits on the quantity of sale or supply of a manufactured good where that good is 'no ordinary commodity' and where it commonly causes significant harm when consumed in excess. Also, in response to the High Court's concerns that a duty of care obligation might be viewed as lacking coherence with other torts, there is nothing special about a law being formally afforded primacy over other laws where that law is designed to protect public health and public safety.

By way of further analysis, I cite Gostin (2000) who argues that while public health interventions affect rights and incur costs, they are generally justified in three circumstances:

1. to avert a risk of serious harm to others – by acting to control those in a position to harm 'patients', such as industry and prescribers
2. to protect the vulnerable – given a power and knowledge imbalance that means all 'patients'
3. to prevent a person harming her or him self

In reading the Gostin (2000) paper, I see analogies to this case involving the duty of care obligations of all citizens and of commercial industry. Once again, putting aside the question of whether this High Court ruling was a legally defensible decision based on balancing existing laws and notwithstanding my concerns, the consequential question arises, what are the mechanisms for our judiciary to trigger a review of the such legislation by our parliaments, with a view to correcting or improving on the law, noting that the judiciary are, like the medical profession, in a well-informed position to provide authoritative and erudite advice on the extent to which the law is satisfying or failing to satisfy a range of important legal, public health and social measures of good (just and evidence based) law, laws that protect and promote the best interests of the individual and society more generally. Did the judges privately feel there was a deficit in the law in this case, or not? If so, did they feel they should communicate this deficit through appropriate channels, and do they have appropriate mechanisms and imprimatur to do so?

I ask - do the 'separation of powers' allow 'erudite integration of powers' based on evidence and analysis? Of course, as I point out in this submission, the consequential question arising pertains to whether and the extent to which elected representatives might heed and act upon any such advice.

This High Court decision captured the attention of clinicians and public health experts across our nation, who were understandably concerned that it would undermine public health efforts to address excessive consumption, including national laws related to 'responsible service of alcohol'.

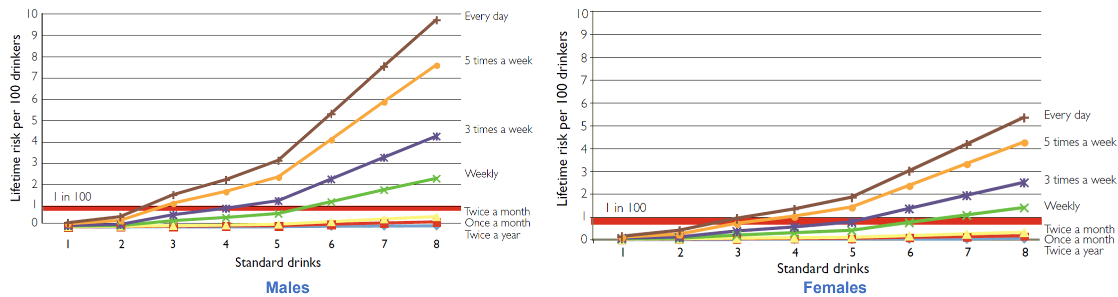
While the ruling and its wording suggests the High Court Judges saw no issues, they did observe that appropriate remedies to the question of duty of care would need to come from legislatures, which seems to suggest otherwise.

Since Licensees continue to advise they are unable to reliably assess how much is too much and refuse supply and since our Courts are equally unable to resolve this problem, I present an obvious legislation-based solution would arise from simply limiting the quantities of alcohol that any licensee can serve a customer and logic would dictate that such responsible server practice would be based on the scientific evidence of that which constitutes 'low risk' drinking., in alignment with the low risk drinking advisories of the NHMRC (2009). This would elegantly solve the dilemmas of definition of impairment and of its assessment, identified in this High Court judgement.

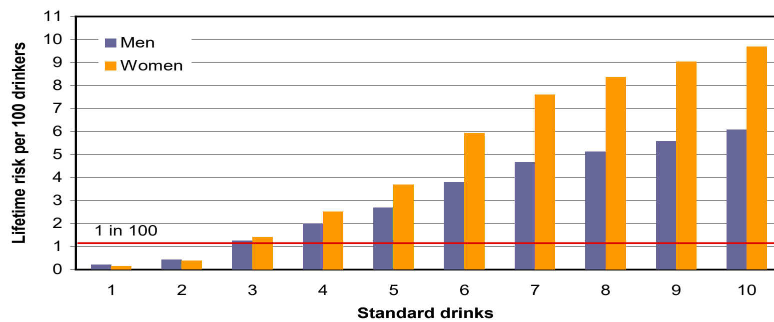
It follows from all these considerations that a genuine, responsible server practice framework would mean serving no more than what the evidence and expert analysis supports as 'low risk drinking', which at present means no more than two standard drinks if drinking on a regular basis and no more than four drinks when drinking more heavily, episodically.

That is to say, four drinks episodically providing the server knows the patron well and their drinking history within the venue and has reason to believe they do not exceed the two standard drinks a day on most days when they drink - but how would they 'know' these things with any reliability? This assessment could be undertaken if all alcohol purchases were made using a smartcard with identification.

Of course, we possess the technology to achieve this end right now. That said, the lay Australian public and our public policy decision makers appear to be a long way removed in their comprehension of what would represent genuine ‘responsible server practice’ and how devoid of sensibility our current frameworks really are.



Lifetime risk of death from alcohol-related injury (NH&MRC, 2009)



Lifetime risk of death from alcohol-related disease (NH&MRC, 2009)

There is no level of drinking alcohol that can be guaranteed to be completely ‘safe’ or ‘no risk’ (NHMRC, 2009). Note the rapid and substantial increase in risk as drinking exceeds the NHMRC ‘low risk’ drinking advisories.

It follows that the NAS (2018-26) should not be supporting outdated and very poorly thought through frameworks for ‘responsible service’ of alcohol, a framework that offers nothing meaningful to address the common sale of highly excessive quantities of alcohol. Moreover, it should set out specific legislative and regulatory strategies to address currently unsafe and untenable server practices.

If the idea of responsible service of alcohol is to be retained, it should be reframed to align with the next version of the Australian Guidelines to reduce Health Risk from drinking Alcohol (NHMRC), possibly due for release some time in 2019, rather than with an industry worker’s late and after the fact, unreliable and invalid subjective assessment of intoxication or behavioural disorder.

Nothing less than this will be credible and acceptable to those who are expert in the fields of Public Health and Addiction Medicine. It is likely the new NHMRC guidelines will **further lower** the ‘low risk’ drinking quantities communicated in its **drinking advisories** for avoiding short- and long-term alcohol-related harm, based on recent international studies and analysis (e.g. Wood et al, 2018 who conclude the threshold for lowest risk for all-cause mortality is about 100g per week).

Commercially Sociopathic Behaviour

I want to drive home the point about current commercial behaviour by drawing upon the standard classification of mental disorders used by mental health professionals, the Diagnostic and Statistical Manual of Mental Disorders (**DSM–5**). The DSM-5 defines antisocial personality disorder as "[a] pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:

1. **Failure** to conform to **social norms** with respect to lawful behaviours, as indicated by repeatedly performing acts that are grounds for arrest.
2. **Deceitfulness**, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to **plan** ahead.
4. Irritability and **aggressiveness**, as indicated by repeated physical fights or assaults.
5. Reckless **disregard for safety** of self or others.
6. Consistent **irresponsibility**, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations.
7. Lack of **remorse**, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

While this clinical tool is not designed for use outside the clinical domain, the commercial behaviours that I describe would appear to satisfy the DSM-5 criteria for anti-social personality disorder at least in part, noting the overlap with collective human behaviour including commercial behaviour.

*It is evident that the alcohol industry, like other unhealthy commodity industries, is engaging in commercial behaviour that at least partly satisfies the DSM-5 definition of anti-social personality disorder, which we might quite fairly refer to as '**commercially sociopathic behaviour**'.*

If industry is disturbed by this analysis or does not like the messages or agree, then let it meet with the medical and other health and human services professions and discuss why we are so disturbed by what we are witnessing on a daily basis and how it can change its business models and its commercial practices to bring itself into alignment with the principles of a caring commercial entity, one that at a minimum, does no predictable and avoidable harm to its customers or to others.

Recommendation 7: that the National Alcohol Strategy (2018 – 2026) describe a completely reconceptualised framework for 'responsible server practice' that is based on and in every way consistent with the low risk drinking advisories contained in the next version of the Australian Guidelines to Reduce Health Risk from Drinking Alcohol (NHMRC).

Secondary Alcohol Supply

The NAS (2018-26) should emphasize protecting children and young adults. There is good reason to reconceptualise the way we regulate **secondary supply of alcohol** through legislation. Some states have with good intention, enacted legislation requiring parental or guardian consent for the supply of alcohol to minors (those under 18 years of age) but once again, given the evidence of significant vulnerability to brain (and other) injury in young people consuming even one or two

standard drinks on a regular basis, there is no defence for the supply of any alcohol to a young person based on basic duty of care obligations and based on international conventions such as the UNICEF Convention on the Rights of the Child. (e.g. DeWit et al., 2000; White and Swartzwelder 2004; Brown and Tapert 2004; Warner et al, 2007; Lubman et al, 2007).

The law should reflect and protect young people from any and all supply of alcohol (not just sale)…

…while recognising of course that some young people will access alcohol in a range of ways and circumstances beyond the purview and control of the law and parental or guardian oversight.

While strong enforcement of laws is often required for good community adherence, legislating against secondary supply might not require significant law enforcement resource demands in the long run, if a comprehensive public awareness campaign is implemented, designed to raise parental awareness of youth vulnerability and communicating the importance of not exposing the young brain and body more generally to alcohol, and providing parents with a rationale and script for confidently declining the request by others to supply alcohol to their children. Whether this is correct or not, we do need to set a new community standard which is by and large adhered to on a voluntary basis over time as parents and guardians come to understand and appreciate the reasons for and value of promoting a non-drinking social standard among children and adolescents.

"The best law is one that so shapes social norms that it becomes self-enforcing"

- WHO, 2004

I ask the question - Why would any adult do anything that could possibly compromise the brain function and other aspects of their child's health, development and safety and jeopardize their future life opportunities?

Parents are generally highly motivated to protect their children and at present, a large proportion of Australian adults possess very poor health literacy including poor knowledge in relation to alcohol.

The Australian Commission on Safety and Quality in Health Care (ACSQHC, 2014) observes that health literacy is a safety and quality issue. It finds that only about 40 per cent of Australian adults have the level of individual health literacy needed to meet the complex demands of everyday life, meaning that only 40% of adults can understand and follow health messages in the way in which they are usually presented. It also means that only about 40% of adults will be able to make good choices based on a thorough understanding of the issues they face and the choices available. The level of health literacy will be much lower among many (but not all) cohorts of adolescents and young adults who are paradoxically assigned primary responsibility by the unhealthy commodity industries to make the healthy choices, in the face of industry best efforts to persuade young people to do otherwise through wide ranging and clever marketing strategy. Of course, other personal, structural and macro-environmental factors will also likely influence whether they are able to translate health knowledge into health protective and health promoting behaviours.

Australian adults are often influenced by a discredited idea of providing or allowing the provision of alcohol to their children under supervision with a view to 'teaching them responsible drinking'.

Children and young adults are more vulnerable to biological harm than adults. By way of example, the following authors observe:

> *The hippocampus plays a central role in learning and memory. Several studies have revealed that alcohol affects hippocampal function differently in adolescents and adults. Glutamatergic (i.e., NMDA) receptor-mediated neurotransmission in the hippocampus is inhibited more powerfully by acute alcohol during peri-adolescent development than during adulthood (Swartzwelder et al, 1995a, Swartzwelder 1995b; Pyapali et al, 1999).*
>
> *Lower doses of alcohol are required to disrupt hippocampus-mediated learning in adolescents compared to adults and researchers have reported finding 'NMDA receptor-mediated currents' at alcohol concentrations achieved with equivalent of a single drink. Developmental sensitivity of NMDA receptor-mediated currents to alcohol exists outside the hippocampus, is observable at the level of single neurons, and is observable at alcohol concentrations as low as 5mM, roughly the equivalent of a single drink (White and Swartzwelder, 2004).*
>
> *The unique potency of alcohol against NMDA receptor-mediated synaptic activity is not restricted to the hippocampus. In humans, the sedative and motor in-coordinating effects of alcohol can limit the amount of alcohol an individual consumes. That is, people might find themselves incapacitated at some point during the evening and unable to continue drinking even if they desired to do so. The existing research regarding alcohol-induced sedation and motor impairments in adolescents and adults has all involved the use of rodents. If such findings extend to humans, the decreased vulnerability of adolescents to the sedative and motor-impairing effects of alcohol might allow adolescents to continue drinking for longer periods of time than adults, and perhaps achieve much higher blood alcohol concentrations, without becoming sedated…As we have seen, adolescents appear to be more vulnerable than adults to some of the cognitive impairments produced by alcohol. Thus, the reduced susceptibility to alcohol-induced sedation and motor impairments, combined with an enhanced susceptibility to alcohol-induced cognitive deficits, could potentially be a very dangerous combination of effects (White and Swartzwelder, 2004).*

*A national social marketing campaign should reference the wise mantra of '**delay, delay, delay'** uptake of drinking as long as possible, noting that early uptake of drinking is associated with an increased likelihood of a young person developing an alcohol use disorder in adolescence, one that is likely to be carried into adulthood (Toumbourou et al, 2014).*

The Case for Regulating Secondary Supply

I make the case that Australian society and our parliaments where a key role, authority and indeed, genuine power (as opposed to bought and lobbying influence) to determine public policy resides, are failing to heed the large body of scientific evidence and expert advice; and do what is possible to protect and promote the best interests of our children today and into the future, as this relates to the alcohol. I further present that Australian society is in effect, setting our children and the young people of Australia up for life outcomes that are not commensurate with their individual potential to achieve and flourish in life to the best of their ability or stated alternatively in plainer terms, 'setting them up for loss of life opportunity, even life failure'. I defend this conclusion and

make the case for more firmly and comprehensively regulating secondary supply on the basis of this analysis and the following considerations.

1. **Risk of Harm:** We know that alcohol poses the single greatest threat to young people's health and safety in Australia. The risks of accidents, injuries, violence and self-harm are high among underage drinkers. Risk-taking behaviour, unsafe sex choices, sexual coercion and alcohol overdose increase when adolescents drink alcohol. So too do the risks of mental health problems such as disordered sleep, anxiety, depression, suicide ideation and violence, either as a perpetrator or victim. The capacity to inhibit risky, irrational behaviours is not complete until adulthood.

    The orbitofrontal cortex (OFC), appears to follow a late developmental schedule in adolescence, since its activity in adolescents is relatively low, matching that of children more than adults. This is accompanied with exaggerated activity in the NAc (Galvan et al, 2006). Adolescents have not yet fully developed their prefrontal capacity to veto affect driven behaviours, as a result of the relatively slow maturation of the OFC. These observations are highly relevant to addiction, because efficient connections are needed from subcortical to cortical regions, particularly the OFC, for the inhibition of affect driven, impulsive behaviours, and these connections are typically impaired in addiction (van der Eijk, 2015).
    The development of addiction requires the use of a substance and a subsequent chain of behavioral events that leads to addiction. The key steps in the development of addiction include the initiation of substance use, the conversion from experimental use to established use, and finally the development of addiction (Bierut et al, 2011).

    Each step is influenced by environmental and genetic factors, some of which are common to all steps, and others that are specific. For example, environmental factors, such as the availability of nicotine, alcohol, and drugs, play a role in each stage in the development of addiction, but accessibility of a substance is relatively more important in the initiation of substance use (Bierut et al, 2011).

    Outside the clinical context, adolescents are the age group most likely to engage in behaviors such as dangerous driving, unprotected sex, and substance abuse (Stenberg, 2004). This, to some extent, could be due to psychosocial factors. However, the above also suggests that adolescent behaviors are influenced by neurobiological development, in a way that predisposes them to affect–driven behaviors. Consequently, they are more susceptible to peer pressure, and more likely to experiment with drug use; and since their cognitive, prefrontal capacities are not fully developed, they are prone to these behaviors despite having some presumed awareness of the risks.(Slovic, 1998; Slovic, 2000) The effects of prolonged drug use on the prefrontal cortex may further impair cognitive capacity, which could explain, to some extent, why most initiations take place in adolescents and why most addictions develop before prefrontal development is complete. Therefore adolescents—as well as young adults under age 25—are especially susceptible to smoking initiation and developing addictions to (alcohol and) tobacco (van der Eijk, 2015).

2. **Adolescents are more vulnerable than adults to many of the adverse effects of alcohol:** Alcohol interrupts the normal process of brain maturation. Alcohol has adverse effects on memory and can injure the brain and alter brain development, affect driving skills and thus safety on the roads, and can cause long-term cognitive deficits. Alcohol is associated with

heightened sensation seeking and reduced impulsive control as both a consequence and as a contributor to early development and associated risks.

3. **Self-reported harm scores** show that 12–14-year-olds report the highest levels of harm per litre of alcohol consumed of any age group (4–5 times that of 40–44-year olds), with 15–17-year-olds reporting more than twice as much harm as 40–44-year-olds (NHMRC, 2009).

4. **Brain Development & Injury:** As WHO and other esteemed health bodies have pointed out, the majority of people who smoke and drink commence in their teenage years, at a time when their brains are not fully developed, when their life experience is limited, when dysfunctional or less than pro-social commercial and adult modelling and constructed social norms can prove overpowering and when their decision-making around health-related (and other) behaviours is often ill-considered, immature and ill-judged.

5. **Childhood and adolescence are critical times for brain development** and the brain is more sensitive to alcohol-induced damage during these times, while being less sensitive to cues that moderate alcohol intake (NHMRC, 2009). Alcohol acts directly on the developing brain and may impair the young person's ability to solve problems, to think clearly, to make judgments, not just at the time but later in adult life if consuming excessively at a young age. Youth who abuse alcohol at an early age later show decision-making impairments (Nasrallah et al, 2009). Early heavy episodic ("binge") drinking may compromise the very cognitive capacities (i.e. executive functions) needed to protect oneself from developing a drinking problem or becoming alcohol dependent. Many people in the general community will know that alcohol impairs thinking, insight and judgment when acutely intoxicated but few may recognize the potential longer-term cognitive harms in this regard.

6. **Young people with alcohol-use disorders display significant and detrimental changes in brain development compared with their non-alcohol-using peers**: Studies have shown that significant changes in brain structure accompany heavy drinking. Hippocampal function, a critical brain region involved in memory formation, is uniquely responsive to alcohol during adolescent development and may be more sensitive to neurotoxicity during this period (White and Swartzwelder 2004). White matter structural irregularities and reduced hippocampal volumes have been reported (Brown and Tapert 2004). There is some evidence suggesting an adolescent consuming alcohol on a daily basis but even within the adult low risk advisory of two standard drinks a day may incur alcohol-related brain injury, yet as NDRI research has found, half of 14-19 year old teenagers surveyed consume 11 or more standard drinks per drinking session, signalling that Australian youth are commonly drinking much more than the adult low risk drinking advisories and they are drinking to deep intoxication. An analysis of emergency department presentations shows that rates of presentation for teenagers are about twice that for all other ages in all jurisdictions (Lensvelt et al, 2015). This is highly worrisome, and the question arises – who bears upstream responsibility for such common and damaging drinking behaviours? And what do we plan to do about this as a nation?

7. Animal studies suggests **greater vulnerability to adverse learning consequences in youth** while human studies suggest cumulative neuro-cognitive impairment secondary to alcohol use over the course of middle to late adolescence (Brown and Tapert, 2004). Hormonal fluctuations, differences in alcohol metabolism, and gender-specific drinking patterns, may partially account for the evidence that adolescent girls suffer greater alcohol-related neuro-cognitive deficits than adolescent boys (DeWit et al., 2000; Brown and Tapert 2004; Warner et al, 2007).

8. **Early Uptake of Drinking & Trajectories:** The evidence shows how important it is to delay the introduction of alcohol as long as possible and certainly until the age of 18 years. Even at the 'legal age' of 18yrs, young people do not demonstrate mature decision-making skills and as any observant parent will know, 18-year-old youth make many less than well considered decisions.

9. **The age of onset of drinking appears to be an independent risk factor for the lifetime development of disordered alcohol use:** Initiation of alcohol use at a young age increases the likelihood of dysfunctional, hazardous, harmful and unsanctioned drinking in adolescence and the development of alcohol problems including alcohol dependence, in adulthood. Treatment service report seeing many young people who are already demonstrating evidence of alcohol dependence in their teenage years. There is also evidence that early uptake of drinking increases the likelihood of hazardous and unsanctioned use of other drugs including illicit drugs, prescription drugs and tobacco.

10. **Associations between Early Drinking and Other Substance Use:** Early use of alcohol arising in no small part as a consequence of aforementioned biological, commercial and sociological factors, elevates risk for a multitude of substance use, mental health and social problems. Hingson et al, (2006) found that 47% of those who begin drinking alcohol before 14 years of age become alcohol dependent at some time in their lives, compared to 9% those who wait at least until age 21. The correlation remains even when genetic risks for alcoholism are taken into account. Of course, there may be uncertainty about cause and effect in such circumstances (what came first, what may have 'caused' and what may have 'contributed' to a substance use disorder) but even so, we can say with good reason that even if there is evidence of 'developmental harm' or 'psychopathology' preceding alcohol and other substance use in a particular individual, the latter is very likely to further fuel the flames of life problems in an already vulnerable individual and to seriously diminish that person's life chances, life opportunities, life trajectory and the probability of an adaptive resolution. Rates of conduct disorder, antisocial personality disorder, nicotine dependence and illicit drug abuse and dependence are significantly higher among youth who drink early (Brown and Tapert, 2004; White, 2006).

11. **Use Commences when Least Capable of Making Good Decisions:** The majority of drinkers and smokers commence consumption in their teenage years, at a time when their brains are not fully developed, when their life experience is limited, when their health literacy is generally limited or poor, when sensation seeking and risk taking is more likely, when commercial promotion and parental modelling and social norms can prove overpowering and when their decision-making around health-related (and other) behaviours is often immature and ill-judged. Spear (2000; 2002) notes that among the prominent brain transformations of adolescence are alterations in the prefrontal cortex, limbic brain areas, and their dopamine input, systems that are sensitive to stressors and form part of the neural circuitry modulating the motivational value of drugs and other reinforcing stimuli. Alcohol acts directly on the developing brain and if consumed may impair the young person's ability to solve problems, to think clearly, to demonstrate good insight, to make judgments, to learn from mistakes, not just at that time but on the basis of inductive reasoning, if consumed beyond an as yet to be determined threshold of quantity, frequency and duration, these adverse cognitive harms will persist into adult life. Arguments made in terms of tobacco regulation to protect young people have salience to alcohol regulation, by way of example:

   The effects of prolonged drug use on the prefrontal cortex may further impair cognitive capacity, which could explain, to some extent, why most initiations take

place in adolescents and why most addictions develop before prefrontal development is complete (van der Eijk, 2015).

Adolescents are not yet fully autonomous; their prefrontal capacity to exercise an autonomous, informed decision to smoke is still developing. It is important to allow this capacity to develop properly, since not doing so effectively undermines the potential of adolescents to become fully autonomous. Interventions that promote future autonomy by restricting tobacco, then, are not a violation of freedom because adolescents are not yet fully autonomous. Second, the importance of protecting adolescents from smoking initiation is already widely recognized by the public health community. Nevertheless, evidence in this section indicates that people should be protected from smoking initiation (and subsequent addictions) until age 25, when prefrontal development is complete. In other words, there is an argument for extending current restrictions, such as a minimum age for tobacco sales law (currently 18 years in most places) to people aged below 25 (van der Eijk, 2015).

12. **Genetic and epigenetic factors:** Family, twin, and adoption studies demonstrate a genetic contribution to the development of addiction to nicotine, alcohol, and illicit drugs. The relative importance of these factors remains uncertain though some authors quote heritability estimates for nicotine, alcohol, and drug addiction are in the range of 50% to 60% (Bierut et al, 2011). Environmental factors including social, commercial and media influences, may have a stronger effect on initiation, whereas genetic factors may play a larger role in the transition from regular use to the development of addiction (Bierut et al, 2011; Vink et al., 2005).

*In addition to changes at the synapse, chronic drug use also involves changes in the **regulation of gene expression**, referred to as **epigenetics**. Environmental events (epigenetic factors) can interfere with gene expression by physically altering the ability of transcription factors to bind to the DNA (deoxyribonucleic acid) and transcribe a given gene (Tsankova et al, 2007).*

Put simply, epigenetics is the study of changes in gene function that occur without a change in the body's genetic code, instead relying on epigenetic markers on, among others, the DNA and certain nuclear proteins to turn genes "on" and "off." Epigenetic changes also are brought about by histone modifications, as well as by the role that noncoding RNA (ncRNA) plays (Shukla and Zakhari, 2013).

Environmental factors, including toxic agents and drugs, can exert some of their harmful effects by altering normal epigenetic patterns, leading to abnormal expression or silencing of essential genes and their encoded proteins. Alcohol is fast emerging as one of the chief agents to alter the epigenome of cells and tissues throughout the organism (Shukla and Zakhari, 2013).

The authors (in this edition) summarize what is currently known about epigenetic changes related to alcohol metabolism and explore the relationship between alcohol-related epigenetic disturbances and in utero development and the pathophysiology of fetal alcohol spectrum disorders (FASD). Other reviews demonstrate how far-reaching epigenetic influences can be, influencing all major body systems, including the liver and gastrointestinal system, the brain, and the immune system (Shukla and Zakhari, 2013).

The authors in this edition of *Alcohol Research: Current Reviews* discuss how epigenetic changes resulting from chronic alcohol consumption can lead to organ pathology. They note the brain responds to its environment and constantly adapts to environmental stimuli through regulated changes in gene expression (Zakhari, 2013). Chronic alcohol exposure causes widespread changes in brain gene expression in humans and animal models (Mulligan et al. 2006; Ponomarev et al. 2012), and many of these changes may mediate the processes of cellular adaptation leading to addiction (Mayfield et al. 2008). Epigenetics may play a role in alcohol-related molecular and behavioural changes through altered brain gene expression (Zakhari, 2013).

13. **Maladaptive Problem Solving:** It is recognised that teenagers cannot always make well-considered, well-informed and wise 'free personal choices' about matters that impact on their present and future health and well-being. Adolescence involves significant life transition (self-concept formation and learning new social skills) and can be a stressful period of time. Often maladaptive adult-child (e.g. parents and industry) power relations can distort and overwhelm the health and other life related decisions of young people, not to mention maladaptive peer influences. Adolescents who learn to cope using alcohol early on in life may rely on this maladaptive coping strategy into the future, with a very real potential for this to generalise to the use of illicit drugs and a wide array of psychotropic prescription drugs as a lifelong cognitive, emotional and behavioural response to everyday life challenge, significantly diminishing that person's life possibilities and opportunities (Blomeyer et al., 2011; De Wit et al., 2002).

14. **Youth with AUD Particularly Vulnerable to Marketing:** Marketing messages may in particular be designed in a way to sway and overwhelm teenage decision making, perhaps more so if 'targeting adults' because this sends a message to youth that like smoking, drinking is an adult behaviour and as such, a behaviour of value to children and adolescents that will in some social circumstances be emulated as a consequence. However, a quick view of mainstream and social media demonstrates that the alcohol industry is aggressively targeting young people in its advertising and promotion (AARB, 2018). Teens with an alcohol use disorder reporting greater monthly alcohol consumption and more intense desires to drink show the greatest extent of neural response to alcohol advertisements and promotions. So once 'off and running', youth are primed to respond to industry advertising and promotion (Brown and Tapert, 2004). We can observe from unhealthy commodity industry behaviour that industry understands these realities very well, noting by way of example the 'clever' product design and marketing of alcopops, e-Cigarettes and cereal content and packaging. Given a demonstrated strong neural response to alcohol beverage advertisements among teens with an AUD, media images may influence continued drinking among teens with alcohol problems and may interfere with effective coping strategies in youth attempting to stop drinking.

15. **Social Drinking Culture:** Drinking in a social environment that values and allows and rewards active promotion of alcohol consumption and in particular, consumption on a regular basis and to the point of deep intoxication, provides optimal conditions and sets the scene for the development of disordered substance use more generally.

16. **Parental Supply and Duty of Care**: The Expert group that wrote the Australian Drinking Guidelines to Reduce Health Risk from Drinking Alcohol (NHMRC, 2009) could find no evidence to support the commonly cited romantic notion of 'teaching responsible drinking at an early age' (the so-called Mediterranean model) and reported instead on substantial evidence to the contrary (Toumbourou et al, 2007).

17. **Parental supply increases the risk of AUD rather than modelling 'responsible drinking**: A prospective cohort study, the Australian Parental Supply of Alcohol Longitudinal Study, surveyed 1927 children annually from a mean age of 12.9 years to a mean age of 17.8 years. The researchers found that adolescents who were supplied with alcohol only by their parents had higher odds of adverse drinking-related outcomes, including binge consumption (more than four drinks on a single occasion; odds ratio [OR], 2.58), alcohol-related harm (OR, 2.53) and symptoms of alcohol-use disorder (OR, 2.51), compared with those reporting no supply. Adolescents supplied with alcohol from non-parental sources had an even greater increased risk of adverse outcomes. Analysis of the relationship between supply sources showed that parental supply was linked with increased odds of later other supply (Mattick et al, 2018).

18. **Mid-teens are almost three times (OR 2.68) more likely to drink whole beverages if their parents have been supplying alcohol in the early teen years.** Additionally, teens who have been supplied alcohol by parents have markedly increased acquisition of alcohol from other sources. They are 15 times more likely to acquire alcohol from other sources, sources such as other relatives (adult or siblings), peers, or self-supply Mattick, 2017).

19. **"Parental supply of alcohol to children is linked with adverse drinking outcomes, and parents are an important target for prevention**. Some parents supply alcohol to their children on the assumption they are reducing the risk of alcohol-related harm, yet longitudinal research on the risks associated with such supply is absent…Our results reinforce the fact that alcohol consumption leads to harm, no matter how it is supplied …to reduce the risk of alcohol-related harm, parents should avoid supplying alcohol to children' (Mattick et al, 2018). The authors identified several methodological limitations to their study, including under-representation of teenagers from low socioeconomic status backgrounds. They also noted their research did not account for the amount of alcohol supplied by parents, or the context in which it was given.

20. **Secondary Supply, Free Choice & Responsibility:** The evidence tells us the delaying uptake of drinking should now become a strategic and public policy goal in Australia. Two policy levers stand out as pivotal to this public policy goal, increasing the legal drinking age and progressive elimination of all forms of alcohol advertising and promotion. The 'Free choice' and 'personal responsibility' arguments that are commonly put by industry do not square with compelling biological and sociological evidence and are misleading and in many cases, less than intellectually honest. The alcohol and tobacco industries like to argue that their products are legal and that citizens, including young people, must learn to take responsibility for their purchasing and consumption choices. These industry assertions have no basis in science and I present, reflect less than socially caring and responsible behaviour, aimed it appears at protecting vested commercial interests at all costs. Industry may assert by way of example, that: *"What is needed is a focus on making people responsible for their actions".* Industry appears to believe this idea does not pertain to its own commercial behaviours. Based on public statements and public policy inertia, so too do many of our elected representatives. As I have outlined above, adolescents are not small adults. They cannot be expected to make fully informed and well considered personal choices or to temper their drinking and behaviour more generally, in isolation from wide ranging biological, sociological and commercial influences. Demonstrably, nor do they.

Responding to other Considerations and Arguments

Anticipating Industry Pushback: One can anticipate the negative, catastrophising responses by those who value alcohol highly for personal or commercial reasons, asserting that:

"Increased regulation and other policy reforms designed to reduce hazardous drinking is unnecessary and will have an unfair impact on 'the majority of responsible drinkers' and reduce autonomy in people including young Australians to make their own decisions, will promote an overly protective 'nanny state', and in the case of children under the age of 18 years, steal away parent's rights and responsibilities to make their own decisions about what is in their children's best interests while potentially criminalizing young people and their parents."

I have substantially addressed these matters already, above. We have come to expect such claims from those who value alcohol and its effects so highly for personal or commercial reasons, more than they appear to value the well-being, life chances and indeed, very lives of others.

That said, present patterns of commercial behaviour should inform us that current policy arrangements are not working well for our nation and that industry is doing a very good job itself in adversely influencing human agency through readily accessible commercial avenues to heavy consumption that impacts adversely on brain function, advertising and other forms of promotion to **powerfully distort decision making**, not to mention cut price drinks, shopper dockets, two for the price of one promotions in supermarkets, and increased number and density of outlets, extended opening hours, to name a few strategies.

The **vast majority of Australians are concerned** about alcohol, with **73%** indicating that they believe Australia has a problem with excess drinking or alcohol abuse and 61% of Australians believing that the alcohol industry downplays research findings linking alcohol consumption to a range of harms such as cancer and family violence, though only a minority are aware of the association between alcohol use and a range of serious medical conditions such as breast cancer and stroke (FARE, 2018).

Regarding the **claims of criminalisation,** I respond, well no more than imposing parking or speeding fines and in any case, if it is unlawful to sell alcohol to adolescents under the age of 18 years, why does this protection not apply to children of all ages with respect to all forms of secondary supply? The young brain does not distinguish source of supply in terms of biological risk. Does public policy based on compelling evidence amount to potential criminalising of adults or is it simply an application of a well proven approach of legislation and regulation designed to influence community behaviours that are associated with predictable though substantially preventable health harm, an approach that we apply to thousands of other products, services and behaviours in civil society that are assessed to carry unacceptable risk to self and others?

Anticipating other common poorly thought through arguments against the policy option of increasing the legal drinking age, is the idea that 18-year-old youth should be able to drink because they are able to **vote** or **go to war.** These are non sequitur arguments that arise from poor scientific knowledge and analysis and a conflation of evidence with personal values and beliefs. The voting age or the age when young people are sent to war represent a value judgment by individuals, sections of society and governments and certainly not one that is based on what is known about the stage of intellectual and other biological, emotional, educational and social development (though perhaps these other policy decisions should also be based on more erudite consideration). A policy decision about where we set the minimum legal drinking age should be primarily based on a broader array of metrics. I present that to do otherwise is to set our children up for avoidable harm and to miss an opportunity to build a smarter, healthier, safer and more economically secure nation into the future.

To a suggest that an **increase in drinking age to 21 years will be impossible to enforce**, I respond, well, no more so in relation to those thousands of other regulations that exist, many of which are largely self -enforcing because society accepts them for their benefits to all. We once had a legal drinking age of 21 years in Australia and international evidence supports a return to this policy. Of course, many young persons will infringe as they will no matter where we set an age limit but at the population level if it likely to shift the drinking harms curve in a favourable direction. This reform will help to drive a change in the so-called drinking culture and so the stories we tell ourselves and each other in this regard will change.

As I outline in the above section on secondary supply, what caring civil societies including our own nation can do to **protect young people** who will become the adults and the leaders of our nation tomorrow, is draw effectively upon the policy levers that most influence the probability of these otherwise predictable though largely avoidable adverse outcomes, namely, the access, pricing and promotion regulatory interventions.

There is a **balance** to be found here. Parents and the adult community more generally do owe young people a duty of care to protect them from poor, indeed, life changing and potentially early life ending choices, as far as possible. Show me one caring, thoughtful and responsible parent who doesn't hold to this view. So why don't those parents respect and value the hopes, expectations and rights of other parents who trust those other parents will support them in protecting their children? Parents, adults more generally and commercial industry owe young people a duty of care, not to offer yet alone glamorize and promote 'personal choices' that are clearly highly hazardous and not to expose and even set them up for unnecessary and avoidable risk and harm, while at the same time allowing them to ease their way into independence in early adulthood, noting the developmental importance of allowing young people to explore their relationship with the world as they mature and the implausibility and potential opposite risks of wrapping our children up in cotton wool.

These arguments hold true for drinking alcohol in the particular. As parents, as adults in commercial product development, promotion and sale, as adults in politics and as adults in other opinion leading and policy decision-making positions, I present we all have duty of care obligations to protect and promote the very best interests of all our children and their future through appropriate pubic (alcohol) policy reform.

Given all of the scientific evidence and analysis, sensible public policy would have us legislate to make all primary and secondary supply of alcohol to minors unlawful. I make this observation not based on evidence that such a policy reform will *in isolation* have a substantial impact in reducing drinking among young people but rather, as a basis for resetting social norms related to youth drinking and providing clear guidance and social and legal support to parents in upholding their duty of care to their children and young people. Government axiomatically shares this same duty of care.

Recommendation 8: that the National Alcohol Strategy (2018 – 2026) make specific reference to a commitment by each of the States and Territories to legislate to prohibit all secondary supply of alcohol to young people under the age of 18 years, buttressed by a sufficiently carefully designed and well-funded social marketing strategy to inform and engage with the people of Australia as to why this is so important.

Priority 2: Managing availability, price and promotion

Priority two: managing availability, price and promotion highlights key evidence related to what contributes to the occurrence and what works in reducing alcohol-related harm. This is the most important section of the document. The draft NAS (2018-26) does not accurately reflect what is written in this section nor does it commit to action as it must if this strategy is to have any impact on public health, public well-being and public safety in Australia into the future. The document needs to be revisited to ensure each point that is included in this section is addressed with an appropriate strategy for which there is not an optional menu but rather, a commitment to act, cross-referencing which area of government, department(s) and agencies are responsible and accountable for implementation and in accordance with what timeline. Also, the document must identify the continuous monitoring, evaluation and reporting requirements that are to be established.

Recommendation 9: that the National Alcohol Strategy (2018 – 2026) is rewritten to ensure each and every point that is included in the section on managing availability, price and promotion is matched with an appropriate strategy, cross-referenced to the area of government, departments and agencies that are to be held responsible and accountable for implementation, including timelines, continuous monitoring, evaluation, reporting requirements and specific accountabilities. Alternatively, that an accountable operational plan be written to ensure these ends are achieved.

In the indicators of change, under the subheading schoolchildren, I suggest the indicator should not be proportion of school students (aged 12 to 17) who drank more than four drinks on one day in the past seven days as this sets a very high threshold for concern. More sensitive metrics of risk and concern ought to be set, including what proportion consuming any alcohol in the last seven days. I comment further on data, monitoring and evaluation later in this response.

Recommendation 10: that the Indicators of change in drinking behaviours as they relate to school children be reviewed and amended to include more sensitive indicators of risk and therefore concern, including the proportion consuming any alcohol in the last seven days by way of example.

Advertising, Promotion and Sponsorship

This draft strategy does not pay adequate attention to advertising, promotion and sponsorship, nor political lobbying and political donations and what the evidence informs us needs to change.

There is comment on **page 17** that the strategy recognises the opportunity to strengthen the codes in operation of **social media and digital marketing** to reduce the exposure of alcohol advertising to young people.

The *Alcohol Advertising Review Board* (AARB), McCusker Centre for Action on Alcohol and Youth, Curtin University experience...

> *…highlights how unethical the industry has become in reaching and using entirely inappropriate social media methods to encourage young people to drink and to drink for inappropriate reasons and in dysfunctional, hazardous and harmful contexts and ways.*

It is fanciful, indeed implausible to suggest that we can protect children and adolescents from alcohol advertising and promotion in isolation of adults and in any case, a strategy of attempting to isolate young persons from advertising can only strengthen the image they have that drinking is **'so adult'** and further encourage them to want to drink like adults do. Any attempt to do so simply increases the attractiveness and potency of the message signalling that drinking is a **rite of passage** for young people turning whatever age is deemed the legal drinking age.

I also recommend amending this section to state, exposure of all Australians to alcohol advertising not just children, noting the evidence and modelling studies in support of complete advertising bans.

In related reviews, Booth et al. (2008) conclude that there is conflicting evidence concerning the effectiveness of restricting alcohol advertising. They found no substantive evidence supporting the effectiveness of counter-advertising — media presentation of factual information and persuasive messages (Agostinelli and Grube, 2002). The authors' note that the volume of counter-advertising used to date has been tiny compared to pro-alcohol advertisements (in Babor et al, 2010).

Many countries are now subject to unprecedented levels of exposure to sophisticated marketing, through traditional media (e.g. television, radio and print), new media (e.g. internet and cell phones), sponsorships and direct promotions, including branded merchandise and point-of-sale displays …Evidence shows that exposure of young people to alcohol marketing speeds up the onset of drinking and increases the amount consumed by those already drinking… Marketing contributes undoubtedly to the ongoing recruitment of young people to replace older drinkers and to expand the drinking population in emerging markets…The extent to which effective restrictions would reduce consumption and related harm in younger age groups remains an open question. The most probable scenario, based upon the theoretical and empirical evidence available, is that extensive restriction of marketing would have an impact (Babor et al, 2010).

Complete marketing bans are rarely implemented, so their evaluation depends mostly on modelling studies. These estimate that advertising bans represent one of the most effective and cost-effective approaches to prevention and health improvement, with the level of effectiveness decaying as the policy moves from a complete to a partial ban (Burton et al, 2017).

Although the evidence is limited by the relative lack of research, it is likely that a total ban on the full range of marketing practices could affect drinking by young people, particularly if diversion of the promotional spending to other channels were blocked.

There is no evidence that the alcohol industry's favoured alternative to marketing restrictions—voluntary self-regulation—protects vulnerable populations from exposure to alcohol advertising and other marketing practices … Three reviews have demonstrated considerable violations of content guidelines within self-regulated alcohol marketing codes, suggesting that the self-regulatory systems that govern alcohol marketing practices are not meeting their intended goal of protecting vulnerable populations (Burton et al, 2017).

Marketing is a commercial strategy with the goal of increasing the market size and share for a product. This is achieved by initiating sales from new consumers and away from those of rival products, and by increasing the frequency of purchase and driving brand

preference…. Short-term aggregate measures of advertising elasticity report that for each 10% increase in advertising expenditure, there is a 0.3% increase in adult consumption…. These studies report consistently that exposure to alcohol advertising is associated with an increased likelihood that children will start to drink or will drink in greater quantities if they already do … People who start drinking early are more likely to become binge and problem drinkers, and underage drinking is associated with educational problems and violent behaviour …. Watershed bans can protect young children from exposure to TV alcohol advertising, but more effective measures are required to protect teenagers with later bed times…. To date, no research has evaluated the impact of banning sports sponsorship, despite it resulting in a considerable number of children being exposed (in Burton et al, 2017).

A substantial and growing body of research literature has found that youth exposure to alcohol marketing is associated with increased likelihood of drinking initiation, and with increased alcohol consumption among young people who have already begun to drink (in Gilmour et al, 2016).

There are so many ***loopholes in the advertising code****. It is through advertising that the alcohol industry seeks to engage with the community, normalise and otherwise shape a culture that is* ***focused on drinking at every socialisation****.*

The WHO (2010) identifies advertising bans as among the alcohol policy control **best buys**. Doran at al (2008; 2013) also identify bans as among the most cost-effective policy levers available to governments seeking to reduce alcohol related harm.

The most effective and cost-effective approach to reducing alcohol marketing exposure among populations is a total ban on alcohol marketing, which is relatively easy to implement, except when it comes to digital media that cross-national borders (Gilmour et al, 2016).

In relation to a **single national advertising code** which covers placement and content across all media which provides consistent protection of exposure to minors regardless of programming, I respond once again that this national strategy should identify as a longer-term goal, to ban all advertising, promotion and sponsorship as in a number of European countries and in alignment with the evidence and the priorities identified in the WHO global alcohol strategy (2010). That said, perhaps as an interim measure, a single national advertising code could be struck, noting that we would need to transition in a carefully managed way to complete alcohol advertising bans if there were agreement to do so.

As mentioned in the Australian National Preventative Health Task Force final report on alcohol advertising…

…the voluntary (self-regulatory) ***Alcohol Beverages Advertising Code*** *(ABAC) Scheme has failed our nation and cannot continue.*

Claims made by industry that its positive contribution should be acknowledged cannot be taken seriously and do not merit the respect of a response.

Despite industry claims that they adhere to codes of responsible advertising, the detrimental influences of exposure to marketing messages are not addressed adequately

by the voluntary codes on the content of alcohol advertisements adopted by the industry under a self-regulation approach. Self-regulation by means of industry voluntary codes does not seem to prevent the kind of marketing that has an appeal to younger people… The evidence demonstrating the impact of current levels of marketing on the recruitment of heavier-drinking young people suggests the need for a total ban to restrict exposure to alcohol marketing, one that is able to cross national boundaries (Babor et al, 2010).

Three reviews have demonstrated considerable violations of content guidelines within self-regulated alcohol marketing codes, suggesting that the self-regulatory systems that govern alcohol marketing practices are not meeting their intended goal of protecting vulnerable populations (Burton et al, 2017).

Placements of alcohol advertising on free to air television is regulated primarily through the Children's Television Standards of the Australian Communications and Media Authority (ACMA) and the Commercial Television Industry Code of Practice (CTICP), a co-regulatory industry code registered by ACMA. While current standards restrict alcohol advertising to certain times with a stated objective of ensuring children and adolescents are not exposed to alcohol advertising, a loophole allows alcohol advertising to be broadcast during sports programs in children's viewing hours at the weekends and on public holidays (O'Brien et al, 2015). Health professionals and public health advocates ask – how did this come about and why and how has it been allowed to continue?

There is good evidence showing that exposing young people to alcohol advertising increases the likelihood that they will see alcohol in a positive light and begin drinking, drink more often and drink more heavily if they have already commenced drinking (e.g. Anderson et al, 2009; Smith & Foxcroft, 2009; Jernigan et al, 2016).

As an interim measure, a code similar to the one set out in the *Alcohol Advertising Review Board*, would be a good start. The AARB was established at Curtin University in Western Australia in response to the clear failings of the ABAC and has also identified the policy failures associated with the ABAC industry self-regulatory approach (see PowerPoint presentation for more detail). The ABAC is serving no useful purpose in regulating the alcohol industry and its aberrant commercial behaviours and once again, should be dismantled. The following table demonstrates the reasons for concern among health advocates about the non-interventionist and effectiveness performance of the ABAC when compared to the AARB.

At this point I can foresee commentary that moving towards complete advertising bans like those applying to tobacco is 'not politically feasible' to which I would respond, unless and until it becomes politically feasible, we will continue to short change the Australian people and fail to meet our duty of care to protect their common best interests and our collective best interests as a nation. We will continue to allow the alcohol industry to offer, seduce and manipulate the population to make unhealthy, unsafe and often life shortening 'personal choices'. I cannot be clearer in this observation.

Under **Priority 2 on Page 17** it is observed that:

"The relationship between alcohol advertising and sponsorship of sporting events is another issue of concern in considering exposure of young people to alcohol advertising, and one that the current arrangements do not address".

	AARB 2015 – 16	ABAC 2015 Annual Report
Complaints received	194	133
Number of ads these complaints referred to	135	71
Number of complaints considered by the Panel	143	35
Determinations by the Panel	110	29
Determinations that upheld complaints (at least in part)	108	8
Determinations that dismissed complaints	2	21[1]

- AARB, 2017

It is very simple. Evidence shows a direct relationship between consumption and harm. Like other industries, the alcohol industry is actively engaged in strategically designed practices to increase consumption, but alcohol is no ordinary commodity (Alcohol and Public Policy Group, 2010).

The Consultation Draft NAS (2018-26) makes the confused observation that controls on alcohol promotion "present challenges for governments to implement due to the conflicting needs of disparate stakeholders" and that there is a need to balance these conflicts. This comment must be removed from the final document of it is to have any credibility as there can be no "balancing" the interests of public and population health with the commercial interests of industry. Australian governments cannot fly the flag of policy reform for national health improvement at "half-mast" and expect good outcomes.

The alcohol industry cannot be allowed freedom to advertise and promote increased consumption of its products to maximise profits as it wishes, when the national goal is to reduce per capita consumption and to reduce dysfunctional, hazardous, harmful and unsanctioned drinking in order to prevent and reduce alcohol-related harm and improve our nation's health and social well-being.

The population health and commercial goals of industry are mutually incompatible. We need to remind ourselves as a nation that moral compass and social justice arguments are powerful and that moral frameworks form the glue of any civil society.

Several European countries have or are taking steps towards eliminating all alcohol sponsorship (WHO, 2014). A first step in moving towards a complete ban on alcohol promotion and sponsorship in Australia would be to develop a strategy with specific timelines to **strongly regulate all advertising and promotion** with a view to ultimately removing all advertising, promotion and sponsorship from **sport**, given its inconsistency with the important health benefits of sport and of activity more generally and given its non-beneficent aims and influence on young people and indeed, Australian society more generally. Industry has had its chance and in truth, industry has become more proactive and brazen in continuing to target young people though various avenues including social media (AARB, 2018). As we have observed over many decades, no reliance can be placed on industry self-regulation (End Advertising in Sport, 2018). Nationally consistent legislation will be required that includes heavy financial penalties and public communication of all breaches. This will in turn require well informed and strong political will and commitment to health as a national priority, though it is not clear where that political leadership will come from.

Our governments are either insufficiently bold or too influenced by the alcohol industry to follow the evidence on these key issues. The public health approach also serves to emphasize that alcohol harm is not just about the small minority of dependent drinkers. (Gilmour et al, 2016).

Hypothecated Taxes

Under **Priority 2 on Page 18** it is observed that an:

"opportunity for action" is to…"direct revenue from alcohol taxation towards preventative health activities (including a focus on alcohol-related harm) and alcohol and other drug treatment services."

History has shown that governments do not favour **hypothecated taxation**. While those working in ATOD sector and in public health more broadly would welcome a decent hypothecated tax to fund the industry's unpaid bills (the 'economic externalities') and while investing to treat alcohol-related societal harm is morally proper, prevention will come primarily from policy reform in the WHO 'best buys' rather than funding specific community actions or even treatment.

Good Sports Program

The Consultation Draft NAS (2018-26) mentions the **Good Sports Program** (GSP). I have had some involvement with the Good Sports Program in Tasmania and many years ago had a significant and professionally rewarding involvement providing medical support as Club Doctor, to a QAFL club. That experience alerted me to the counterproductive influence of the alcohol, gambling, tobacco and unhealthy food industries on the behaviour and decision making of club officialdom and on the health and well-being of young people engaging it what should otherwise have been a safe and healthful experience.

A research evaluation of the Good Sports program (Kingsland, 2015) found reductions in risky drinking and alcohol related harm in sporting clubs adopting the program while membership increased in sporting clubs that implemented the highest level (3) of the program (Crundall, 2012). Based on these promising evaluations and noting the perversity of alcohol's adverse influence on sport, the Good Sports Program merits continued policy and government funding support, with further adequately funded evaluation.

Recommendation 11: that the National Alcohol Strategy (2018 – 2026) be amended to include a commitment to an independent review of the international literature on the effectiveness of various approaches for tightly regulating alcohol promotion, with a view to developing a legislative framework and plan for phasing out all alcohol advertising, promotion and sponsorship.

Priority 3: Supporting individuals to obtain help and systems to respond appropriately

Priority three: supporting individuals to obtain help and systems to respond appropriately identifies Australia's obligations under the United Nations sustainable development goal 3.5. It also identifies the importance of engaging the primary care sector in identifying and treating people with

alcohol-related problems. There is mention of early and opportunistic brief interventions as part of frontline service providers and health professionals' roles, working in hospital settings. This is supported.

There is mention of the importance of building capacity and capability of the **treatment** service system which is all very positive and supportable, though the devil is in the detail, noting that governments have favoured delegating responsibility and outsourcing treatment to the non-government and private sectors often in the absence of attention to detail including ensuring appropriate **workforce** and **organisational standards** (knowledge, skills, qualifications, scope of practice, safety, mechanisms to ensure good clinical governance etc.), and technical capability and willingness to invest in meeting these standards, is achieved.

So often across our nation, the complex assessment and care needs of people with alcohol and other drug problems are delegated to ('less expensive') **non-government organisations** which usually don't have any in-house medical or nursing capability (though they may sometimes engage GPs on a sessional basis) to assess and safely manage the biological and pathophysiological factors and may not have appropriately trained and qualified allied health professionals on staff to deliver contemporary **psychosocial** interventions.

Alternatively, responsibility for the delivery of treatment may have been shifted to the **primary health** setting but without the necessary health care funding structure, training, clinical governance and specialist multidisciplinary health professional support are provided to deliver key **non-medication** focused **multi-modal** interventions that we know, are also essential when treating people with substance use disorders and other complex 'human problems'.

In a study undertaken to determine the percentage of health care encounters at which a sample of adult Australians received **appropriate care**, it was estimated that:

> *Adult Australians in this sample received good care in 57% (95% CI, 54%–60%) of 35,573 eligible health care encounters. Compliance with indicators of appropriate care at condition level ranged from 13% (95% CI, 1%–43%) for **alcohol dependence** to 90% (95% CI, 85%–93%) for **coronary artery disease**. (Runciman et al, 2012)*

This low estimate for the delivery of appropriate treatment of alcohol dependence ought to be ringing alarm bells for us all.

Improving **health literacy** is also touched upon in the Consultation Draft NAS (2018-26) though we haven't really made a good fist of this as a nation in relation to alcohol specifically or in relation to health more generally. The community does not generally understand the principles, practices and findings of scientific process or of epidemiology and biostatistics and it is apparent that neither do many policy decision makers.

> *Parents will often not know or not fully comprehend (or accept) the magnitude of increased risk to their children in relation to drinking, particularly if they themselves have been deeply enculturated into an industry promoted social norm of drinking as a core part of their every socialization or if they have an emerging or well-established alcohol use disorder.*

Even if parents do understand the evidence of risk, they may not recognise they can and should say 'no' to their children and to other adults who may offer to 'supervise' their adolescent child's

drinking. They may not fully appreciate that drugs and in particular alcohol, have more significant biological and behavioural effects on young people when compared to adults, both acutely and longer term.

*To this I add the importance of **health policy literacy**, which is equally poor, not only in the Australian community but also apparent and perversely so, among many working in public administration and in our parliaments where health policy is debated and decided.*

Foetal Alcohol Spectrum Disorder (FASD)

In the matter of **Foetal Alcohol Spectrum Disorder (FASD)**, I note emphasis on improving its diagnosis and clinical management but no real focus on prevention. This signals an ineffectual strategy in this regard. While **pregnancy** related **health warnings** on alcohol beverage labels may be one appropriate, targeted strategy to address FASD, I make the point that reducing overall population consumption including overall consumption among women of child bearing age in combination with actions targeting specific risks are likely to have a more significant population level impact.

*I point yet again to the highly lamentable behaviour of the alcohol industry which has publicly signalled its **strategic intention to target young women**, identifying them as a 'lost opportunity' from a commercial perspective.*

*"**LADIES, it's time for frothies over coffees**. That's the message from Carlton United Breweries, which has admitted it has neglected women in the past and now wants them to start sipping on the liquid gold. As beer sales continue to fall, the brewer will target females in a bid to persuade them that beers are not just for blokes and can be as classy as holding a glass of champagne or an espresso martini. CUB's Jeremy Griffith said the brewer now wanted more women to start enjoying beer, admitting it had got it wrong with its advertising that he described as "irrelevant" and "unappealing" to females. "We've seen a decline in beer consumption more broadly over the last few decades and we know that is partly due to the industry only talking to blokes and ignoring opportunities to talk to women as well," he said.*

Women called to join the shout

CHEERS TO BEER: Emily Schulz from South Yarra and Oliva Joel from Flinders have a coldie.

ALEKS DEVIC

LADIES, it's time for frothies over coffees.

That's the message from Carlton United Breweries, which has admitted it has neglected women in the past and now wants them to start sipping on the liquid gold.

As beer sales continue to fall, the brewer will target females in a bid to persuade them that beers are not just for blokes and can be as classy as holding a glass of champagne or an espresso martini.

It comes as figures showed beer was the drink of choice on Australia Day and one of the biggest selling days of the year with sales estimated to hit $300 million in the lead up, falling just behind Christmas and Boxing Day.

CUB's Jeremy Griffith said the brewer now wanted more women to start enjoying beer, admitting it had got it wrong with its advertising that he described as "irrelevant" and "unappealing" to females.

"We've seen a decline in beer consumption more broadly over the last few decades and we know that is partly due to the industry only talking to blokes and ignoring opportunities to talk to women as well," he said.

Beer drinkers in Victoria and New South Wales and Queensland prefer premium and contemporary beers, which are easier to drink and less bitter, while those in South Australia prefer lighter brews and drinkers in Tasmania are your "classic types, according to CUB.

Aussies are spoiled for choice when it comes to their favourite brew with 1700 beer brands on the market, compared with 500 a decade ago

Young women who are of **childbearing age** will not necessarily know that they are pregnant until well into the first trimester and the alcohol industry has told us that it is wittingly and strategically acting in ways to encourage young women to drink and to drink more, potentially harming two generations, the young pregnant woman who continues drinking in the first trimester and often beyond and their unborn babies. Even when aware of their pregnancy, as the draft NAS (2018-26) points out, far too many women continue to drink and in ways that present a very real risk to their unborn babies. Such is the influence on the drinking culture created, shaped, reinforced and enabled I present by the alcohol industry, through its substantial investments in advertising, other forms of promotion and sponsorship. Of course, **partners**, family and friends can also influence the decision of women of child bearing age and those who become pregnant, to drink, but we must ask, why? Well, they are also influenced by upstream public policy and commercial practices.

Johnnie Walker also at it – 'embracing the feminine side to woo women drinkers'

Around 1 in 2 women report consuming alcohol during their pregnancy, with 1 in 4 women continuing to drink after they are aware they are pregnant. Of these women, 81% drank monthly or less with 16.2% drinking 2–4 times a month (AIHW, 2016).

*The Consultation Draft NAS (2018-26) pays no serious attention to **upstream strong regulation** of the alcohol industry and its **less than socially responsible commercial behaviours** which as we see (news clips above), are brazenly telegraphed.*

Indeed, it is difficult to imagine a less socially responsible commercial approach than the above items highlight. This was at a time when the industry's poor response to adopting health warnings on drinking and pregnancy was being discussed by health advocates and the media.

What is the point of investing in health literacy for young women or other strategies that place the onus of responsibility on their drinking decisions while our nation's policy decision makers allow industry to take no responsibility for its commercial choices and do as it pleases in attempting to persuade and manipulate the 'young Australian female market' to 'drink up'? To this observation I beg the question – are our policy decision makers in public administration and in our parliaments making good 'policy choices' and demonstrating responsibility for their policy choices?

Nowhere in the Consultation Draft NAS (2018-26) do I see any attention to this detail or a strategic intent to address the commercially irresponsible behaviours of the alcohol industry actively seeking to increase drinking amongst young women. This is a critical but seldom mentioned elephant in the room.

Where more important a place to start in seeking to reduce the incidence of FASD than legislating to prevent the alcohol industry and retailers from endeavouring to persuade, encourage and seduce women of child bearing age to drink?

This problem demands a structural solution to a structural problem of allowing disingenuous, vested, uncaring industry behaviour. Industry has in effect made the case that it is the responsibility of young women to make the right, safe and healthy choices for themselves and for their unborn babies in the face of its heavy weight counter punches, and if they do yield to industry 'choices' and promotions and make the wrong decisions, this is not the responsibility or fault of industry.

This case elegantly demonstrates the faulty thinking that lies behind **permissive public policy** that exposes members of the community to the commercial interest first behaviour of the unhealthy commodity industries. It demonstrates perfectly the basis for the observation of Moodie and colleagues (2013) that:

> *…the only thing that works in prevention is public regulation and market intervention and the reality that primary responsibility for protecting and promoting the best interests of the Australian public rests with government in regulating an often-maverick industry.*

The alcohol industry's commercial behaviour here exemplifies the disingenuous nature and inconsistently applied neoliberal ideology favoured by some sectors of commercial industry, political actors and others.

If policy decision makers are serious about preventing and reducing the incidence and prevalence of FASD in Australia, they must support a national alcohol strategy that focuses on the primary upstream determinants of dysfunctional, hazardous, harmful and unsanctioned drinking among females of child bearing age, rather than on downstream strategies such as education and warning labels that place unrealistic expectations of women to remain impervious to social pressures and to the commercial strategies of industry that are so clearly designed to oppose and overwhelm otherwise healthy citizen choices.

Recommendation 12: that the National Alcohol Strategy (2018–2026) name up a commitment to legislate at an early stage of the life of this strategy so that it becomes unlawful for the alcohol industry to in any way advertise and promote the uptake of drinking, drinking of specific brands and products and increase drinking among female adolescents and women of child bearing age, as a prelude to more comprehensive bans of alcohol advertising and promotion, with monetary penalties that match the seriousness of any breaches.

Alcohol Industry Interference in Public Policy

In the first draft of the NAS (2018-26) released in 2017, there was mention that the *'Australian alcohol industry needs to actively support and promote responsible consumption among adults, and minimise the advertising exposure of children to contribute to the reducing alcohol-related harms'* My written response was that industry should never be requested, expected or allowed to promote anything related to alcohol control policy or intervention including 'responsible consumption'. Industry's view of 'responsible drinking' is not aligned with the evidence (e.g. NHMRC, 2009) and erudite analysis. I further commented there should be no reference to the contribution of industry to reducing Australia's alcohol-related harm in the final NAS because industry has a commercial interest in maximising its sales and history has taught us that it is unable and unwilling to act in the public interest. It is a meaningless and implausible, indeed, unwise statement.

Page 24 of the current Consultation Draft NAS (2018-26) states that:

"Australia does not support any ongoing role for industry in setting or developing national alcohol policy".

Health professionals and advocates across our nation will strongly support and endorse this statement. However, it remains evident that elected representatives neither understand nor accept that view and should this disconnect between the evidence and the advice of public health experts continue in the context of completing and implementing the NAS (2018-26), the strategy will fail.

I reiterate the importance of elected representatives and those working in all relevant areas of public administration grasping and accepting this advice.

The WHO has repeatedly communicated that the alcohol industry has no role in the formulation of alcohol policies and that such policies must be protected from distortion by commercial or vested interests.

¨"The challenge for industry (as it sees it) is to exploit markets, especially in countries with low & middle incomes, and increase profits … The alcohol industry will continue to affect policy by encouraging ineffective policies" (Beaglehole & Bonita, 2009).

It is salient to note that in a paper published in 2017, Freeman and colleagues address themselves to the issue of whether tobacco and alcohol companies should be allowed to influence Australia's National Drug Strategy. They observe as follows:

- *The NDS goals are at odds with the commercial agenda of industries that support regulatory stagnation, **oppose and undermine effective action**, ignore and distort evidence, and **prioritise profits over health***
- *Commercial interests of tobacco and alcohol corporations to maximise profits mean that they are effectively required to **oppose public health measures** that would affect their bottom lines*
- *This raises the question of why representatives of **addictive industries** – whose commercial interests are diametrically opposed to the aims and objectives of public health – are given equal standing with others in contributing to governmental policy processes aimed at minimising the harm caused by their products*
- *As the NDS consultation document notes, 15 000 deaths each year result from tobacco use, and 3000 deaths and 65 000 hospitalisations were attributable to alcohol consumption in 2004–05*
- *Combined costs to Australia in 2004–05 were $46.8 billion – 83.5% of the total cost to the nation of all drug use in the country*
- *There is a strong global history of the tobacco industry exercising undue influence on governments, resulting in weak and delayed tobacco control policy reforms*
- *Allowing the tobacco industry to participate in government processes – in this case through a closed submission to the NDS consultation process – could possibly be in violation of the WHO international FCTC*
- *A more appropriate and effective approach would be to prevent these industries from influencing the formulation and development of public health policies and programs*
- *Strategies favoured by conflicted industries, such as self-regulation and public–private partnerships, are globally recognised as weak and unproven in protecting public health.*

Consistent with these observations and as I have already outlined in this submission, the alcohol industry continues to engage in activities designed to deny, negate and oppose those policies and strategies that the evidence shows will work best in preventing and reducing dysfunctional, hazardous, harmful and unsanctioned drinking while promoting those approaches that they know are ineffective (e.g. 'more alcohol education' and 'individual responsibility for making the healthy choices'), through political lobbying, political donations and well-funded counter evidential marketing through mainstream and social media.

Once again, the WHO has pointed time and again to the importance of excluding the alcohol industry (like the tobacco industry) from the public policy decision making and planning table and any other avenues of policy interference. The previous Director General of the WHO, Dr Margaret Chan, observed that "*In WHO's view, the alcohol industry has no role in formulating policies, which must be protected from distortion by commercial or vested interests"* (Chan, 2013).

> *Despite clear evidence of the major contribution alcohol makes to the global burden of disease and to substantial economic costs, focus on alcohol control is inadequate internationally and in most countries. Expansion of industrial production and marketing of alcohol is driving alcohol use to rise, both in emerging markets and in young people in mature alcohol markets. Cost-effective and affordable interventions to restrict harm exist, and are in urgent need of scaling up. Most countries do not have adequate policies in place. Factors impeding progress include a failure of political will, unhelpful participation of the alcohol industry in the policy process, and increasing difficulty in* ***free-trade environments*** *to respond adequately at a national level. An effective national and international response will need not only governments, but also non-governmental organisations to support and hold government agencies to account. International health policy, in the form of a Framework Convention on Alcohol Control, is needed to counterbalance the global conditions promoting alcohol-related harm and to support and encourage national action (Casswell and Thamarangsi, 2009)….*
>
> *Alcohol is a major risk factor for burden of disease, and countries are estimated to spend more than 1% of their gross domestic product (adjusted by purchasing power parity) on economic costs attributable to alcohol relative to these harms, alcohol is not high on the global health agenda and, unlike tobacco and illicit drugs, no international policy is in place. The role of vested interests in subverting development of an effective public health response to alcohol-related harm is similar to that of tobacco. Cost-effective interventions exist and are focused on total populations; these interventions control availability, affordability, marketing of alcohol, and driving while under the influence of alcohol. Some national governments have implemented effective policy, but in most governments a strengthened response is urgently needed. Implementation needs multisectoral activity driven by national governments, but also including local governments and community-level responses. The WHO, other international agencies, and the non-governmental organisation sector are showing raised concern and engagement with alcohol harm and alcohol-control policy. An international health response to reduce harm from alcohol—a* ***Framework Convention for Alcohol Control****—is needed to spur national action and enable collaboration and negotiation on international and regional issues (Casswell and Thamarangsi, 2009).*

There are very good reasons for concern about ***political donations*** *from the unhealthy commodity industries including the alcohol industry. Such*

donations are clearly incompatible with objective policy decision making that is in the best interests of public and population health.

We cannot continue to allow the alcohol industry, alcohol interest groups and organisations closely aligned with the alcohol industry such as *Drinkwise* to influence health policy if we are to move forward and address the serious health and social consequences arising from alcohol consumption. An effective national alcohol strategy and its operational plan and implementation will address these structural anomalies. This will require genuine good governance.

The implementation plan will need to signal a clear intention and operational plan adopted by governments (Commonwealth, States and Territories and local government) to address the fundamentally critical structural errors that are contributing to wide ranging alcohol-related harm that are so evident in the Australian community - through evidence based public regulation and market intervention.

In the absence of adequate attention to operational detail, and in particular in the absence of revised, efficient and effective governance processes that support Commonwealth, State and Territory policy decision makers to act in accordance with the evidence and in a coordinated and integrated manner, this draft national 'blueprint for action' is unlikely to measurably improve our nation's health, safety and prosperity during its life time.

Recommendation 13: that the National Alcohol Strategy (2018 – 2026) include a commitment to the regulation of alcohol industry political lobbying and political donations with a view to ultimately eliminating these commercial strategies for influencing alcohol policy in Australia.

Recommendation 14: that the National Alcohol Strategy (2018 – 2026) firmly commits Australian National, State and Territory and Local) governments to a review of the contexts, decision making structures, processes and manner in which elected representatives and political parties draw upon relevant high level evidence and expertise to arrive at and commit to policies and strategies that will reduce dysfunctional, hazardous and harmful drinking (as defined by the WHO, 1981) in the Australian community, with all the positive health, social and economic benefits this will bring.

Making Treatment More Available & More Accessible

The Drug and Alcohol Service Planning Model (**DASP**), previously referred to as the Drug and Alcohol Clinical Care and Prevention model (**DA-CCP**), is a planning tool available to governments to determine the level of need for drug and alcohol treatment services across Australia. This tool was commissioned early in 2010 by the Ministerial Council on Drug Strategy (MCDS) through the Inter Government Committee on Drugs as a project under the cost shared funding model (CSFM). The Mental Health and Drug and Alcohol Office within the NSW Department of Health was the lead agency. This tool was never endorsed by the MCDS, it has been suggested largely because State and Territory governments did not wish to commit themselves to a tool that would identify how far short they are in their investments in the drug and alcohol treatment sector. That there is no formal reference to this work that researchers and other can quote, underscores the problems associated with alcohol tobacco and other drugs governance in Australia.

That said, several jurisdictions have subsequently undertaken a body of planning work utilizing this modeling tool and with the support of State and Territory Health Departments and a range of peak bodies, Ritter and colleagues undertook an 'independent report', though attributing all

conclusions to the researchers alone. Once again, that action in itself appears to say something very important.

Use of the DASP tool led Ritter and colleagues to conclude that every year approximately 200,000 Australians are able to access drug and alcohol treatment. However, the researchers estimated that an additional 200,000 to 500,000 Australians are **unable to access the treatment** they need, annually (Ritter et al, 2014).

Our research estimated that approximately 200,000 people receive AOD treatment in any one year in Australia (Chapter 7). At the same time, modelled projections of the unmet demand for AOD treatment (that is the number of people in any one year who need and would seek treatment) are conservatively estimated to be between 200,000 and 500,000 people over and above those in treatment in any one year This has significant implications for treatment planning and purchasing (Ritter et al, 2014).

The researchers pointed out that treatment is **cost effective** and saves government more than it costs them when investing in effective interventions. One estimate is that for every $1 invested in drug and alcohol treatment, society gains $7 (Ettner et al, 2006).

The question arises, what specifically are we intending to do as a nation to make treatment more accessible, effective, grounded in evidence; building a well-trained, qualified workforce, and ensuring treatment is affordable, accessible, attractive and engaging?

Strategic documents have signalled an intention to address these shortfalls for several decades now and when such words are repeated in this way in the absence of appropriate policy responses, they run thin and lose credibility.

*The findings of Ritter et al (2014) highlight the importance of building the **clinical** and **policy capacity** and **technical capability** of the alcohol, tobacco and other drugs sector and the need for a national health workforce strategy (i.e. broader than a workforce development approach).*

We have been saying that we need to invest in **workforce development** since a two volume white covered National Campaign Against Drug Abuse (NCADA) funded report was released in 1987 following the work of a NCADA appointed working group, identifying the need to build drug and alcohol related policy and technical capability and capacity to support the wide ranging health and human services workforce that inevitably engage with citizens with substance use problems, and the need for an overarching national strategy. We are yet to properly complete this important body of work and so many persons working in the ATOD sector remain under-qualified, under-trained and under-skilled. Notwithstanding, successive governments have been happy to continue purchasing drug and alcohol services on the cheap from often under skilled organisations.

Treatment is included in the ten point **WHO Global Alcohol Strategy (2010)** though it is not one of the three best buys. Treatment is as mentioned, cost effective and it has a very important role to play in a compassionate caring society though it is to be acknowledged that treatment has a lesser impact in preventing and addressing population level harms arising from dysfunctional, hazardous, harmful and unsanctioned drinking (WHO, 1981) than the *Best Buy* public policy reforms discussed above. Treatment impact will also be limited in its prevention impact because only a small proportion of people with established alcohol problems present and are able to access quality

treatment and an even smaller minority who drink in 'risky' ways, contexts and quantities and those with early alcohol problems, receive at least a brief intervention following health screening activity in primary care and sustained effect sizes for discontinuing dysfunctional, hazardous, harmful and unsanctioned drinking are at best modest among those who do receive such clinical intervention. This is important given the high prevalence and widespread occurrence or dysfunctional, hazardous, harmful and unsanctioned drinking in the Australian community.

Sadly, over many decades governments have not only failed to act upstream in addressing the causal chain of alcohol-related harm through these best buy policies (price, access and promotion), they have also failed to seek and heed expert advice for clear direction in providing high quality downstream treatment services to help those who are harmed by this drug. We would not tolerate this as a society for almost any other area of healthcare, for example, in cardiology.

> *Alcohol treatment services have good evidence of effectiveness, but they can be expensive to implement and maintain, with the exception of mutual help organizations. At the population level, their impact is limited relative to other policy options, as full treatment for alcohol problems can benefit only those individuals who come to treatment. Nevertheless, these programmes have the potential to impact the heaviest drinkers in a society, and could lower population levels of alcohol consumption and harm if they could be disseminated widely…Regarding the clinical management of non-dependent high-risk drinkers, the cumulative evidence shows that brief interventions, consisting of one or more sessions of advice and feedback provided by a health professional, can produce clinically significant reductions in drinking and alcohol-related problems. Despite evidence of the benefits of brief interventions, it has been found difficult to persuade practitioners to deliver such care… In most comparative studies, out-patient and residential programmes produce comparable outcomes. The approaches with the greatest amount of supporting evidence are behaviour therapy, group therapy, family treatment and motivational enhancement … Despite advances in the search for a pharmacological intervention that could reduce craving and other precipitants of relapse (alcohol-sensitizing drugs, medications to directly reduce drinking and medications to treat co-morbid psychopathology), the additive effects of pharmacotherapies have been marginal beyond standard counselling and behaviour therapies (Babor et al, 2010).*
> *Primary health care is the most extensively studied setting for the evaluation of IBA (Identification and brief advice), and reviews and meta-analyses consistently report that IBA reduces hazardous and harmful consumption at 6 months and 12 months (Burton et al, 2017).*

ATOD Treatment should certainly be bolstered though I recognise that in the absence of evidence-based policy attention upstream, it is an almost futile response (we will always be 'chasing our tail'). The present absence of government commitment to both ends of the cause and effect equation signals a society that is unwilling to think carefully about and commit to that which is in its citizen's best individual and collective interests. A caring Australian society would do both – invest in evidence based public policy reform for prevention and invest in helping those who are affected adversely by this drug.

When considering how we might improve access to drug and alcohol treatment, it is relevant to consider theoretical constructs including the taxonomy of treatment '**need'**. By way of example, **Bradshaw (1972)** discusses the differences between 'normative need', felt need', 'expressed need' and 'comparative need' while **Culyer and Wagstaff (1993)** explore four definitions of equality in healthcare which they argue can provide direction to governments wishing to maximise **flourishing** in the communities they serve:

i. equality of utilisation
ii. distribution according to need
iii. equality of access and
iv. equality of health

*While investing in treatment is not only the right thing to do and while it provides very good returns on investment, we will never reduce the pressures on our **emergency departments** and **hospital beds** and health **budgets** if we continue to think and act downstream as we are at present.*

The proportion of health spending by State and Territory Governments will continue to burgeon and as former Federal Treasurer Wayne Swann's report, ***Intergenerational Report, Australia to 2050, Future Challenges (2010)***, points to the reality that without a change in policy course, healthcare will ultimately consume a lion's share of State and Territory government budgets. Legitimate concerns are being expressed by economists and others that if we do not pursue evidence based public policy reform, there will be too little or 'no money left' for all other essential functions and responsibilities including education, police, conservation and environment, roads, railways and public transport, public works, agriculture and fishing, community services, sport and recreation, prisons, emergency services and so on.

Our national health resource is limited so it must be used wisely. We can ill-afford decision-makers who do not possess this knowledge and who do not demonstrate a commitment to act on this knowledge.

Recommendation 15: That the National Alcohol Strategy (2018 – 2026) commits the Australian, State and Territory governments to substantial increased investments in treatment and a drug and alcohol related sector workforce strategy, utilising the Drug and Alcohol Services Planning (DASP) tool as one among a range of tools, decision making frameworks and methods to assess and address unmet need for treatment.

Priority 4: Promoting healthier communities

Low Risk Drinking Advisories

Priority four: promoting healthier communities discusses the poor understanding and awareness among the population in relation to risky alcohol consumption. It talks about 32% of males and 9.1% of females believing they can drink three more drinks every day without putting their health at risk. These are worrisome statistics. To this I add another estimate, referenced in a parliamentary enquiry in Western Australia in 2011, that only **12%** of the Australian population could cite the **NHMRC** low risk drinking advisories. Notwithstanding this comment (with no reference that I can find), to my knowledge, we have no reliable information on what proportion of the Australian community knows and understands the current NHMRC (2009) drinking advisories yet alone their attitudes and whether and how this information influences their drinking behaviours. We should gather that information. I note that FARE has undertaken some recent research in this regard.

Most importantly and in-defensively, no action was ever taken by the Commonwealth Government to promulgate these low-risk drinking advisories when released in 2009, to ensure more general knowledge, understanding and community acceptance of these guidelines within and across the Australian population. Neither did the States and Territories to my knowledge.

When the new NHMRC guidelines are finally released, it will be important that the Australian Government and the States and Territories take decisive action to promulgate those guidelines and to ensure the community does understand and embrace the advisories and their rationale. Major investments in a carefully constructed **social marketing campaign** will be required, among a range of coordinated and integrated communications strategies. This should include attention to other specific public health risks including **drinking in pregnancy** and **FASD**. This campaign should extend to encompass the large number of medical conditions including various cancers that are causally associated with drinking (with oral cancer occurring even at one standard drink/ day), noting that the general public has a very poor understanding of these wide-ranging chronic health harms.

Recommendation 16: that the National Alcohol Strategy (2018 – 2026) commits the Australian government to an adequately designed, multifaceted and well-funded social marketing campaign and other strategies to ensure the Australian public is made aware of the new NHMRC low risk drinking advisories when released alongside clear explanation of the evidence and reasons for supporting and promoting these new benchmarks, aimed at reducing both dysfunctional, hazardous, harmful and unsanctioned drinking.

What Works in Prevention - Universal or Targeted Approaches?

*The alcohol industry naturally deeply fears the **population approach** to alcohol control policy reform and consistently protests about its inappropriateness and asserts that drinking problems affect only a small minority.*

By way of example, witness the following ill-informed or misleading statement:

> *"When government is seeking to reduce alcohol misuse it should be cognisant that population wide alcohol policies that seek to reduce total consumption in Australia will not reduce misuse but rather simply impact the majority of consumers who are already drinking in moderation... There is a growing body of evidence that targeted interventions that focus on patterns of drinking rather than total consumption are a better means of addressing harmful consumption" (Brewers Association of Australia and New Zealand, 2013).*

A most important deficit of this document is that it fails to draw upon the best available evidence on what works in prevention.

The following commentaries in the literature are relevant here:

"The market as it currently works fails our health – obesity is a commercial success and market failure...."

- Moodie et al, 2006

"Public regulation & market intervention are the only evidence-based interventions to prevent harm by the unhealthy commodity industries"

- Moodie et al, 2013

Series

Non-Communicable Diseases 4

Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries

Rob Moodie, David Stuckler, Carlos Monteiro, Nick Sheron, Bruce Neal, Thaksaphon Thamarangsi, Paul Lincoln, Sally Casswell, on behalf of The Lancet NCD Action Group

Lancet 2013; 381: 670–79 The 2011 UN high-level meeting on non-communicable diseases (NCDs) called for multisectoral action including

Moodie et al, 2013

Many of the interventions (that work) are universal measures that restrict the affordability, availability and accessibility of alcohol. Alcohol taxes and restrictions limiting the opening hours, locations and density of alcohol outlets have a considerable amount of research support. The enforcement of a minimum purchase age for alcohol is another very effective strategy (Babor et al, 2010).

Under **priority 4, page 22** of the Consultation Draft NAS (2018-26), there is comment that: "A key aspect to reducing alcohol-related harm includes effective health promotion and prevention. Messages need to be informed by the evidence, and communications **targeted to at-risk populations** and populations experiencing **disproportionate harm**."

My first comment is industry will welcome the statement that 'messages need to be informed by the evidence, and communications can target at risk populations experiencing disproportionate harm'. Industry loves a strategy that targets only those experiencing the most extreme health problems associated with their drinking particularly one that links this to 'evidence' and of course, it also likes to lay blame on those drinkers for making the unhealthy choices, choices that industry is providing and indeed heavily and persuasively promoting without accepting any sense of responsibility themselves.

In addition, in this statement, the Consultation Draft strategy completely misses the point about the importance of **universal** as well as **targeted** policies, strategies and actions. This ought to be explained as well as supported by commitment to appropriate strategies – the WHO best buys.

This statement must not make it into the final document as presently framed.

If we follow industry advice to governments that they target only the 'small minority' who have problems or those who are thought to be at higher risk, axiomatically, this takes evidence-based prevention out of the equation because prevention (through population wide structural reform etc.) is about shaping the 'health behaviours' of those who do not yet have a problem. This demands a population-based approach because we can't reliably identify or predict who will experience harm yet alone hope to influence their personal decision making in isolation from population level legislative reforms that regulate what others are able to do to adversely influence those decisions and their 'health behaviours'. So, we shouldn't just target pregnant women with advice they not drink but rather, we should provide appropriate advice and legislate to prevent the alcohol industry from targeting all women of child bearing age in their marketing and other commercial activity, if we are serious about reducing the incidence and prevalence of FASD. If the high risk/ already harmed

approach is modelled, it soon becomes evident that the prevalence of problems can only remain as at present or grow over time.

Recommendation 17: that the National Alcohol Strategy (2018 – 26) commits the Australian, State and Territory governments to a balanced mix of targeted and universal prevention strategies with particular attention to the WHO best buy policy reforms, regardless of inevitable industry push back and attempts at manipulating governments to abandon these approaches in their submissions to this national consultation.

Minimum Unit Price

Under this section it is pleasing to see this iteration of the draft NAS (2018-26) commenting on regulatory measures to prevent promotion of discounted/low priced alcohol including bulk-buys, two-for-one offers, shop-a-dockets and other promotions based on price. That said,…

…the final NAS (2018-26) should make the logical consequential leap and outline a plan for prohibiting these industry actions to promote products and consumption in ways that set citizens up for potentially serious health problems and indeed, lost opportunity to flourish to their potential in life; and for introducing a minimum price. This is a good example of the public regulation and market intervention legislation that is required.

The question arises, will this national strategy when signed off, signal the Commonwealth, States and Territories are now committed to these important policy reforms, or will the NAS (2018-26) become little more than a 'wish list' menu from which governments may or may not choose to act upon?

It is relevant to note that a ***minimum unit price*** *on alcohol will deal much more effectively with price discounting than any other strategy, particularly those strategies that amount to chasing one's tail given industry determination to find loopholes and ways to maximise its own commercial successes.*

In a sense, it is unrealistic to expect industry to freely make commercial decisions that do not maximise a return on investment for shareholders and other interested parties. Industry leaders make the commercial policy and strategic choices they see available, attractive and expected of them by these vested interests, just as vulnerable citizens make choices to engage in dysfunctional, hazardous, harmful and unsanctioned drinking based on the options they see made available, affordable, accessible and attractive to them, consolidated by personal, commercial, sociological and biological factors.

It is salient to note that unlike a volumetric tax, revenue obtained through a minimum unit price will go to industry not government, but overall, any reduction in consumption that arises consequently, is the most important outcome to focus on.

AUS$2 MUP has a greater impact on heavy drinkers and low-income households who consume larger quantities of alcohol, one year after implementation (Burton et al, 2017). While somewhat limited, the evidence suggests that raising the minimum price of the cheapest beverages is effective in influencing heavy drinkers and reducing rates of harm.

Other research shows that alcohol consumption can be reduced by increasing the price of drinks (e.g. alcopops) that are designed and marketed in a way that appeals to young adults (Babor et al, 2010).

Minimum unit pricing. A public health ideal, combining both the previous two objectives, would be to have a single set of taxation rates based entirely upon ethanol content and with set minima (that is, minimum unit prices), which would remove the myriad different rates of tax typically applied to alcoholic drinks91. The UK proposals, passed into law in Scotland but not yet implemented, link the minimum price directly to the alcohol content (Gilmour et al, 2016).

Under **Priority 4 on page 22** of the Draft NAS (2018-26), there is also comment that;

"Regular repetition of evidence-informed messages will, over time help to create the groundswell for positive changes to attitudes and a cultural shift towards healthier and lower risk alcohol consumption behaviours. Australians are currently subjected to mixed messaging via news and public promotion of alcohol (such as the association between sport and alcohol promotion/ consumption and unbalanced reporting of alcohol health impacts). It is important to encourage consistent messaging across all media in relation to the harms of alcohol."

AND

"There is a need to improve personal knowledge and susceptibility of the harms associated with risky drinking and to ensure local communities provide a policy environment that support low risk drinking choices and discourages risky drinking. This Strategy encourages leveraging opportunities for embedding alcohol risk literacy in other programs, encouraging healthy lifestyle choices and health promotion activities to actively reduce the risks associated with alcohol consumption.

*It is clearly important that adequately funded **public awareness** strategies and actions be adopted to improve **health literacy** and **health policy literacy** across the Australian community.*

This includes literacy in relation to alcohol consumption and related risks and harms. This is consistent with the *WHO Global Alcohol Strategy, 2010*. However, such approaches will always have their limitations in isolation and when compared to the effectiveness of public regulation and market intervention.

Educational efforts alone that seek to change individuals' drinking behaviour have been largely unsuccessful, and although treatment of alcohol dependence is important, clinical addiction treatment has not been shown to result in population level reductions in harm (Gilmour et al, 2016).

The overarching finding that providing information and education does not produce sustained behavioural changes may arise from the fact it is delivered in an environment with widespread and unrestricted marketing of alcohol. The alcohol industry attempts to "reinforce and exaggerate strong pro-alcohol social norms", which have the power to overshadow health information campaigns (in Burton et al, 2017).

Alcoholic beverages are promoted extensively around the world. In the USA alone, 14 alcohol companies spent US$3.4 billion on marketing in 2011 (Gilmour et al, 2016).

However, the emphasis of this national strategy must be on the upstream commercial and other factors that promote and encourage drinking not on the individual citizen making the 'healthy choices'.

Recommendation 18: that the National Alcohol Strategy (2018 – 26) commits the States and Territories to implementing a minimum unit price that is anchored to evidence demonstrating the level per standard drink required to reduce hazardous drinking.

Healthy Choices Paradigm

Notwithstanding my comments above, it is pleasing to see this iteration of the Consultation Draft NAS (2018-26) does not contain reference to individuals bearing primary responsibility for making the healthy choices in relation to their drinking. Indeed, under Priority 4 it is stated:

"There is a need to improve personal knowledge and susceptibility of the harms associated with risky drinking and to ensure local communities provide a policy environment that support low risk drinking choices and discourages risky drinking."

So often, we read comments made by those in policy decision making positions, comments reflecting poor knowledge and faulty analysis and strategy, emphasising the responsibility of individuals to make the safe and healthy choices in a vacuum of policy protections (targeting the alcohol industry) that act upstream in the causal chain of choices to drink and drinking related problems.

That said, the question arises, to what extent does this document make commitments to act upon the ***'cause of the cause of the causes'*** and on the '*causes of the causes*', in this case, on the policy levers for **primordial** and **primary prevention**; noting that by primordial prevention refers to underlying conditions leading to causation (values, beliefs and perceptions, as reflected in socio-political ideology, legislation, policy, social norms and social sanctions), whereas primary prevention is aimed at altering specific causal factors which expose individuals and communities to risk. Primordial prevention targets the total population and selected groups while primary prevention targets the same groups as well as healthy individuals.

An example requiring attention to primordial prevention is as follows:

"Media campaigns prepared by government agencies and non-governmental organizations (NGOs) that address responsible drinking, the hazards of drink- driving and related topics are an ineffective antidote to the high-quality pro-drinking messages that appear much more frequently as paid advertisements in the mass media … In sum, the impact of education and persuasion programmes tends to be small, at best. When positive effects are found, they do not persist and a focus upon educating and persuading the individual drinker to change his or her behaviour without changing the broader environment cannot be relied upon as an effective approach" (Babor, et al, 2010).

I recognise that I am repeatedly emphasising this point, but I do so because I don't hear anyone else voicing these concerns and certainly, this Consultation Draft NAS (2018-26) does not address itself to this critical point.

The most important choices are those made by governments and what choices they allow industry to make that impact on the choices of individuals.

Once again, we're talking here about ***primordial prevention*** – the cause of the cause of the causes. Left to their own devices, the alcohol industry, like the other unhealthy commodity industries (e.g. ultra-processed food, soft drink, tobacco, gambling and gun industries in particular) will continue to make very poor commercial choices in so far as they are designed to maximise profits while axiomatically demonstrating no care in placing citizens in potentially serious harm's way. It is not as if industry does not fully understand the harmful impacts of its products and services, even if it is commonly ready to deny or distort the evidence in public commentary.

Common alcohol industry commentary about the health and social harms associated with its products and services demonstrates an apparent cognitive and emotional distancing if not disconnect in processing of the evidence on cause and effect, science and those who are harmed.

The alcohol industry not only distances itself from the harms associated with its products and services but routinely lays the blame at the feet of those who succumb to its best efforts to promote and sell as much alcohol as it can, e.g….

"It is a source of frustration for the industry and for police when known offenders repeat violent behaviour in and around licensed premises. There needs to be more consideration of how to deal with juvenile offenders. It is important to change their behaviour before they are legally entitled to visit licensed premises."

Public policy is the upstream, primordial tool for effective prevention which governments can choose to use and use well, or not.

It is critical that the final version of this NAS (2018-26) signals a clear intent by governments to make that choice and to use the primordial prevention tools that are available to governments, and only governments.

The question arises, by what policy decision making processes can those responsible for this strategy engage and achieve such commitment? Herein lies a fundamental error in present national policy and strategy development processes.

<u>Recommendation 19:</u> that the National Alcohol Strategy (2018 – 26) is not amended in any way that yields to inevitable pressures from the alcohol industry to reinstate commentary about the responsibility of citizens to make healthy choices in terms of alcohol consumption and that the strategy extends and that the strategy extends its commitment from ensuring that governments and local communities provide a policy environment that 'supports low risk drinking choices and discourages risky drinking', to one that actively addresses industry attempts to block or work around those policy reforms and sought-after outcomes.

National Strategies with Very Few Beneficial Outcomes

There have been only three national policies or strategies specifically focused on alcohol since 1977 and no meaningful evaluations of these strategies or corrective actions were ever undertaken:

1. **National Health Policy on Alcohol (1989)**
2. **National Alcohol Strategy: A Plan for Action 2001 to 2003-04**
3. **National Alcohol Strategy 2006-2009**

In a Report in **1977** from the Senate Standing Committee on Social Welfare chaired by NSW Senator Peter Baume, ***Drug Problems in Australia - an intoxicated society***, a range of recommendations were made based on the best available policy evidence at that time to address national alcohol (and other drug) problems. These recommendations centred on maintaining or increasing the real price of alcohol, reducing availability, and eliminating advertising, sponsorship and promotion of alcohol. These recommendations remain valid 41 years onwards. Indeed, since that time, the evidence in support of these policy reforms has consolidated and feature in the WHO Global Alcohol Strategy (2010). It is therefore highly regrettable that Australian and State and Territory governments have continued to largely ignore this evidence, even though Australia has launched three national alcohol strategies since that time and has instead implemented only strategies and actions that have no clear foundation in evidence and that are known to be ineffective. The only areas of success relate to drink driving and the fortification of flour with thiamine. The people of Australia cannot be proud of their governments in this most spectacular failure of public policy related governance.

In this report, the Select Senate inquiry report (1977) observed:

The Dimensions of a National Disaster *(p.25):*
"Alcohol is the major drug of abuse in Australia. It now constitutes a problem of epidemic proportions. Faced with the above summary of the extent of the alcohol problem in Australia today, any failure by governments or individuals to acknowledge that a major problem-and potential national disaster is upon us would constitute gross irresponsibility."

The World Health Organisation (WHO) Expert Committee on Drug Dependence, in 1969, set out two main conditions 'at least one of which must exist for a drug to be considered in need of control':

(1) the drug is known to be abused other than sporadically or in a local area and the effects of its abuse extend beyond the drug taker; in addition, its mode of spread involves communication between existing and potential drug takers, and an illicit traffic in it is developing;
(2) it is planned to use the drug in medicine and experimental data show that there is a significant psychic or physical dependence liability; the drug is commercially available or may become so.

Alcohol clearly satisfies these conditions.

A Declared Strategy:
The Committee urges the Commonwealth Government to declare the following seven-point strategy, developed fully in Chapter 1, as its approach to drug abuse. The

Commonwealth having provided the lead, State Governments should then be encouraged to make similar declarations.

1. Total elimination of drug abuse is unlikely, but government action can contain the problems and limit their adverse effects. Control of drug abuse requires a long-term commitment within a publicly declared program with clearly identified goals, and with time frame, monitoring procedures, financing arrangements and standards all specifically stated.

7. The Federal Government has particular responsibility for giving national leadership in coping with drug abuse. The States have an equally important role, especially in the direct provision of services. No national control program will be effective unless all governments co-ordinate their activities. The Commonwealth Minister for Health should have primary responsibility for Commonwealth action relating to all forms of drug use and abuse.

Among the key recommendations that have been ignored is the following:

- *That government revenue policies operate to keep at approximately the same level the prices of the absolute alcohol contained in beer, in wine and in spirits, bearing in mind that the Government has at its disposal various revenue devices with which it can achieve this aim.*
- *That State Governments defer relaxation of regulations regarding sales outlets and that the Commonwealth Government not in any way increase the availability of alcohol*
- *That the Commonwealth Government ban the advertising of alcoholic beverages, whether by way of corporate advertising or by exhibiting of the brand name of such beverages in a planned fashion, on radio and television and in areas under direct Commonwealth control, such as in the Territories and at airports*
- *That, until a total ban has been implemented, the question of substantial compliance with the voluntary code for the advertising of alcoholic beverages by brewers, distillers, wine makers and all retailers of alcoholic beverages be reviewed annually.*
- *That State Governments and local government authorities be encouraged to ban the advertising of alcoholic beverages.*
- *That the Federal Minister for Environment, Housing and Community Development, and the State Ministers responsible for youth, sport and recreation, appeal to sportsmen and sportswomen throughout Australia not to lend their names and prestige to the promotion of alcoholic beverages*
- *That the Commonwealth Government make any grants to sporting and cultural bodies conditional on their not accepting money from manufacturers and retailers of alcoholic beverages and investigate the possibility of indemnifying such bodies for loss of revenue, at least in the short term*
- *That the National Standing Control Committee on Drugs of Dependence be required to report publicly every two years on the activities and progress of the Sub-committee on Drugs and Driving.*
    - A very important omission – has meant taking eyes off the ball, no accountability and ultimately no action spanning over 40 years.

- *That the Commonwealth Government develop and announce a specific policy on alcohol and alcohol abuse, which should include a clear statement of the*

Government's intention to bring about an overall reduction in the level of alcohol consumption in the community.

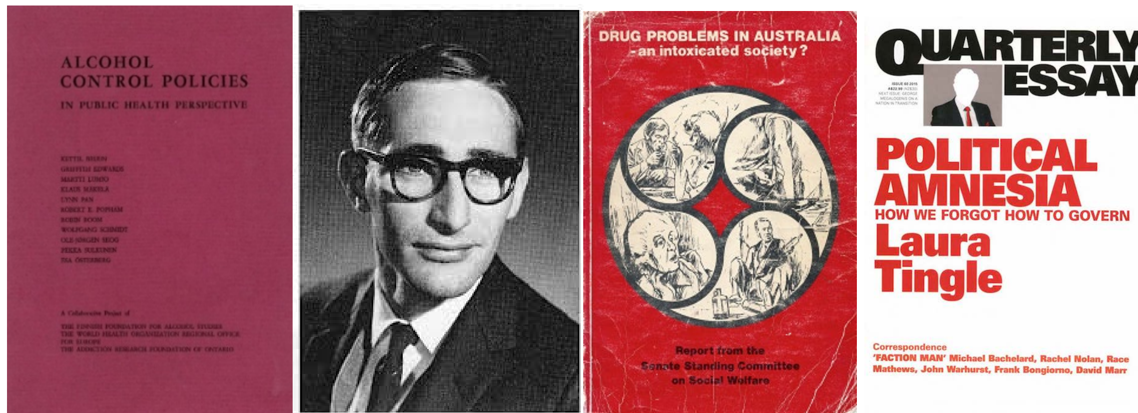
- Note the Hawke Government did launch the ***National Campaign Against Drug Abuse*** in 1986 replaced by the National Drug Strategy in 1993 and there have been many iterations of a National Alcohol Strategy but none of these have grasped the ball and acted on the evidence of what would have most impact on out alcohol problems in Australia.

A report by FARE (2016) provides a detailed analysis of the Baume report, what has been achieved and what has not and what merits careful consideration. It is a well written report and deserves careful consideration.

The Baume Report and the critical policy failures of Australian governments over many decades was the focus of a plenary paper and workshop t at the International Medicine in Addiction **(iMIA)** Conference held in Sydney in March 2017. Over 720 delegates from 17 countries attended this conference, Australia's premier medicine focussed alcohol, tobacco and other drugs conference that is co-sponsored by three medical colleges, the RACP, RACGP and RANZCP.

At this conference, speakers and delegates discussed the questions – *'why our parliaments and public institutions are so often choosing to ignore or even deny the evidence and showing such clear disinterest even apparent contempt for the principles of good science and for those with expertise in their policy deliberations and decision making?' How is it that the people of Australia continue to tolerate these poor decision-making processes?* Health professionals agreed, these matters demand our serious attention as a nation. The conference discussed core issues of governance and of consequential policy failure described in **Laura Tingle**'s Quarterly Essay: *Political Amnesia – How we forgot how to govern* (2015), **Peter Baume's** Senate Standing Committee report: *Drug Problems in Australia - an intoxicated society* and Peter Baume's book: *A Dissident Liberal. The political writings of Peter Baume (2015)*. Peter Baume is a well-known and highly respected physician, former Senator, Federal Minister for Aboriginal Affairs, Minister for Health, Minister for Education and Chancellor of ANU among his many other leadership roles.

Laura Tingle's observations and analyses were the subject of a lively workshop held at this Conference, where Laura joined a workshop of health and public policy experts following her plenary presentation: *'Alcohol, a case study in Parliamentary failure to translate evidence into policy, historically and in the post truth era'*.



Publications of Historical Public Policy Salience

The workshop began with a videotaped interview of Peter Baume who was asked how he felt about the reality that the major alcohol policy recommendations of a Senate Standing Committee into Social Welfare that he chaired in 1977 and that have stood the test of 40 years, remain to be adopted by our parliaments. Peter Baume was clearly concerned and disappointed.

Fifteen years after the Baume Senate report (1977), **Wodak (1992)** observed with concern that governments were doing nothing in particular to address our national drinking problem. Among other insightful comments, Wodak commented:

> *"Consideration of the adverse consequences of alcohol use in Australia is usually followed by an outbreak of gnashing of teeth and wringing of hands. Education, a prevention strategy with limited evidence of effectiveness, is usually proposed as a panacea. It is less well known that measures to prevent alcohol related problems have been identified for which there is general agreement on the evidence of effectiveness. Raising the price of alcoholic beverages relative to income, reducing the availability of alcohol by decreasing the number of outlets or hours of opening and increasing the minimum legal drinking age.*
>
> *Raising alcohol excise has several seemingly attractive features. Government revenue would rise and alcohol-related morbidity and mortality would decline, helping to empty out expensive hospital beds. Sizeable economic benefits are likely to accrue to the community at a time when there is general agreement on the urgent need to reform taxes, wages and industrial policy to maximise economic productivity. Will alcohol excise be reformed?"*

In effect, what we are witnessing in relation to alcohol policy in Australia is '**Groundhog Day'**. As the Clinical Director of Tasmania's public-sector Alcohol and Drug Service, I have to say that I am exceedingly concerned about the impact that alcohol is having on the health and well-being of our state and indeed, our nation. Like Wodak (1992), I have in my professional capacity as a doctor witnessed widespread and significant human suffering among drinkers and among innocent bystanders for over 30 years and I have felt consistently gobsmacked by the inaction of our parliaments in response. However, on reflection, I recognise that our parliaments respond to what they perceive to be commonly shared concerns in the community and alcohol is a drug that forms such a central part of the lives of so many among us, so much so that we are willing to ignore, deny, rationalise and excuse the associated anti-social behaviour, health harms and human tragedy for which I say the alcohol industry must accept primary responsibility.

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LEADING ARTICLES

The dismal science and our favourite drug

Australians are now very conscious of both the gravity of our nation's economic problems and the chronically intoxicated state of our society. Are these issues connected? Two recent reports[1,2] have emphasised the importance of the economic consequences of alcohol and drug use and the potential role of economic factors in decreasing alcohol-related harm. A recent conference on Alcohol and Drugs in the Workplace[3] drew attention to the need for developing more effective interventions to reduce alcohol and drug problems in the workplace, and so improve the health of employees, reduce industrial accidents and increase industrial productivity. As the Federal Minister for Aged, Family and Health Services (Mr Staples) stated when opening this conference, alcohol and drugs in the workplace constitute ". . . now a major issue of microeconomic reform".[4]

to correlate with increasing alcohol excise.

Crowley and Richardson have estimated (using national 1988–1989 data) the economic costs and benefits for Australia of five options for alcohol excise involving a revenue-neutral reorganisation of taxation (so that rates are proportional to absolute alcohol content) and an increase in tax by either 20% or 30% with and without standardisation of excise across beverage classes (beer, wines and spirits).[7] In three of these options (standardised alcohol excise without increased rates and standardised excise with 20% and 30% increases), net social welfare is increased. ("Social welfare" refers to the sum of health, social and economic consequences plus the loss of any pleasure derived from patterns of consumption altered by the imposition of any tax.) The paucity of data on the relationship between marginal changes in alcohol consumption and changes

I do note a more optimistic view expressed in a report from the National Preventative Health Taskforce (NPHTF) (2009, p.29) when it observed:

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 (Brand et al, 2007). 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'. (Babor & Winstanley, 2008).

Alcohol policy experts remind us that that while there are 'some significant disappointments', there are also 'some wonderful examples of successful Australian public policies around alcohol from the past two decades': drink driving legislation and enforcement, the compulsory fortification of bakers' flour with thiamine, and liquor licensing restrictions that are working well for some Aboriginal communities (Stockwell, 2004).

I make the important observation that these important achievements, were made several decades ago and we can hardly continue to trot these old policy reforms out as evidence of good progress, noting also that the high and most important hanging fruit remain to be picked. Also, comparisons with other countries are hardly something to trumpet about, noting that although there are some lessons that might be learned from Norway by way of example, no country in the world has comprehensively tackled all three of the triad of WHO 'best buy' alcohol policy reforms that matter most, product promotion, price and access. Indeed, the National Preventative Health Taskforce (2009) further observed that:

None of this should be cause for complacency. If success is to be measured on the basis of any change in rates of overall per capita drinking, and of adult binge drinking and outcomes such as alcohol-related deaths, hospitalisations and crime, these strategies alone are not enough (NPHTF, 2009).

Given no country has shown outstanding lesdership in these matters. I say, let's do just that.

Recommendation 20: That clear processes be established for monitoring and publicly reporting on progress in the implementation of this national alcohol strategy, aligned to Commonwealth, State and Territory targets and accountabilities, with mechanisms for addressing any perceived or real barriers to progress against the strategy.

Purpose of this National Strategy

There is a statement on **page 4** of the Consultation Draft NAS (2018-26) under the heading, **Purpose of a National Strategy**, that "*for more than 30 years, Commonwealth, State and Territory governments have collaborated to provide comprehensive, evidence informed approaches to reducing alcohol related harms.*"

Furthermore, it adds:

> *"This draft NAS (2018-26) continues the long-standing national commitment to tackling risky alcohol use and related harm in the community through a combination of law enforcement, prevention, early intervention and health care strategies".*

This statement is contestable and should be reconsidered because I do not see how it can meet any test of critical evaluation. Indeed, as I point out in this submission, it would be very difficult to identify evidence to support this claim and easy to adduce evidence to discredit it.

On all these counts, successive Australian, State and Territory Governments have failed the people of Australia. So too have those working in public administration and my Health and Human Services professional colleagues who have sat and watched and done nothing much in particular to ensure that governments have met their duty of care obligations in drawing upon, legislating and communicating the evidence in seeking to protect and promote the health and well-being of all citizens.

Of course, these things are critical if our nation is to move forward in this matter. Therefore, the NAS (2018-26) should talk about how we are now going to achieve this important test of good governance.

> *In many nations, there is a vacuum in advocacy for the public interest. Commercial interests have moved increasingly into this vacuum in the policy arena. Although the alcohol industry is not monolithic in terms of its motives, power or operations, in most instances the industry's producers, retailers and related groups share a common commercial imperative to make a profit (Babor et al, 2010).*

Once again, there has been no apparent deep understanding, acceptance and buy in to appropriate public policy review and reform by our parliaments and by the wide range of government departments and agencies that play a potentially significant role in determining the extent and pattern of unhealthy commodity consumption in Australia. Do we really believe as a nation that we can continue in this manner if we want our nation to be a safer, healthier, more prosperous and better place to live into the future?

Alcohol Consumption Reduction Target

The next most important question that arises is whether the targets, as loose as they are, are appropriate and achievable? Specifically, is a 10% reduction in harmful alcohol consumption an appropriate target?

I must say I was surprised to see this target in the context of the breadth, extent and magnitude of alcohol-related harm is in Australia and just as importantly, in the context of previous prevention

work that has been undertaken by the National Preventative Health Task Force and its report delivered in 2009 and of course, targets set by other Western nations experiencing similar kinds and levels of harm. The answer is, if Australia were to adopt the WHO best buy policy reforms in a timely way, based on evidence and modelling studies, we could likely achieve far more than a 10% reduction in harmful drinking, but possibly not over a period of eight years given our cumbersome and ineffectual ATOD related state and national governance arrangements, given the often poor health policy literacy among elected representatives and given the demonstrated weddedness to serving vested commercial interests before public and population health. Byrnes at al (2008) estimated that a **volumetric tax** on **wine** alone would lead to a 24% reduction in alcohol consumption while providing for an increased taxation revenue of $3B.

Regardless of what is feasible politically, based on the high prevalence of the significant, wide ranging and substantially avoidable harm and based on evidence for the effectiveness of the WHO three best buys, a 10% reduction in hazardous drinking is insufficiently ambitious.

That said, the issue is more complex than this, since seeking to reduce 'harmful drinking' alone misses the point about prevention, which demands that we reduce dysfunctional, hazardous and unsanctioned drinking as well, that is to say, address the numerically larger proportion of the population that is drinking in quantities and in patterns and social contexts that place them at risk for adverse events (e.g. physical or psychological harm to self-and/or to others) and reduce the proportion drinking in excess of the low risk drinking guidelines (NHMRC, 2009). What we also need to prevent young people commencing drinking in their teenage years yet alone drinking to deep intoxication and prevent moderate drinkers from becoming episodic or regular heavy drinkers.

It is salient to note the comments of Jurgen Rehm at the APSAD Conference in 2016 when he observed that interventions that affect heavy and very heavy drinkers over time, are critical. He further observed that the relative gain in risk reduction for mortality (as distinct from health and social morbidity) by reducing from 14 to 11 drinks per day is about ten times as much as reducing from three drinks a day to zero. However, abstinence is associated with the lowest mortality rate (Rehm, 2016; Roerecke et al, 2013).

There can be no escape from the reality that Australians are drinking far too much alcohol, noting that since the 1990s, national consumption of pure alcohol has varied between 9.5 – 10.5 litres per person. More correctly, the ABS refers to the quantity that is 'available for consumption', noting that if there is a significant difference between the two, Australians would need to be stockpiling or 'wasting' that difference), with 10 litres per person calculated to be the equivalent of approximately **2.1 standard drinks per day per person** aged 15 years and over (ABS, 2017). The latest per capita alcohol consumption estimate is **9.7 litres per person per annum**. That our national average consumption has consistently remained at or above the NHMRC low risk drinking advisory of no more than two standard drinks per person per day is reason enough to be concerned, noting this estimate includes those who don't drink and those who drink at lower levels episodically. That international evidence is showing these low risk drinking advisories will need to be further lowered should heighten our concerns and our motivation to act on this knowledge.

In its report in 2009, the National Preventative Health Taskforce identified that a **30%** reduction in harmful drinking target is more appropriate and achievable, though how this is interpreted, operationalised and measured has been the subject of much discussion in published and grey literature. A 30% reduction in **per capita consumption** would align Australia more closely with the per capita consumption of Norway, the country that is number one on the United Nations Human Development Index (Australia is second) and it adopts a strong regulatory approach to alcohol advertising and promotion. It would also bring the consumption of many people in Australia down

to or below the low risk drinking advisories (and 'below' would yield substantial health and social benefits).

Currently, one in five (20.4%) Australians aged 14+ years drink at short-term risky/high-risk levels at least once a month, and one in 10 (10.3%) drink at long-term risky/high-risk levels. Reducing the prevalence of both short-term 'binge' drinking and long-term 'regular heavy' drinking will be important. Achieving the target of a 30% reduction in both groups, as proposed in the Taskforce Discussion Paper, would see the prevalence of short-term risky/high-risk drinking drop to 14.3% and long-term risky/high-risk drinking drop to 7.2%.

It should be evident to all that we also need to reduce dysfunctional, hazardous and unsanctioned use as well as harmful use if we are to achieve meaningful reductions in alcohol-related harm and improve population health in Australia. There is nothing complicated about this. There is consensus among researchers that both universal and targeted policies and interventions are required to achieve this end. This logically means a general contraction rather than growth in the alcohol industry.

Per capita consumption in Australia is estimated to be about 9.7 litres per person per year, which would equate to just on two standard drinks a day if every person aged 18 years and over consumed alcohol every day. However, not every person does drink or drink on a regular basis - in 2010 most Australians aged 14 and over consumed alcohol; 47 per cent drank alcohol at least once a week and 34 per cent drank less often than weekly. Indeed, in 2010, 7.2% of adult Australians were drinking on a daily basis (AIHW, 2011). It is evident that among those who do drink on a regular basis, on average, they are drinking in excess of the Australian guidelines to reduce health risks from drinking alcohol (NHMRC, 2009). Twenty-one per cent of males and 11 per cent of females are drinking at risky levels (AIHW, 2011a).

It is reasonable to suggest that based on the ABS data cubes on alcohol consumption in Australia…

*… we should be looking to reduce overall **per capita consumption** by at least one third which would bring us closer in alignment with per capita consumption in Norway.*

Of course, this is exactly what the National Preventative Health Task Force (2009) recommended. It is interesting to note that Norway is a country where alcohol advertising has been banned since 1975 (advertising of all alcoholic beverages over 2.5 percent alcohol by volume is prohibited by the Alcohol Act, Chapter 9, §2). (Hallberg and Österberg, 2015). I observe this alcohol strength distinction does not make good sense from a public health regulatory perspective.

*More specifically, we should also be looking to **reduce episodic heavy** drinking across the population, drinking amongst **high-risk populations** such as pregnant women and young people, drinking in **high-risk contexts** such as when driving or at work and exceeding the lifetime risks for short- and long-term harm.*

The *Australian Health Policy Collaboration* (AHPC) **Health Tracker 2025** sets a more modest target of a **20 per cent** reduction in harmful use of alcohol regarding per capita consumption, lifetime risk and Emergency Department presentations.

I suggest the target for reduction requires further nuancing given that our overall national public health and safety goals and considering the various sub-population and contextual vulnerabilities and alcohol-related health disparities. Aiming low is what we have done for over 40 years and it has taken us nowhere special as a nation and we need to set out a more detailed and clearer pathway and timelines for achieving this. I have heard some colleagues suggest we should not concern ourselves overly with the reduction in drinking and related harm targets and instead focus on agreeing on a national plan to implement the WHO best buys with fidelity and get cracking on this. However, if we adopt this attitude we will never know where we are going and how we are performing as a nation in addressing the serious alcohol-related harms that are so prevalent. Indeed, apart from the suggested target of a 10% reduction in harmful drinking, aligned to the low risk drinking guidelines (NHMRC, 2009), research colleagues have pointed out that there is no additional specification that allows for any meaningful evaluation against a broader set of consumption and harm (to self and to other) targets over the life of the plan.

While Australia's '**drinking culture'** appears so ingrained and is commonly viewed as a part of our national identity and while it may seem so difficult for many to imagine this changing…

*… it is important to recognise our so called '**national drinking culture'** is not innate but rather a convenient human construction by those who like to drink and by the alcohol industry through advertising and promotion, reinforced by mainstream and social media.*

Tobacco control has been successful because the medical profession and health advocates have been successful in persuading the community and policy decision makers that the harms far outweigh any perceived benefits. The harms of alcohol are also substantial and justify strong national strategies and policies to reduce dysfunctional, hazardous, harmful and unsanctioned consumption. I note the following positive and enlightened observations:

The Committee acknowledges that promoting or recommending strategies that may seem to go against the grain of Western Australia's deeply entrenched drinking culture will not be easy. However, Australian culture is what as a society, we think, feel and do. Thirty years ago, binge drinking was not accepted as part of our culture. As a community we can alter the current culture that has developed in relation to the consumption of alcohol. Parliament has a major role in assisting the community to change the culture by introducing legislation that supports community opinion (Western Australian Parliamentary Education and Health Standing Committee, 2011).

Recommendation 21: that the National Alcohol Strategy (2018 – 26) sets a more ambitious target of 30% in the reduction of harmful drinking, by 2026, while adding that a range of more nuanced targets that include reductions in dysfunctional, hazardous and unsanctioned drinking also demand our careful reconsideration.

Is this Consultation Draft Strategy firmly anchored in the evidence?

Is this Consultation Draft strategy firmly anchored in the evidence which identifies the upstream macro environmental and structural ('social') determinants

of dysfunctional, hazardous, harmful and unsanctioned use of alcohol and the consequential health, economic, legal and social harms?

In short, the answer is **no**. While substantially improved from the previous iteration, as noted already, this draft still pays too little serious yet alone erudite attention to these critical upstream factors which shape whether, when, how and to what extent Australian citizens consume alcohol.

In this submission, I have emphasised that the draft strategy pays no serious attention to the critical influence of the alcohol industry from agricultural production through manufacturing to advertising, promotion, sponsorship, sale and political lobbying and donations. I have made the point that **political donations** need to end, and that political parties and elected representatives must come to a recognition that their first role and responsibility is to promote and protect public health and public safety. If industry commercial objectives and behaviours run counter to these two fundamentally important priorities, they cannot be supported.

Even if the unhealthy industries' arguments about creating jobs had veracity (as if money will otherwise disappear into thin ether and be unavailable for the creation of alternative jobs involving healthy products and services), there is no point and no moral basis for supporting commercial practices that create a society of people who are increasingly sick, have a poor quality of life and are unable to flourish in life to the best of their abilities and social opportunities.

> *Public policies that support or create social injustices including disparities in health and economic wellbeing are bad policies and inevitably end up harming entire nations.*

The only positive commentary this draft document makes in relation to the industry is that contrary to earlier drafts, it appears to rule out any industry involvement in this policy's development (though as noted above, the industry was unfortunately afforded that opportunity at the MCDS meeting held in Canberra in 2013) and in the proposed Advisory Committee that is to be established to provide direction and support the government in the implementation of the strategy. The medical, other health professions and health and social advocates must hold Government to this commitment.

Can this Draft National Alcohol Achieve the changes required?

The answer is no, not without clear commitments, a clearly defined process and accountabilities and timelines for each component policy reform and action. Though containing several very appropriate 'options' for consideration, as written this Strategy will take our nation essentially nowhere like the preceding three national alcohol strategies. Indeed, as already noted, Australia is racking up a lengthy list of national strategies that have taken our nation little or no distance towards the stated and desired outcomes.

I reference by way of example in recent times, the previous National Alcohol Strategy (2008), the National Pain Strategy (2010), and the National Pharmaceutical Drug Misuse Framework for Action (2012), which have all gathered dust and have been the subject of minimal political, financial and policy investments or actions by governments, relevant departments and agencies in the singularity or in the collective.

As I have also mentioned, the key elements of an effective strategy are missing from this draft and the people of Australia are entitled to ask – what is the point of continuing to invest large sums

of money and waste the precious time of experts across the nation in writing national strategies and plans if the major political parties and relevant government departments are not centrally involved in their development including the Commonwealth Departments of Prime Minister and Cabinet and State and Territory Departments of Premier and Cabinet (or Chief Minister) and Treasury and if there is no intention to fully resource and implement them? As an analogy, the common and classic MBA taught strategy adopted by many managers of directing already over stretched health professionals to develop and present a detailed business case for a well-conceived initiative when that manager has no intention of supporting the case, has not lost credibility and traction and is unlikely to be accepted by health professionals as a delaying or negating tactic by management, into the future. Up front honesty and transparency is now expected, indeed, demanded. Wasting one's precious professional time in undertaking a substantial and fruitless body of work is no longer acceptable.

I present that it is time to return to basics and reconsider how we think, plan and follow through strategically in such matters and where the authority for leadership and critical decision making resides, as a basis for delivering genuine 'good governance' (Reynolds, 2003).

Continuing to write strategic plans in isolation of key players makes no sense and is not serving our nation well. It is also wasting a great deal of scarce human and other resources and diminishes trust, respect and confidence among Australian citizens that elected representatives will always act in their collective best interests, based on best available scientific evidence and expert advice.

"Doing the same thing over and over again, and expecting different results, is insanity. No matter how you measure it" (Albert Einstein).

The Commonwealth government's recent management of the **up-scheduling of over the counter compound analgesics containing codeine** (OTC CACCs) initiative stands as an exemplar of the role that the Commonwealth Government can play in leading the development and implementation of an expert engaged, evidence based national health strategy. The Nationally Coordinated Codeine Implementation Working Group (NCCIWG) led by the Deputy Secretary for Health Products Regulation and operationally managed and chaired by the Chief Medical Adviser to the Therapeutic Goods Administration (TGA) with support from TGA staff, has been an outstanding success in bringing together those with technical expertise across the country and other key stakeholders in a way that blended expertise with representativeness for designing and implementing an effective plan of action. This is now a model that we should look to replicate in implementing the NAS (2018-26) as has been mooted for a reinvigorated and revised National Pain Strategy.

Recommendation 22: that the National Alcohol Strategy (2018 – 26) be amended to identify the specific alcohol policy reforms and actions that the Australian, State and Territory governments intend to take with a view to reducing current levels and preventing future dysfunctional, hazardous, harmful and unsanctioned drinking in Australia, based on revised methods of engaging governments in policy review, planning and reform.

Recommendation 23: that the Commonwealth Government emulate the structure and processes adopted for the successful Nationally Coordinated Codeine Implementation Working Group (NCCIWG) in bringing together all of the States and Territories, those with relevant expertise and other key stakeholders, to facilitate the planning for and effective and timely implementation of the NAS (2018-26). It would I assume be most appropriately led by the Drug Strategy Branch, Population Health and Sport Division, (Commonwealth) Department of Health.

Most Effective Public Policy Levers for Reducing Alcohol Harm

Page 11 of the draft states that:

"Responses will be evidence-based, and where evidence does not yet exist for the most effective interventions, actions will be guided by the best available information and practice. Robust evaluation of the Strategy, new policy interventions and responses will contribute to the future evidence base."

The second part of this paragraph is highly worrisome by inference. There is already ample evidence to provide clear guidance on what governments can and must do if and when they are ready to take our national alcohol problem seriously and act upon the evidence to prevent and reduce alcohol-related harm.

As discussed above, we know the most cost-effective strategy that governments can adopt is volumetric taxation whereby alcohol products are taxed on the basis of their alcohol content, in tandem with a minimum price per standard drink. There is also strong evidence in support of setting a minimum price per standard drink. After taxation, reducing the general availability and access to alcohol and more strictly controlling and then prohibiting all advertising and promotion, are the next most potent and cost-effective policy levers available to government to reduce alcohol-related harm.

Hitherto, on the basis of an incomplete and inadequately conceived calculus of social benefit and harm, it is apparent that governments of all persuasions have demonstrated a reluctance to forgo the immediate benefits of alcohol taxation even though they are much less than the net economic costs, and as noted above, **national taxation receipts** that are now in excess of **$6.5B** per annum according to the Parliament of Australia, Parliamentary Budget office, Alcohol taxation in Australia, Report no. 03/2015, which compares unfavourably with the estimated costs that range from **$15B to $36B per annum**, depending on the economic model used and whether harm to others is included. (Collins and Lapsley, 2008; Laslett et al, 2010). It is notable that the Consultation Draft NAS (2018-26) does <u>not</u> mention this economic comparison or most importantly, **harm to others** in relation to its targets.

<u>Recommendation 24:</u> that the National Alcohol Strategy (2018–26) be amended so that it signals a clear commitment by the Australian, State and Territory governments to act upon the evidence, rather than framed as a 'menu of options for consideration'.

<u>Recommendation 25:</u> that the final version of the National Alcohol Strategy (2018–26) focusses first and foremost on implementing the WHO 'best buys' and other priorities identified in this submission and only then consider new and 'innovative' policies and strategies to reduce dysfunctional, hazardous, harmful and unsanctioned drinking in Australia.

Governments Faulty Calculus of Benefit/ Risk/ Harm

We often read that our governments are *'addicted to the tax receipts'* arising from the sale of alcohol and tobacco, while the 'victims' of these highly harmful substances overwhelm our health systems. Any erudite health economics assessment would readily lead governments to adduce the reality that these tax receipts go nowhere close to meeting the public health, law enforcement, loss of employment and other social harms arising among those who use these substances and innocent

others (AERF, 2010). This is without considering all of the social and quality of life losses. It would also lead governments to recognise their moral as well as population health and economic responsibilities in adopting a comprehensive population level, evidence-consistent policy response. In short, the medical and other health professions who witness and who do their best to pick up the pieces of the health and human consequences of harmful drinking expect governments to hold the alcohol industry to account.

Sadly, the draft strategy misses the mark on 'preventing the shattering of Australian society into those pieces by the alcohol industry' and focuses instead on 'picking up the pieces'.

As one Coroner has suggested, industry should be required to fully fund the negative externalities associated with its products and services, noting however that this level of accountability would likely put many sections of the industry out of business.

The financial burden that alcohol-related harm places on society is not reflected in its market price, with the costs to individual consumers being lower than the impact of alcohol on taxpayers (Burton et al, 2017).

As I know all too well based on my experience as an Addiction Medicine specialist, contrary to industry claims about the economic and employment benefits, alcohol contributes to substantial **loss of employment**, lack of employability, **lost productivity**, social, cultural and religious harm, loss of life opportunity and economic costs that substantially outweigh the economic benefits, and that is associated causally or by contribution to substantial premature loss of life which cannot be readily costed (Collins and Lapsley, 2008; Laslett et al, 2010).

*The alcohol industry may view itself as a commercial success, but it is clearly a **market failure** from a community best interest perspective.*

It is a **market failure** and a spectacular one at that, when the Commonwealth government continues to ignore advice from those with relevant economic and other expertise to reform the alcohol taxation system, one that favours industry in its entirety but in particular, the wine industry.

It is a market failure when State and Territory governments continue to prop it up with all manner of **subsidies** and **protections**, perversely, to assist the industry to increase production and sales and equally perversely, in contradiction of neoliberal ideology that lays claim to supporting anti-protectionism policy and of not propping up industries that are market failures.

It is a market failure when the burden of **wide-ranging economic externalities** not to mention the **health, social and legal harms** associated with its products and services are born not by industry but by individual citizens whom governments owe a duty of care to protect.

It is a market failure when industry engages teams of **political lobbyists** to out manoeuvre elected representatives and health and human service professionals and researchers providing truckloads of scientific and other evidence demonstrating the harms associated with present alcohol policies and industry freedoms to do as it wishes to maximise profitability before people.

Once again, good policy would see industry made fully accountable, financially, legally and morally, for those economic and other externalities. Good policy would sanction industry from

engaging in what are in essence, ‘sociopathic commercial’ practices. This argument requires no further prosecution. Only government commitment to action. In anticipating industry pushback to elements of the Consultation Draft Strategy that are based on evidence of effectiveness, it is important to note that money lost from the alcohol industry…

> *…when we do reduce national per capita consumption and thus downsize or reshape the alcohol industry, will become available for alternative household expenditures and therefore, alternative industries and employment opportunities. Productivity will increase, more jobs are likely to be created than lost and more Australians are likely to be employable because of the prevention impacts of an effective national alcohol strategy.*

A recent report published by the Australian Institute of Health and Welfare identified that at least **31 per cent** of Australia’s burden of disease arising from smoking, drinking, high body mass and physical inactivity, is **preventable** (AIHW, 2016).

> *Any state or national preventative health strategy that neglects to address dysfunctional, hazardous, harmful and unsanctioned alcohol consumption through evidence informed public regulation and market intervention axiomatically fails as a viable plan. Current levels, patterns and contexts of drinking are incompatible with a healthy Australia and must be addressed.*

Most importantly, as noted already, it is not in any case a legitimate scientific or moral exercise to attempt to balance serious health, social and legal harms experienced by so many Australians with perceived and wanted personal and commercial benefits of alcohol. While our courts of law may take into account ‘good behaviour’ in their sentencing, serious unsanctioned and socially harmful behaviours are decided on the basis of the facts and on the law that is designed to provide carefully thought though benchmarks of ‘justice for all’ and to protect the whole of Australian society.

Alcohol Diminishing our National Cognitive Capability

The report of the National Preventative Health Taskforce (2009) highlights the importance of addressing harmful drinking amongst vulnerable populations such as youth and pregnant women, to which I add drinking in high risk situations such as driving and drinking among individuals occupying a highly responsible positions where good decision-making is critical to the well-being and safety of the community. For example, among the members of the medical profession, airline pilots and elected representatives, particularly when in our parliaments where …

> *…no drinking should ever occur in any important decision-making contexts.*

It is well established this is not the case. Is salient to note that alcohol injures the brain as it does most other tissues and organs in the body and while there is no precisely identified threshold and relationship between quantity, frequency and duration of drinking and brain injury, there can be little doubt that each heavy drinking episode injures the brain and this damage compounds over time, though some recovery may occur when there are lengthy periods of time between low to moderate risk drinking.

Due to individual variability, there is no amount of alcohol that can be said to be safe for everyone…there is always some risk to the drinker's health and social well-being, although there are ways to minimise the risks….(p.20)…as for adult drinking, it was not possible to set a 'safe' or 'no risk' drinking level for children and young people. The safest option for children and younger people is not to drink at all and the safest option for older teenagers (15-17 tear olds) is to delay the initiation of drinking for as long as possible". NHMRC, 2009).

Topiwala (2017) found that alcohol consumption, even at moderate levels (112-168g/ week) is associated with adverse structural and functional brain outcomes including hippocampal atrophy and abnormal cognitive function.

So, just as we now advise, 'every smoke is doing you harm', based on available evidence and inductive reasoning, it is quite possible that 'every drink is doing you harm'.

Toumbourou (2007) discusses the evolving evidence that the brain of a young person's is much more sensitive to the injurious effects of alcohol than that of an adult and that young people are more vulnerable to the health harming effects of alcohol more generally. The author also discusses the evidence that an adolescent consuming alcohol on a regular daily basis but within the adult low risk advisory of two standard drinks a day may incur alcohol-related brain injury within a relatively short period of time. Of course, a worrisome proportion of young people in Australia are drinking and at levels well beyond this on a regular basis. Two-thirds (61%) of 18–29-year olds report consuming alcohol to get drunk (Laslett et al. 2010). Among other areas of the brain including the hippocampus which is central to memory processes, alcohol damages the frontal cortex which is critically involved in cognitive processes underpinning insight and judgment.

Early heavy episodic ("binge") drinking may compromise the very cognitive capacities (i.e. executive functions) needed to protect oneself from developing a drinking problem or becoming alcohol dependent.

There is a continuum of brain injury as highlighted by adolescent and other studies, which may recover partially or substantially if discontinuing 'risky drinking' but if not, the quantum of brain impairment is likely to continue to accumulate over time. At the severe end of the spectrum, alcohol causes clinically diagnosable alcohol related brain injury (ARBI), including Wernicke's encephalopathy and Korsakoff Syndrome.

Decision making is impaired when under the influence of alcohol, even when consuming relatively small quantities by Australian drinking community standards. If an individual shows no visible evidence of impairment to the unskilled eye when consuming say 6 or more drinks, such alcohol tolerance demonstrates that person is drinking too much too often and on the balance of probabilities, is likely to be adversely affected in their cognition, decision making, judgment and emotions from both the acute and long terms effects of their drinking. This exemplifies the WHO (1981) definition of dysfunctional drug use, use/ drinking that is associated with impaired psychological or social functioning.

Policy or other important decision making that is made under the influence of any level of alcohol can be problematic and when it is, can be said to represent impaired social functioning. Both acute intoxication and alcohol withdrawal can injure the brain and recovering from heavy drinking is also associated with impaired cognition, affect and decision making (e.g. de Bellis et al, 2000; White

and Swartzwelder, 2004). However, the lay community does not pick up on this as it does not possess the knowledge, skills and metrics for identifying and assessing such impairment.

> *Inductive reasoning leads me with the inescapable conclusion that **drinking is diminishing our collective national intellectual capability** and in effect, can be said in colloquial terms to be **'dumbing our nation down'.***

That is something I never hear colleagues or others talking about. It is however, something that as a doctor specialising in Addition Medicine, I often identify suggestive clinical evidence in people occupying senior positions in industry and in government. Just as when a sedative medication is given pre-or intra operatively or before an endoscopy (e.g. a benzodiazepine or propofol), the surgeon or gastroenterologist will for duty of care and medico-legal reasons, routinely advise their patient that they must not drive a car, use machinery of any sort, sign any important documents or drink alcohol for at least 24 hours, I assess the same standards will one day be applied to important government, private enterprise and personal decision making after drinking alcohol and a declaration of no consumption clause will be entered into all contracts. It is simple logic that the adversely affected community and then the law will catch up with the evidence in this way.

If genuine good governance is a priority for our nation and I present that everything in civil society flows from the quality of the structures and processes of governance including our health and our economic prosperity, then we need to develop a clear understanding the problem and consider how we respond from clinical, organisational, legislative and other public policy perspectives.

> *Given the evolving evidence, we can anticipate that into the future, legal precedents will be established and significant financial, policy, political and other major decisions impacting on communities will be open to legal challenge where repeated dysfunctional, hazardous and harmful alcohol consumption in decision makers is identified. As a consequence, alcohol is likely to be removed from our parliaments, industry board rooms, indeed, anywhere that important decisions are made.*

> *We cannot aspire to be a 'smart nation', to flourish and to compete to the best of our collective ability on the world stage when we drink so much, so often and in almost every socialisation, where so many among us feel we must always offer or have alcohol available.*

Recommendation 26: that the National Alcohol Strategy (2018 – 26) commit to research to understand whether and the extent to which current levels and patterns of drinking are diminishing our national cognitive and other high level brain functions at the population level, and how this is impacting on all manner of decision making in governments, in industry and in Australian society more generally, with a view to communicating to the people of Australia why the WHO best buys are so important is we are to address this particular alcohol-related harm, one that has hitherto gone largely unrecognised and unaddressed.

Alcohol Taxation Framework

Former Treasury Secretary Ken Henry is among numerous highly credentialed authorities who have observed Australia's current alcohol taxation framework is illogical and needs urgent reform. I read that there have in fact been 13 taxation reviews recommending the Wine Equalisation Tax (which encourages consumption of cheap wine and is contributing significantly to severe end of spectrum health and social harm) be replaced by a volumetric tax, but successive governments have elected to ignore these recommendations. This seems difficult to believe. Concerned citizens are entitled to ask – what kind of ineffectual governance is this and is this what we aspire to as a nation?

Unfortunately, a previous Federal government squibbed it when undertaking a review of the general taxation system because it was persuaded that it should protect the wine industry for very curious reasons – there was a wine glut!

As a doctor, I must say I was deeply perplexed by what I would say amounted to confused policy thinking and befuddled thinking about the role and responsibility of government. I note that the current Federal government signalled its plan to undertake a further review of our taxation system soon after it came into office. While in receipt of a discussion paper that was reportedly strongly critical of the tax regime for wine and while not ruling out reviewing the Wine Equalisation Tax Scheme before the recent Federal election, government elected not to do so. One wonders what level of analysis and critical thinking sat behind this decision. This represents another lost opportunity for the elected representatives of our nation to do the sensible and right thing.

The present **wine equalisation tax** (WET) has been quite aptly described as '**corporate welfare**, with Australians paying a billion dollars a year to subsidise the wine industry', noting that wine is taxed on its wholesale value not its alcohol content. As so many have pointed out, the WET does not reflect the health and social costs of drinking while also failing to deliver appropriate levels of taxation revenue to government. 'It subsidises cheap wine most associated with problematic drinking'. It is an unwise and unjust policy because it increases health and social disparities.

Since **price** is the most important factor influencing drinking decisions, it is critical that Australia now establish a coherent, evidence-based taxation system as a central plank of renewed efforts to address alcohol-related harm in this country. This includes abolishing the value-based Wine Equalisation Tax (WET) and adopting a volumetric tax on all alcohol beverages, not just spirits and beer. This National Alcohol Strategy represents yet another opportunity to act upon this most important policy lever for addressing alcohol-related harm in Australia.

If this target is not achieved within the lifetime of this strategy, it will have failed dismally as will those who sign off on it. Any other achievements will likely be dwarfed by this policy failure.

If the NAS (2018-26) fails to deliver, our nation must face the reality that governments and 'governance' as we know it in Australia today, are unlikely to ever deliver on the best health interests of the people of our nation.

As noted elsewhere in this submission, a carefully constructed process undertaken by a select group with relevant expertise in taxation, public policy and public health is required, to design a staged process to present options for moving our nation towards the adoption of a volumetric tax underpinned by a floor price on all alcohol products.

<u>Recommendation 27:</u> that the National Alcohol Strategy (2018 – 26) commit the Australian, State and Territory governments to a far reaching and independent review of Australia's alcohol taxation framework and to implementing recommendations arising from this review, notably, the adoption of a volumetric tax and a floor price on all alcohol products.

Liquor licensing Decision-Making & Corporate Capture

Another powerful structural determinant of ill health arising from dysfunctional, hazardous, harmful and unsanctioned alcohol consumption that is presently of concern is the legislative and decision-making frameworks for liquor licensing across our nation. Like industry deregulation, these frameworks are clearly working very well for an industry that is seeking to grow itself. But these liquor-licensing systems are not in any way designed to protect and promote public health, notwithstanding undefined and in effect, meaningless claims of community 'best interest' or 'harm minimisation objectives'.

> *There can be no plausible contest to the conclusion that liquor licensing arrangements across the country have hitherto served the best interests of the alcohol industry exceedingly well. Equally, there can be no dispute that they have not served the health and well-being of the people of our nation at all well.*

This raises technical and moral questions at a State and Territory level as to the extent if at all, do liquor licensing bodies across the nation see themselves as having a duty of care to the Australian community in terms of population and public health and to what extent does the membership of these bodies know and understand the evidence on what influences alcohol consumption and alcohol-related harm? The evidence suggests that at least until now, they have demonstrated very poor command of the evidence and have paid very little if any attention to these matters. Alternatively, and most worrisome is the possibility they do possess this knowledge but are willing to ignore this evidence. Finally, where is the medical profession and other health policy advocates in all of this?

These liquor licensing bodies do not routinely incorporate within their structures and processes, those with relevant knowledge and expertise including Local Government, Public and Population Health and Addiction Medicine. This must change if we are to move forward in this critically important area of 'health governance'. I do hear some positive signals from within in this regard, which is encouraging, but is this genuine we must ask.

The Consultation Draft NAS (2018-26) provides no meaningful commentary on issues related to the **structures, decision making metrics**, and **governance** adopted by the liquor licensing boards across the country. However, the draft does make mention of "Licensing procedures that consider outlet density, trading hours, impact on amenity, and related risks and harms, drawing on local evidence and local community concerns". This has significance in terms of the alcohol **availability** and **access** policy levers, the principal responsibility of the States and Territories, for which there are significant issues of concern at present.

There is a strong relationship between **alcohol outlet density** and rates of **family violence** (Livingston 2011).

Licensing in England has been increasingly viewed as an administrative process in a system primarily defined by market demand. This may have led to the overprovision of availability, explaining the limited changes observed in evaluations of the Act…

Legislation requires that all licensing decisions examine evidence about specific outlets or local areas and consider the licensing objectives. Public health is not a licensing objective and so local authorities may struggle to present a health argument as a counterpoint to a licensing decision….Reducing late-night hours of on-trade (bars, etc) sale substantially reduces rates of violence. Reducing on-trade outlet opening hours targeting the most densely populated areas with simultaneous enforcement is cost-effective (Burton et al, 2017).

Two reviews (Hahn et al., 2010; Middleton et al., 2010) conclude that there is good evidence that introducing or maintaining existing limits to days or hours of alcohol sale reduces consumption and alcohol-related harm. Campbell et al. (2009) argue that such policies are, however, dependent on alcohol availability in surrounding areas and may be more effective if implemented regionally, nationally, or in isolated communities (Broadly speaking, the evidence for a relationship between higher outlet density and social disorder is strong; for alcohol consumption, the evidence is less clear; and for chronic health harms, the evidence is emerging (Martineau et al, 2013).

Increasing the time and days on which alcohol is sold increases alcohol consumption and harm, particularly road traffic crash and injury (Burton et al, 2017).

Research indicates strongly that as alcohol becomes more available through commercial or social sources, consumption and alcohol-related problems rise. Conversely, when availability is restricted, alcohol use and associated problems decrease. The best evidence comes from studies of changes in retail availability, including reductions in the hours and days of sale, limits on the number of alcohol outlets and restrictions on retail access to alcohol. Consistent enforcement of regulations is a key ingredient of effectiveness. Licence suspensions and revocations often provide the most direct and immediate enforcement mechanism (Babor et al, 2010).

An effective national alcohol strategy would hold the alcohol industry to account for fully funding the **negative economic externalities** associated with its products and services and with its commercial practices. By way of example, some commentators have discussed the following ideas:

*State and Territory governments should introduce a license renewal and harm based annual licensing fee system that, as a minimum, offsets the cost of alcohol-related harm borne by Government and the community. Criteria established for the development of the scheme should be based on, as a minimum, the duration of trading hours and crowd capacity but might into the future be designed to ensure liquor outlets meet the costs of all negative externalities associated with their products and services through a **Pigovian tax**. State and Territory governments should work to improve broad based public awareness, engagement and input into all licensing decisions. Those applying for an annual license to sell alcohol products should be required to complete a questionnaire that ensures they are reminded of the wide ranging and serious health and social harms associated with these products and when selling or serving quantities in excess of the low NHMRC (2009) risk drinking advisories.*

A r**isk-based licensing fee** to counterbalance and compensate for the costs associated with alcohol is an appropriate way to address this matter.

Sadly, as important as the paradigm has been in protecting our nation in a range of ways, the term '**harm minimisation'** has become a catchphrase that almost anyone can lay claim to as it suits. Australia's National Drug Strategy (NDS) and its predecessor, the National Campaign Against Drug Abuse (NCADA) have been based on a definition of harm minimisation that sits upon the three pillars of supply, demand and harm reduction. Harm reduction has in turn been defined in various ways but the CCSA National Working Group (1996) observed that *harm reduction* can be conceptualized either in terms of *goals* or in terms of *strategies*.

Furthermore, Room (2004) observed that:

> *In drug harm reduction, it has often been conceptualized in terms of strategies: a needle exchange, an injection room, or opiate substitution therapy are all strategies to reduce the harm from drug use, strategies which share that they* ***do not require abstinence*** *from drug use.*

While the principle of diminishing risk to the drinker (and to others) while continuing to drink in dysfunctional, hazardous or unsanctioned ways remains important (consistent with the definition of Room (2004), our equally important national strategic challenge is to both prevent the uptake of problematic drinking and promote a shift away from problematic drinking in those who are at risk or harmed. We need to reduce per capita consumption as well as problematic consumption among at-risk sub-populations (e.g. youth, pregnancy women) and in high risk social contexts (driving, work environments and where important decisions are made).

> ***Corporate capture*** *of the idea of ''harm reduction'' has been used by the industry to counter effective evidence-based alcohol policy development…*
>
> *Corporate capture refers to the process by which corporations deliberately attempt to ''dominate the information environment, so they can significantly affect decision-making''….(McCambridge et al, 2014).*

The failure to regulate the **heavy discounting** of alcohol by packaged liquor outlets is contributing substantially to alcohol related health and social harm. So too is our national failure to place necessary limitations on **industry growth**, such as number and density of outlets, trading hours and other industry strategies to increase sales through price, access and product promotion levers.

> *The areas for which most evidence exists for reducing population level harm are restricting trading hours, limiting outlet density and having older minimum purchasing age laws (in Gilmour et al, 2016).*
>
> *Generating doubt about the nature of the independent evidence is a key strategy of the alcohol industry and other corporate sectors, as doubts among policy-makers will restrict the actions they take….*
>
> *The ability of the alcohol industry to shape alcohol policy nationally and globally needs to be curtailed because of a fundamental conflict of interest with reducing alcohol harms (McCambridge et al, 2014).*

While the evidence suggests the relationship between increased **density** of licensed outlets and identified harm may be inelastic, the evidence in Victoria suggests harm rates have increased more

rapidly than the general increase in the population. For example, there has been more than 200% increase in emergency departments presentations in the last decade (Livingston, 2008).

We know that **general licences** (pubs) and **packaged licences** (bottle shops) are both significantly related to **assault**-related hospital admissions. We know that packaged liquor outlets are strongly associated with rates of chronic alcohol-caused disease and with family violence, which is what we would expect given the lower prices of off-premise alcohol (Livingston, 2008). Packaged liquor density and lower prices are likely to be associated with the prevalence of alcohol-related **chronic disease**. Increased per capita consumption is likely to be associated with an increased prevalence of cirrhosis of the liver and alcohol dependence, just as we are seeing at present in the United Kingdom (Sheron et al, 2009). Bunching of licensed outlets is likely to increase competition, increase price-cutting and increase consumption.

Of special concern is the observation by Livingstone (2008) that there are high rates of packaged liquor outlets in disadvantaged neighbourhoods in Victoria and that is what we are also seeing in Tasmania, for example, an additional license was granted in Bridgwater in Tasmania on the basis of a very strange argument about 'community best interest'. As a doctor I would respond – 'run that past me again, would you please? While the evidence on liquor license numbers and density and such matters is looking a little more complex than I present here, I am sure the reader will understand the general basis of my concerns.

Trading hours have been progressively stretched over the decades and this has contributed to excessive and hazardous consumption. In a disingenuous attempt to address 'alcohol related violence', lockout laws were introduced.

*In a recent systematic review of the effectiveness of **lockout laws**, Kypri et al (2014) and Nepal et al (2018) conclude there is no good evidence that such lockouts prevent alcohol-related harm, in contrast to reducing earlier cessation of drinking in licensed premises for which there is evidence effectiveness.*

So, **access in all its forms** (like price, advertising and promotion) really matters. These are all very powerful structural and environmental influences on population behaviour and on population health. Indeed, advertising and promotion and other industry strategies like **loss lead** pricing are designed do just this, to weaken or remove human agency and shape personal decision making.

When human beings can obtain products and services with minimum effort (and when they are affordable, and their use is seen as a social norm and socially desirable or 'cool'), they are much more likely to do so. When people need to expend time, effort and money to obtain a product or service, they are less likely to do so. That is why alcohol should never be available in supermarkets (though it is in most States) or liquor licensed outlets that are in close proximity to a shopping centre or supermarket (though they are of course strategically placed for this very purpose, to maximise visibility and access).

*This tells us that the public policy focus of attention must be on **earlier last drinks** and **earlier closing times**, rather than industry favoured approaches which industry claims are aimed at reducing violence by lessening the interaction of intoxicated persons in public places, if we are serious as a nation about reducing alcohol-related harm.*

Supermarket entry into the alcohol market has substantially increased access to alcohol, noting that nearly 80 per cent of alcohol consumed in Australia is sold at takeaway liquor outlets and noting that the packed liquor retail market is now dominated by the two major Australian supermarket chains, Woolworths and Coles.

Misguided licensing bodies adopting a narrowly focussed **quasi-legal framework** demanding new evidence be presented on each occasion to block a new license, may say the world is not really round where a new license is sought unless and until concerned citizens or community bodies can establish once again and often at great cost, that it is indeed 'round' at this location and will cause yet more preventable harm. Liquor licensing bodies will, based on weak legislation, continue to ignore the evidence on outlet density and violence and continue to approve and defend yet another licensed outlet based on a specious argument, that for example, '*more convenient access in a competitive and modern environment to those who live and shop in a locality'* is a community good. But in doing so, they earn the disrespect of those who work tirelessly to protect and promote health and safety of Australian communities and those who do their best to help those who are harmed.

"It is difficult to get a man to understand something when his salary depends on his not understanding it." (Sinclair, 1934)

Recommendation 28: that the National Alcohol Strategy (2018–26) be strengthened to include a commitment to reviewing benchmarks for the composition, structures, processes and objectives of liquor licensing bodies across the nation, so they are genuinely expert in the area of 'alcohol control', so they incorporate relevant external bodies including local government and experts in Public and Population health and in Addiction Medicine, and are given the legislative framework and authority and administrative and political support to make decisions that align with the evidence on what works in minimising current levels and future dysfunctional, hazardous, harmful and unsanctioned drinking in Australia, particularly as this relates to accessibility of alcohol.

Choosing & Implementing the Right Policy Instruments

The challenge for our nation is to place all the facts in front of our public policy decision-makers so they see they have no option but to act in an evidence-informed, strategic and committed manner. We need to inform and reinforce the message to our elected representatives that when they adopt the policy instruments which the evidence supports, they will in one fell swoop, protect the community from immense and avoidable harm, save many lives and reduce health care costs while at the same time increase revenue through tax receipts. They will also improve the health and well-being of our nation, not to mention our '**collective cognitive and creative capability'**.

Doran et al (2008) point out that if governments selected the most cost-effective policy instruments available to them, they could achieve a ten-fold health gain from the same investment.

Governments and the community may need to be reminded repeatedly they cannot afford to forgo this rich opportunity for such significant socially beneficent action, not to mention the economic benefits in addition.

Doran et al (2013) undertook an economic modelling study demonstrating a number of options for the Federal government to consider, each of which provide varying but, in all cases, and for a very modest investment, impressive returns in the form of reduced losses of life and of disability

adjusted life years through reduced alcohol consumption, reduced healthcare costs and equally impressive increases in tax receipts. The authors show that abolishing the WET and replacing it with a volumetric tax on wine would increase taxation revenue by $1.3 billion per year, reduce alcohol consumption by 1.3%, save $820 million in health care costs and avert 59,000 DALYs. They show that alternative scenarios would lead to substantially higher taxation receipts and greater reductions in alcohol use and harm.

The Australian Prevention Partnership Centre is presently undertaking **dynamic modelling studies** utilising a computerised decision tool into which best available outcome studies are drawn upon to forecast the likely effects of new and scaled-up existing interventions (individually and in combination) to reduce alcohol-related harms. Impact on both acute and chronic alcohol-related harms will be forecast. It is hoped that governments might pay more attention to this information than they have hitherto and to all of the researchers, clinicians and public health experts across our nation over the past fifty years. This initiative is most welcome, but it does demonstrate the manner and extent to which we now find ourselves having to engage to communicate with and persuade our decision makers in public administration and in our parliaments, to heed and respond to the overwhelming evidence and expert advice, which I have reflected upon in making this submission. We might ask, how well does this reflect on us as a nation?

Monitoring and Evaluation

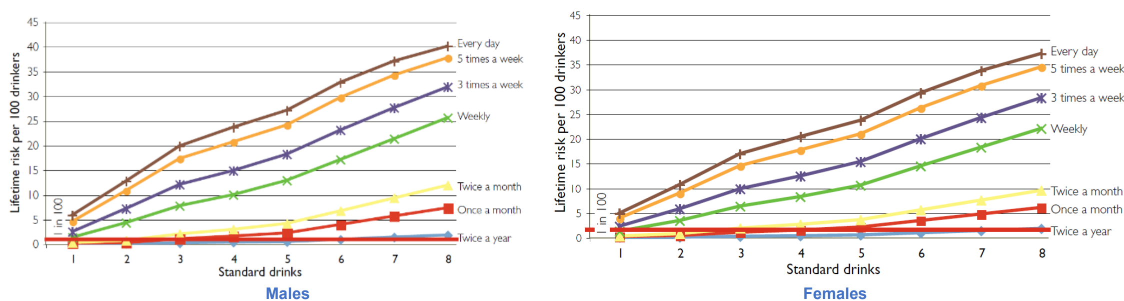
Page 26 of the Consultation Draft NAS (2018-26) addresses the issue of monitoring progress. It provides a range of suggested measures of success. This is a rather poorly developed section of the draft NAS (2018-26), particularly given the observation that the previous three national alcohol strategies were never evaluated, and no meaningful national policy adjustments were made in accordance. Apart from fundamental problems in the poor-quality data that is currently collected and its highly questionable veracity and reliability (which is not mentioned), this document provides little detail on what is to occur that is different to the present situation. The indicators that are included are not necessarily the indicators I would choose in many instances. Or at least, what is absent is more prominent than what is present.

Appropriate **funding** will need to be allocated to develop better data sets and systems that facilitate monitoring and evaluation of the plan against appropriate measures that align with the plan's goals and objectives, led by an appropriately constituted expert group, as an early action in the life of this strategic plan.

*As the Consultation Draft Strategy points out, there are over 200 ICD-10 codes associated with alcohol-related harm (and over **60 clearly defined medical conditions** seen commonly in primary and tertiary healthcare settings).*

Case finding of these conditions is very low in our hospitals to the extent that the current data suggests we have 430 admissions to the 1,332 Australian hospitals each day across the nation (Bonomo et al, 2017). Cancers were responsible for the largest proportion (36%) of alcohol-attributable deaths in 2015, while neuropsychiatric conditions were responsible for 37% of all alcohol-attributable hospitalisations in 2012/13 (Lensvelt et al, 2018). An estimated 430 hospital admissions suggest one admission to each Australian hospital every three days when other analyses suggest that between **10 and 30% of hospital presentations** are in some way **alcohol-related.** The real figure is clearly much higher, at least an order of magnitude higher.

The disconnection between published data and what other research and clinical experience demonstrates is quite staggering. Our data collections and our methodologies are clearly deficient to the extent that they cannot reliably inform the Australian Parliament on the nature and extent of alcohol-related harm presenting to Australian hospitals.



Lifetime risk of hospitalisation from alcohol-related injury per 100 male/ female drinkers, by number of standard drinks per occasion and frequency of occasions

Current data collections include estimates of per capita consumption (ABS), Heavy episodic drinking (NDSHS), heavy episodic drinking in adolescents (ASSAD), long term risky drinking (NDSHS), Emergency Department injury presentations (NSHS), hospital admissions related to alcohol use (NAIP) and alcoholic liver disease deaths (ABS). There are many problems associated with these indicators, for example, the ED presentations indicator does not cover all states (not Tasmania or Western Australia) and adopts an indicator of "alcohol-involved" for cases presenting between certain late night/ early morning hours on Friday, Saturday and Sunday nights.

Accessing reliable and quality data that is collected is a problem in our country and data custodians may lay claim to a need to protect their data for reasons that may or may not have veracity. There are a range of methodological issues that bear our carefully considered attention.

This should include collection of alcohol sales data and **'last drinks' data** at hospital emergency departments across the country (Miller et al, 2013; Curtis et al, 2017, Nepal et al, 2018). It should also include **sales data at the outlet**, which is very least any commercial operator can be expected to do given they are willing to make available, promote and sell products that are causally associated with so much harm, suffering and lost life opportunity.

Recommendation 29: that the National Alcohol Strategy (2018 – 26) be strengthened to the include a plan to undertake detailed research and analysis of current deficits in data collections and the associated technical and other errors including methods of approach with a view to established refined methods for collecting more detailed data reflecting the wide ranging medical and other conditions associated either directly or indirectly with dysfunctional, hazardous, harmful and unsanctioned drinking, so a comprehensive measure of health and other harms can be adduced and communicated to the people of Australia and to governments, monitored and more appropriately responded to in public policy reform and intervention.

Good Governance for Good Policy Decision-Making is Critical

I am concerned to witness an apparent ramping up of less than well-informed drug and alcohol policies and interventions in several States and Territories at present, in the face of the serious health, public safety, economic and social problems faced by those jurisdictions.

I am concerned about the often less than well informed or wise public policy decision making that those with deep knowledge and content related expertise constantly witness, often with a sense of despair. Why and how is this occurring, they ask? In a Quarterly Essay published in late 2015 *(Political Amnesia, - how we forgot how to govern)*, Laura Tingle, former Political Editor of the *Australian Financial Review* and now Chief Political Correspondent for the ABC television program, *The 7.30 Report*, described her observations of relevance to this question. Among other maladies of governance, Tingle observes that:

- *"Decisions are taken that are not informed by knowledge of what has worked, or not worked, in the past, or even by a conscious analysis of what might have changed since the issue was last considered…"*
- *It has cleared the way for us to find ourselves on a shifting battlefield of fairly ugly ideology rather than "evidence-based" politics and policy…"*
- *Ambitious public servants will tell you that the best path to promotion is to switch regularly between departments rather than stay in the one place, meaning no one develops deep expertise in anything, with just a few exceptions, such as defence, national security and foreign affairs…"*
- *Equally, going outside a policy department to get the best private-sector experts in a field to consider an issue has a lot going for it. However, it also means the department never gets the opportunity to develop that expertise itself. But it also means that not only does the public no longer know whether those services are being properly delivered, nor do the public servants responsible for their delivery…"*
- *One of John Stone's successors as Secretary to the Treasury, Ken Henry, says simply:* ***"I think many departments have lost the capacity to develop policy; but not just that, they have lost their memory. I seriously doubt there is any serious policy development going on in most government departments."***

Packham (2012) makes similar observations to Tingle (2015:

- *"FORMER Treasury secretary Ken Henry has delivered a scathing assessment of the quality of public policy debate in Australia, declaring it at its lowest ebb in a quarter of a century. Dr Henry, who is drafting the government's white paper on Australia in the Asian Century, said governments were making critical public policy decisions without properly understanding the issues…*
- *'I think it is quite serious. There is an insufficient understanding of the issues that Australia confronts. There is a role for deeper analysis, there's a role for deeper thinking, and there's a role for a much higher quality of public policy debate and all of this needs to happen before governments make and announce decisions."*
- *Dr Henry says governments are in the habit of making policy decisions on the fly to score political points, often leaving voters and experts scratching their heads'*

Tingle (2015) further observes:

- *"Today, in some institutions, smart people look around at their colleagues and find there is no one to talk to, to learn from, who has experience in delivering real reform. The combination of these two things is a decline in the quality of advice and an erosion of capability, to the detriment of good government..."*
- *We have not just lost frank and fearless advice; we have lost the memory of how policy has been made before, of the history of the groups and issues with which government must interact every day. Government in the broader sense of the word, therefore, has lost much of its capacity to remember and thus to learn from past mistakes…"*

- *Public servants find themselves shoved into the public arena to defend decisions that their political masters have made, although they often had little input in the original decision, nor do they have any direct way of controlling its implementation by contracted parties."*

To the extent that these observations are true, we ought to be very concerned as a nation and we ought to be setting about analysing and correcting the underpinning structural errors. The observation that this National Alcohol Strategy has been in development since 2014 certainly supports comments made by Henry, Tingle and others regarding the loss of departmental and government policy capability as well as the limitations and problems associated with our national drug and alcohol governance structures and processes (p. 90).

To what extent is the public service serving the best interests of the public? To what extent does it possess the technical capability, sense of imprimatur, confidence and support to do so?

An exemplar of poor governance is reference to the so-called **'pub test'**, which we have witnessed commonly in recent politics. I observe that a pub is the very last place we should look to for wise, informed and carefully considered advice or opinions regarding matters of national importance. Indeed, any place where alcohol is being consumed.

*It quite stark witnessing a **retreat from science** and to observe personal opinion, political ideology and the **'pub test'** often appearing to trump evidence and collective expert analysis and advice.*

Notwithstanding my comments on **lockout laws** above, in 2016, we witnessed poorly judged community protests to these laws in New South Wales leading the brother of Thomas Kelly to take his own life, when targeted by those who did not understand and did not accept the policy intent associated with these laws or his campaign for a safer Australia. Stuart Kelly had spoken passionately about the impacts of alcohol on Australian communities leading to the tragic death of his brother Thomas because of alcohol related violence.

People with poor health and health policy literacy who appear to love their 'grog' more than life (or the life chances and very lives of others) protested measures to restrict their access to alcohol and the media played right into their hands.

On 8 August 2016 we read on www.news.com.au that:

"Stuart Kelly was targeted by online trolls and bullies who took exception to the campaign his family ran against alcohol fuelled violence — which partly led to the introduction of NSW's tough lockout laws"

Stuart Kelly's death was a double tragedy for the Kelly family as it was a sorry reflection on the knowledge, wisdom, integrity and values of our nation more generally. This was a most shameful event in the history of our nation.

These are the times when our parliaments and elected representatives should take extra care to research and think things through and not seek to appease ill-informed populist wants, seek seemingly quick savings and make inadequately informed policy decisions, at the expense of inevitable longer-term financial and human costs.

Alcohol focused mob mentality: 'we want more access to grog and don't get in our way'

The alcohol and drug sector faces particular governance and structural problems insofar as the sector is disproportionately small and highly variable in its workforce skills, when compared to the complexity and significant **national burden of disease** and injury associated with alcohol (5.1%), tobacco (9%) and other drug use (1.8%)– a staggering **15.9%** (AIHW, 2016). The sector is so small that it is it is often unable to effectively reach out into the community and provide the spectrum and continuity of services that the community needs and deserves. Expectations may often be quite reasonably high, but delivery will often fall well short of the mark, as outlined in the New Horizons Report (Ritter et al, 2014).

In addition, governance is a critical issue in several States where public sector drug and alcohol services have been placed within **mental health services** based on a superficial argument of facilitating the treatment of high substance use and mental health comorbidity, noting however that mental health problems are but one among a very large array of comorbidities seen in people with substance use disorders and policy matters confronting and managed by the drug and alcohol sector.

This has often been associated with insufficient policy and organisational attention, serious neglect of the drug and alcohol sector, poor and incoherent management of funding allocation, inadequate forward thinking, misalignment of clinical practices within mental health when compared with contemporary evidence on what works in preventing and treating substance use disorders, paucity of well informed and strong leadership and shifting of already small budgets and human and other resources from the drug and alcohol sector to the mental health sector.

Mental health sector bureaucrats often attend meetings as mangers of the ATOD sector and where major ATOD related decisions are made, without even consulting experts in the ATOD field, yet alone engaging them routinely and extensively in problem analysis and solutions generation, such is the common nature of representative rather than expert directed policy decision making in Australia. The Mental health sector is not equipped to provide contemporary clinical governance to the ATOD sector and this is serving not only to stall progression but sometimes, promote regression in clinical and policy thinking and practice. APSAD colleagues have referred to this national ATOD governance malady as a 'diffusion of responsibilities for policy development and its implementation". These matters are in short, serious and important in a nation where alcohol, tobacco, prescription and illicit drugs are responsible for such a large share of the health burden.

This should lead us all to ask: what are the governance structures and processes and decision-making frameworks in operation that has led Australian national, State and Territory governments to

this unhappy situation? How do we make genuine progress as a nation while we continue with such outdated, unfit for purpose decision making processes?

Several years ago, at the national level, the alcohol and drug sector lost its *Ministerial Council on Drug Strategy (MCDS)* and then its *Intergovernmental Committee on Drugs (IGCD),* meaning that it no longer had a high level national forum where Federal, State and Territory Ministers for Health and Police met routinely several times each year to progress a raft of policy reforms, programs and plans related specifically to alcohol, tobacco and other drugs.

Instead, the sector now sits two, three and four layers removed from its definitive policy decision-making bodies, meaning that strategic and policy progress has come almost to a standstill.

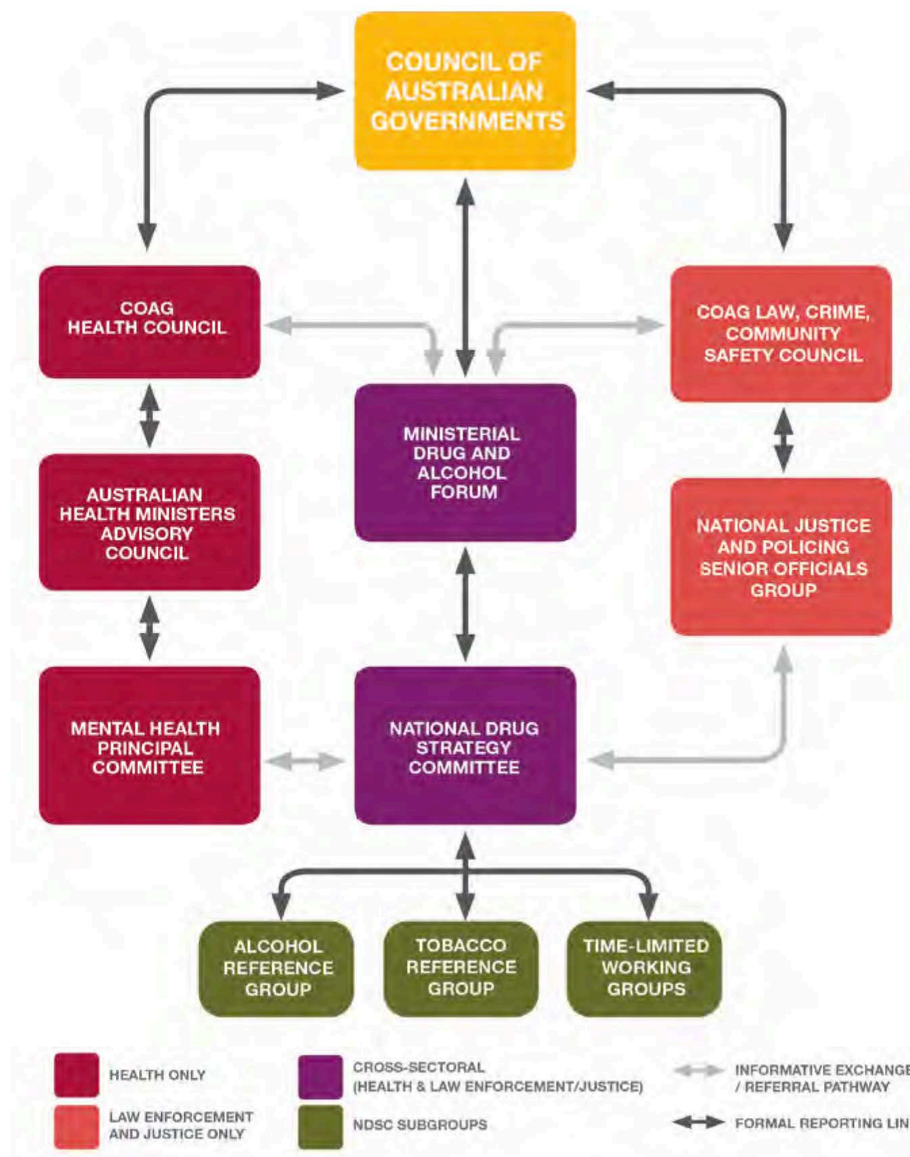
The ATOD sector must now manage its business through two pathways including the *Mental Health Principle Committee* but demonstrably, the mental health sector does not possess the expertise, interest or commitment to address drug and alcohol issues in any effective and meaningful manner and inevitably finds itself in constant turmoil trying to manage its own complex business. That said, it is surprising that the mental health sector has not paid much more attention to the upstream determinants including alcohol policy alongside other salient avenues for prevention (e.g. smoking and nicotine dependence, cannabis, amphetamine type stimulants), given their significant impact on mental health in Australia.

It is equally surprising in a nation that aspires to establish equitable access to the highest standards of education and in a nation that ranks second on the United National Development Program, Human Development Index, that over the 32 years life of our National Campaign Against Drug Abuse and its rebadged National Drug Strategy, we have never managed to move beyond the limited and limiting framework of understanding and action of the three pillars of "**Supply", "Demand" and "Harm Reduction",** as important as these approaches remain. It is surprising that we have not attempted to develop systems and approaches for working upstream in the prevention agenda and it is surprising that we have not attempted to solve the problem of **intersectoral** integration and coordination, noting that the **structural** and **macro-environmental determinants** of health reside more outside than inside the health sector.

Colleagues I speak to across the country advise they don't really have a clear understanding of how the national combined ATOD/ MHS sector governance structure is meant to work in moving the vast alcohol, tobacco and other drugs policy, planning and implementation agenda along and in an efficient, timely way. They note that every group on this organisational chart connects to one or more other components on the chart with two headed arrows, signalling confusion about where decisions are made and where authority for this decision making resides. They note no reference to relevant Departments outside Health including Treasury and Prime Minister and Cabinet, or to the States and Territories which must also commit to informed, and nationally integrated and coordinated policy reform and action. Once again, this suggests a lack of attention to detail and a less than solid grasp of what is required for good governance and decision making that links relevant departments and Ministers, that is expert engaged and informed and that is responsive to the needs of our nation and timely. Colleagues naturally ask – who is responsible and who is accountable? And how are these accountabilities communicated to the people of Australia whose well-being rests on good governance and managed?

There is well placed reason for concern that only a small number of important agenda items can be examined through this complex decision-making structure and not necessarily taken through to completion on an annual basis. Given the significant national burden of disease and injury, not to speak of the social and economic harms associated with substance use in this country, it is naturally

important that our national governance structures and processes facilitate good policy decision making. Alcohol policy reform and strategic planning presents yet another example of this.



The current National Drug Strategy governance arrangements are poorly conceived and have not worked, are not working and I present, cannot work. The **National Drug Strategy Committee** (NDSC), which acts as a Secreriat for the **Ministerial Drug and Alcohol Forum** (MDAF), has no identifiable content expertise and no apparent ongoing connectivity to such expertise. It is certainly unfortunate when elected representatives make uninformed and unhelpful statements like: "I think the solution to our national 'Ice' (methamphetamine) problems is to make alcohol cheaper", demonstrating exceedingly poor health policy literacy. The NDSC is not a functional engine room for policy development and implementation and it appears to meet only episodically in preparation for its infrequent meetings and those on the of the MDAF. It may meet to address specific issues but not in a way that renders it a functional driver of wide-ranging policies and actions. There is no other effective governing engine room that coordinates, integrates and provides national leadership in continuously driving policies and actions forward in close communication with salient national expertise. Instead, we read on the Australian Government National Drug Strategy web site that 'State and Territory governments are responsible for policy development, implementation and evaluation' and for the delivery of services. This is clearly not working at all well. The reference

groups and the other connected groups are no doubt meant to provide that expert support, direction and avenues for implementation, but we are yet to see evidence that they have or will have any real influence on key policy decision making and strategic actions. This governance framework is not designed to facilitate genuine expert engagement in important national ATOD policy decision making and timely responses to our vast and complex national drug and alcohol agenda. It is difficult to imagine we will make serious inroads into alcohol (and other drug) policy reform and intervention with this framework for governance.

The NAAA, FARE and the Australian Policy Coalition have described a process of establishing an **expert intergovernmental taskforce** to provide expert advice on **alcohol taxation reform**, commencing with a **Green Paper** setting out options for taxation reform and the introduction of a minimum price. This is a logical approach and necessary next step. The NAAA and FARE have similarly recommended establishing an **intergovernmental committee** to review **alcohol advertising regulation** across all forms of media with a goal of establishing a nationally consistent and effective approach to regulating all forms of alcohol advertising in Australia. I support this in addition.

The NAS (2018-26) should include a commitment to monitor and **evaluate** not only the **effectiveness** of the **NAS (2018-2026)** in achieving specific impacts and outcomes but also the current **governance structure** and **processes**. It should signal that an appropriate framework and benchmarks for evaluation will be developed during the early stages of the life of the plan drawing upon appropriate expert bodies and individuals and publicly communicated.

An adequately funded research project is now required to undertake a **stocktake** of outstanding alcohol, tobacco and other drug policy and other issues requiring attention by each level of government and other bodies alongside measures of resource, political and other inputs required.

I make the additional observation that the role of our **Drug Strategy Branch** is never clearly identified and documented in governance documents of this nature or in discussions within the ATOD sector. The branch is essentially invisible to the ATOD sector and to the Australian community when it ought to have a prominent role within the Commonwealth government and it ought to have close working relationships and clear lines of communication with key elements of State and Territory Policy units, clinical leads like myself and with the National Research Centres. It did many years ago and it has become somewhat more visible in recent times, which is encouraging. The **Therapeutic Goods Administration** has certainly become much more visible and has engaged lead clinicians and researchers very effectively in the last several years, for example in relation to the up scheduling of over the counter compound analgesics containing codeine, examining the evidence related to cannabinoids for medical purposes and the Schedule 8 strong opioids consultation. The TGA is now setting standards of engagement with the expert medical and other community in ways that other Commonwealth departments could emulate.

I would like to see consideration being given to the establishment of a senior position of **Chief Medical Adviser, Alcohol, Tobacco and Other Drugs** (or similar), placed within the Drug Strategy Branch and working with other senior medical officers within the Commonwealth Government, for example, with the Therapeutic Goods Administration. I suggest this position require a Fellowship in Addiction Medicine and extensive experience working in the drug and alcohol field. Public health qualifications and experience would be highly desirable.

It would be helpful if the NAS (2018-26) were to make reference to and signal a commitment to **broaden the framework** for addressing the upstream **macro-environmental** (economic, cultural, social, commercial and physical) and **structural determinants** (factors that have an impact on more than one person and that result from the way social institutions are structured including health,

taxation, education, housing, welfare systems and the labour market) of health and of substance use in the particular - beyond the conceptually limited, limiting and now dated supply/ demand/ harm reduction framework. The price, access and promotion policy levers discussed in this submission are examples of upstream policy environments that influence use and related harms. It would be helpful if the NAS (2018-26) described a plan to engage with and link these broader social determinants and key departments and agencies in the policy, planning and decision-making processes.

It follows from my aforementioned comments that priorities for action to more effectively prevent and address alcohol, tobacco and other drug related problems in Australian society must include attention to our national, state and territory governance structures and processes, building expert public policy capacity within Federal, State and Territory and local government, improving health literacy and health policy literacy in the community and in our parliaments and reconceptualising and broadening the base of medical and other health and human service professional education and training.

> *However, knowledge and evidence are of no help in building a safer, healthier and more prosperous nation if elected representatives and our public institutions base their decision making on sectional interests and less than well informed personal opinions. Our nation's policy decision making leaders must move to a position of respecting and engaging with best available evidence and content expertise in guiding and making important 'big' policy decisions for our nation.*

Recommendation 30: that the National Alcohol Strategy (2018 – 26) include a commitment to monitor and evaluate the effectiveness of the NAS (2018 - 26) in achieving specific impacts and outcomes and also, the effectiveness of current governance structure and processes in identifying and managing the broad array of strategic, policy and other actions identified as important and necessary in addressing our national alcohol (and other drug) problems.

Recommendation 31: that a genuinely expert committee be established to develop a detailed implementation plan in broad consultation with key health and human service stakeholders; that it be given appropriate authority to closely monitor and evaluate implementation of the NAS (2018-26) against set outcome targets and accountabilities; and report through appropriate channels on a 6-month basis to facilitate and ensure effective implementation of the plan across its 8 year lifetime.

Recommendation 32: that the National Alcohol Strategy (2018 – 26) signal an intention to strengthen the technical capability of the Drug Strategy Branch by establishing a senior position of Medical Adviser, Alcohol, Tobacco and Other Drugs (or similar), with a requirement that that position holds a Fellowship in Addiction Medicine and/ or in Public Health and extensive expertise and experience working in the drug and alcohol field.

Recommendation 33: that the National Alcohol Strategy (2018 – 26) signal a commitment to broaden the framework for addressing the upstream macro-environmental (economic, cultural, social, commercial and physical) and structural determinants of dysfunctional, hazardous, harmful and unsanctioned alcohol (and other drug) use beyond the current conceptually limited, limiting and now dated supply/ demand/ harm reduction framework.

We Must Decide What We Want for our Nation

Policy inertia or policy made in an apparent inattention to evidence and pro-social values vacuum is something I have witnessed time again when working in low-income countries that have adopted ill-informed public policy approaches to serious public health problems. But we are not a developing country, we are a fortunate country in so many ways and we need to demonstrate we are able to make best use of these advantages.

The existence of an annual **Fizzers Award** sponsored by the National Alliance for Action on Alcohol (**NAAA**) is testament to the extent of concern among public health advocates across our nation, regarding the intransigence of our nation's policy decision makers in failing to act in any adequate manner on the evidence of what could prevent and more effectively address alcohol related harm in our country.

> *The National Alliance for Action on Alcohol (NAAA) is a national coalition of health and community organisations from across Australia, which was formed in 2009 with the goal of reducing alcohol-related harm. Today, the NAAA is a national coalition representing more than 40 organisations from across Australia. The NAAA's members cover a diverse range of interests, including public health, law enforcement, Aboriginal and Torres Strait Islander health, child and adolescent health, and family and community services.*
>
> *This broad coalition of interests highlights the widespread concern in Australia about alcohol-related harm, and emphasises the importance of cross-sector community partnerships. The far-reaching impacts of alcohol-related harm urgently require a coordinated strategy across Australian governments to drive and sustain action on this pressing community issue.*
>
> *The Alcohol Policy Scorecard is an initiative of the National Alliance for Action on Alcohol (NAAA) and aims to raise awareness of progress in alcohol policy development, recognise good practice in alcohol policy, and motivate governments to improve alcohol policy. This is NAAA's fourth Alcohol Policy Scorecard and provides detailed results from 2017.*
>
> *The Scorecard uses two separate scales, resulting in two Fizzer Awards for the worst performance. The first is for jurisdictions' policies and their implementation in 2017. The second is for the level of improvement (or regression) between 2016 and the end of 2017 (National Alliance for Action on Alcohol, 2018).*

Those who occupy senior positions of health and other sectoral leadership and policy influence, should ask themselves the questions, "how and why as a nation, are we so stuck and what am I doing to contribute to remedying the problem?" "Why have those who sit in our parliaments chosen not to rise to the occasion and indeed, declined to go where no one else has gone even when the 'do nothing much in particular' option continues to deliver such poor outcomes?" After all, we rank second on the United Nations (UNDP) Human Development Index and have the capability to lead the World in this important area of public policy reform.

Our use of alcohol in Australian society ***'to alter the way we perceive, think, feel and behave'*** sets the scene at a young age for broader maladaptive ways of living our lives, for socialising and for dealing with life problems. It sets the scene and teaches a maladaptive behavioural model for the dysfunctional, hazardous, harmful and unsanctioned use of prescribed and illicit drugs and all of the

drug related problems that arise. We cannot address illicit and prescription drug problems as a nation, in isolation from attention to alcohol.

We should remind ourselves that even if we were to adopt an economically focussed approach and forget about avoidable health and social harm and suffering, an unhealthy, fearful and indeed sick nation is one that cannot support government in fully achieving its higher-level policy objectives. Health is a resource for life like no other, no matter which rationale for evidence-based policy action one chooses.

So, we **must decide** as a nation **what and whom we value most**. A genuine commitment to a health for all objective that will among the other best buy strategies discussed above, require action in the areas of price and product promotion and a capping and then gradual reduction in the number of licensed outlets across the nation, OR continuing with a deregulated system that allows industry to continue to grow, make ever more accessible and promote its products as it pleases, with all of the inevitable tragic health, economic and social consequences. We cannot meaningfully address the adverse impacts of alcohol on public health and safety in the absence of nationally coordinated and integrated policy actions aimed at reducing access, increasing price through taxation reform, and controlling the advertising and promotion of alcohol.

I make the obvious observation that, should we continue as a nation in deciding not to act in a strategic and comprehensive manner based on the evidence that is available to us today in relation to alcohol and indeed, any other health-harming determinant, one thing is certain, demands on our health care systems will continue to rise, above already difficult to manage levels. Unless we want to place more severe and explicit restrictions on health expenditure and consciously exclude increasing numbers of people from treatment of the wide-ranging health problems that arise from harmful drinking, this policy inaction will inevitably increase the demands on State and Federal budgets until they really do burst at the seams. Perhaps that is where we are headed in any case, with hospital 'bed block' now a daily reality across our country. It is of concern to note that many regional health and hospital planners and administrators continue to act only at the bottom of the health cliff, thinking only it seems about novel ways of discharging patients earlier while placing some of those patients at obvious risk; while failing to think and plan for better ATOD assessment and treatment delivery; and while failing to engage with those who possess relevant expertise in the prevention policy agenda.

> *The next wave of significant improvements in population health and reductions in health expenditure in Australia will come from drawing upon existing (and expanding) evidence and understanding and acting on this evidence through more refined structures and processes for 'good governance'. Two consequential questions arise for those in public administration and our elected representatives: are you well enough informed and are you ready to lead these necessary policy advancements?*

I am optimistic and firmly believe the penny will soon drop and the community will soon start to place substantial pressures on policy decision-makers to do the smart and right things. As concerned and responsible health professionals, we should now assist the community (and our policy decision makers) to understand the evidence and move firmly in this direction. We need to forge a clear pathway through improved health and health policy literacy, so the community not only understands and accepts but also expects our policy decision-makers to make the necessary policy reforms and so our elected representatives feel politically safe, supported and compelled to make those decisions.

It should be recognised that the previous Federal Government did something very special in this space when it pushed through cigarette plain packaging legislation. Not that plain packaging is in isolation a game changer, but it does signal that important changes in policy thinking and reform are possible, even in the face of substantial opposition from vested commercial interests.

Concluding Remarks

Alcohol is a national public health problem of the highest order. It is responsible for nearly 6,000 deaths each year, wide ranging and significant social problems and more than sixty serious and often fatal medical conditions. It is a drug that diminishes the ability of too many Australians to flourish in life to the best of their ability. It is a drug that has in the past and continues to diminish our national cognitive and creative capability and it is a drug that is adversely impacting on important decision making in all areas of Australian life, decisions that will most certainly be subject to legal challenge into the future. It is a drug that is responsible for substantial though largely avoidable harm to innocent third parties, including our children whom we ought to be demonstrating as a caring, responsible civil society that we value above all else.

At present, we allow the alcohol industry to offer and vigorously promote unhealthy drinking choices. These are not the commercial behaviours of a caring and responsible industry, demonstrating industry is not capable of self-regulating. Allowing such overt 'profit before people' commercial behaviour is not something we can be proud of as a nation. Our national failure to act upon long held evidence of 'what works' in preventing and reducing alcohol-related harm is to our national shame. Regardless of the value anyone places on this drug and its effects, we cannot as a nation afford to continue ignoring the high health burden and associated healthcare costs associated with this drug. Economic modelling suggest the States and Territories will be increasingly unable to afford to fund other basic services such as public education as health budgets burgeon should we continue with our fiddling at the margins approach to the preventative health policy agenda, noting that an estimated 31% of our national health burden arising from smoking, drinking, high body mass and physical inactivity is preventable, being due to modifiable risk factors (AIHW, 2016). Modifiable risk factors that are in large part offered and promoted by the unhealthy commodity industries.

It is time for our public policy decision makers to stop turning a blind eye to this reality. It is time they cease picking the low hanging but low value policy and activity fruit in order to appear to be doing something of political merit when they are not. It is time they made a genuine start on the most important policy tasks for governments identified by the WHO way back in its 1975 (Kettil Bruun) report and included in the recommendations of the Select Senate Committee, chaired by Senator Peter Baume, in 1977.

Once again, current alcohol policies that are framed and defended based on people's love of this drug's psychotropic effects ('the taste'), inconsistent adherence to neoliberal ideology and industry profit are in no way justified given the widespread and serious health, social and economic harms, not to mention the substantial suffering and lost life opportunity among a substantial proportion of the Australian community.

While much improved from previous iterations, I present that the Consultation Draft NAS (2018-2026) does not cut the mustard. Among other changes, I have presented in this submission that the draft requires additional strategies and amendment to add specific targets, timelines, accountabilities and reporting commitments. In its present form, history suggests this national strategy is likely to achieve very little if any measurable improvement across its term and if that is the case, another eight years will be lost. Already we have squandered nine years since the National

Preventative Health Taskforce made its general recommendations to address alcohol-related harm in Australia, not to mention 41 years since the Baume Senate report was released and 43 years since a report from the Kettil Bruun/ WHO group in Finland assembled and presented similar evidence on 'what works' (Bruun et al, 1975).

While I recognise the ambitiousness of the idea, this strategy could form part of the new national approach to any national strategic planning exercise into the future, one in which elected representatives across political parties are more actively engaged in planning and sign off on those plans, directly informed and guided by evidence and relevant expertise. This would demonstrate that as a mature and intelligent nation, we value, respect and heed high quality evidence and expertise in all policy decision making. Plans could be written to reflect a true strategy with specific operational commitments being made by governments and supported by parliaments as outlined in this submission.

There is little point writing a National Alcohol Strategy that members of our Commonwealth, State and Territory parliaments and local governments do not understand and have no intention or commitment to implementing. While there is some urgency attached to the present task, in the context of 40 years doing 'nothing much in particular', an extra period of time doing the job properly this time, will be time well spent.

A key element missing in this Consultation Draft NAS (2018-26) is a strong commitment to focussing on **public regulation** and **market intervention** and Members of our Federal, State and Territory parliaments might like to consider to extent to which they have the potential and carry primary responsibility for implementing an effective national alcohol strategy requiring such regulation and intervention. As such, the strategy (and attached operational plan) – should identify the Commonwealth, State and Territory and local government legislation and regulations that will need to be written or amended to achieve these outcomes. It will need to consider the governance structures, processes and other investments that will be necessary. Without a series of legislative and regulatory instruments, there can be no national strategy of any relevance or effectiveness in preventing and reducing alcohol related harms in Australia. These are among the key deliverables required of this process and national strategic plan. In their submission, NAAA-FARE have provided detailed recommendations with respect to government process for managing the NAS (2018-26) forward in a carefully planned and staged manner and although I have adopted a stronger position on some matters, I fully endorse the NAAA-FARE submission.

Clear and strong objectives, strategies, actions, targets, accountabilities and reporting mechanisms are required. Targets need to be measurable, and clearer statements are required in relation to mechanisms and responsibilities for monitoring and publicly reporting on implementation.

I say more than forty-one years of relative alcohol policy inaction is as lamentable as it is unacceptable. Well informed, confident and ethical leadership is what is required now, rather than all too common learned helplessness among those who say it is unrealistic to believe that we can translate best international evidence into public policy reform and practice. These are not the Australians who will take our nation to a better place or who will be remembered in the history books.

While freedom to express one's point of view and question decision makers are important and positive features of Australian society and in a democracy, let those who are not well read and indeed, not expert in matters related to alcohol be open and transparent about their absence of salient expertise and desist from attempting to unduly influence policy through ill-informed personal

opinions or vested interests, just as they would rightly expect that goods, services and community amenities they avail themselves of - including the medical care they and their loved ones seek, the water they drink, they air they breathe, the aeroplane they fly in, and so on - are safe and designed on the basis of best evidence and expert advice. Let our policy decision makers begin working closely with those with relevant expertise to adduce and apply best Australian and international evidence and let these special Australians take our nation to a position of international leadership in alcohol policy for our nation's equitably enjoyed future health, social well-being and economic prosperity. A partnership of those with the necessary attributes to lead healthy public policy reform among health professionals, academics, researchers, health advocates, elected representatives and those in public administration now need to step up to the plate.

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18 February 2018

Note: This is an amended version of that which was submitted in February 2018, with additional analysis and commentary, re-ordering of certain sections and references and recommendations added.

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