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THE GLOBE



**Global Alcohol Policy Conference
'From the Global Alcohol Strategy
to National and Local Action'**

THE GLOBE

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GAPA Chairman Derek Rutherford,
Thailand's Minister of Public Health
H.W. Withaya Buranasiri and
CEO of the Thai Health Promotion
Foundation Dr Krissada Ruengareerat
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NCD Alcohol Target Dropped to Placate Drinks Industry

In the monitoring framework for the prevention and control of non-communicable diseases, the World Health Organization has removed the target to reduce per capita alcohol consumption. The first draft of the framework included a target to achieve a *10% relative reduction in per capita consumption of litres of pure alcohol among persons aged 15+ years*. Compared with the 25% per capita consumption reduction in the Health For All target of a generation ago, the suggested target was more realistically achievable and should have been acceptable to Member States, who had previously agreed to the WHO Global Alcohol Strategy.

The exclusion of an alcohol target in the revised framework paper is both puzzling and a cause for concern. In the WHO's Feedback from the first draft targets it is reported that **“some Member States expressed concern about the implicit difficulties in working with the alcohol industry towards a goal that is counter to their best interests.”** Collaborating with the drinks industry will hinder effective strategies to reduce alcohol-related harm.

Until now, alcohol has maintained its position within WHO as one of the major risk factors for NCDs, following recommendations made at

the UN high-level meeting on NCDs in September 2011. Suggested exposure targets for the prevention of NCDs included reductions in the consumption of alcohol, salt and tobacco. Whilst targets remain in the WHO framework for salt and tobacco, alcohol has been removed. The removal of the per capita alcohol consumption target is also due to concerns from Member States that it is not a valid proxy of harmful alcohol consumption. This goes contrary to strong evidence of the well accepted “total consumption model”: When total alcohol consumption increases in a society, there tends to be an increase in the prevalence of heavy drinkers. Because heavy drinkers account for a significant proportion of total alcohol consumption, it would be difficult for the total consumption level to increase without an increase in their drinking.

The amount of alcohol-related harm in any society tends to rise and fall in line with changes in the total or average level of consumption. The more alcohol is consumed by a society, the higher its level of alcohol-related harm is likely to be. The lower its level of consumption, the lower its level of harm.

Another concern was raised about the difficulty of obtaining an

accurate measure of per capita consumption, which could be hindered by the supply of unrecorded, informal alcohol. This appears a weak argument given the work conducted by WHO in tracking per capita alcohol consumption, resulting in three Global Status Reports (1999, 2004 and 2010). The last report, Global status report on alcohol and health, is a comprehensive knowledge base on the status of alcohol consumption. WHO has been actively involved in documenting and reporting in this field since 1974 and from 1996 data was collected in the Global Alcohol Database, which was further developed and transformed into the Global Information System on Alcohol and Health in 2008.

The Global Strategy points to effective, evidence-based public health interventions. Including a target on per capita alcohol consumption would be in accordance with the Global Strategy to reduce the harmful use of alcohol. To exclude the target of reducing alcohol consumption from the NCD monitoring framework is ill advised. It is imperative that WHO continues to adopt a public health approach to tackle the growing burden of alcohol harm. Now is the time to move forwards not backwards.

Global Alcohol Policy Conference

13-15 February 2012, Nonthaburi, Thailand

Opening Ceremony



At the opening ceremony the voice of Thai children rang out a simple but apt message to the delegates that at local, national and regional level “ACTION IS NEEDED” to change from “HARM TO HOPE” and that “TOGETHER WE CAN”.

This was followed by a very powerful address from Dr Anarfi Asamoah-Baah, Deputy Director General of WHO. In welcoming delegates he declared:



“We must not underestimate the alcohol industry. They will hit back, attack our evidence, attack our science and attack our policies. Resistance will come from well-financed lobby groups.”

The conference was jointly organized by the Thai Ministry of Public Health, WHO, the Global Alcohol Policy Alliance and the Thai Health Promotion Foundation. GAPC saw leaders from all over the world, who are committed to working towards implementation of effective alcohol policy, come together to provide an opportunity for policy makers, advocates, academics, and campaigners to share and exchange their knowledge and experience.



Dr Anarfi Asamoah-Baah outlined five prerequisites for action on alcohol:

Photographs by kind permission of the Indian Alcohol Policy Alliance



*Dr Anarfi Asamoah-Baah
Photo courtesy of Patrick - André Jacquet
(p.jacquet@gmail.com)*

“The first is political commitment. Taking action requires national and local political commitment, and this includes taking global action. Together, some people refer to this as “global action.”

“The second prerequisite is to present good news: a menu of effective, affordable policy solutions exist at every level, including pathways to drinking and the social and cultural levels. These options must continue to be supported by the latest scientific evidence.

“The third is leadership of the health sector in both treatment and prevention. We must adopt a human rights approach and move away from discrimination and blaming of the victim.

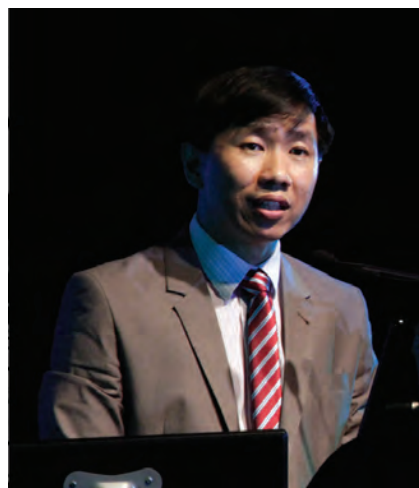
“The fourth is partnership with various organizations in legislation, enforcement and policy implementation. We should include the private sector, law enforcement, private security, finance and implementing tax policies.

“The fifth prerequisite is financial commitment. The backing of champions is needed.

“Your voices will be critical to bringing change. To overcome resistance the passion and the innovation of civil society organizations is needed. Stick to well-documented critical evidence. This is a noble fight and WHO cannot be a bystander. If ever there was a time to accelerate alcohol and tobacco control, this is the time. It is my prayer that if ever the history of alcohol control is written, this conference was a turning point.”

Speaking alongside Dr Asamoah-Baah at the opening ceremony was Derek Rutherford, Chairman of Global Alcohol Policy Alliance (GAPA), who complimented the Thai Health Promotion Foundation for overcoming the challenges presented by the recent flooding in order to host the event. He said now is the time for countries to work together to face the challenge posed by alcohol:

“No region of the world is unaffected by the growing epidemic of the social and public



*Dr. Krissada Ruengareerat
Photo courtesy of Patrick - André Jacquet
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health harm of alcohol use. The global alcohol strategy presents a tough stance against alcohol - if countries unite.”

Dr Krissada Ruengareerat, CEO of the Thai Health Promotion Foundation explained how Thailand had recognised the importance of curbing alcohol harm in order to improve public health and social standards and prevent damage to the economy. He highlighted that countries could learn from Thailand’s approach to tackling the problem of alcohol:

“Thailand has taken an innovative approach to alcohol control. We introduced a new finance model, using a 2% surcharge tax from alcohol and tobacco to fund ThaiHealth. Furthermore, The 2008 Alcohol Control Act is a ground-breaking alcohol control policy for Thailand. It is well recognised that global marketing contributes to the rising trend of alcohol consumption and we urge countries to follow the Thai example of restricting alcohol marketing practices to protect young people.”

GAPC marked an important milestone for global alcohol control efforts. The Conference brought together 1,120 participants from 59 countries, including parliamentarians, government officials and NGOs, to discuss policy solutions to the global problem of alcohol harm.

On leaving the conference Dr Asamoah-Baah concluded, “I came, I saw and I am impressed.”

Corporate Social Responsibility initiatives used “to undermine alcohol control policies”

Professor Parichart Sthapitanonda, from Chulalongkorn University presented research findings that showed that as marketing restrictions for alcohol in Thailand increased, the alcohol beverage industry turned to corporate social responsibility (CSR) initiatives as a means to drive publicity and brand loyalty, thus threatening to undermine the Thai Alcohol Control Act’s ambition of protecting young people from alcohol harm.

Professor Sthapitanonda’s study identified and analysed CSR activities promoted by the alcohol beverage industry in Thailand between 1997 and 2008. Results showed a marked increase in alcohol industry CSR activities following the 2002 announcement of the planned Thai Alcohol Control Act, which came into place in 2008.

Before this announcement, between 1997-2002, 56 CSR activities were recorded. Following the announcement of the planned marketing restrictions within the Act, between 2003-2008, 407 CSR activities were recorded, 171 of which took place in 2008, the year the Act was introduced.

Professor Sthapitanonda attributed the rise in prevalence of CSR initiatives to the increased restrictions on alcohol advertising introduced with the

Thai Alcohol Control Act in 2008:

“The Alcohol Control Act set very strict restrictions on advertising, sales promotion tactics and executions to make it more difficult for alcohol beverage companies to promote their brands, particularly among young potential consumers. Therefore, the alcohol beverage companies had to look for loopholes in the legislation in order to find channels where they could reach consumers. One of the strongest has been CSR activities, which have been steadily expanding, particularly during the past decade.”

The majority of CSR activities recorded in this time period were based around corporate philanthropy, including direct donations to charitable organisations and sponsorship of sports and music entertainment activities. Other initiatives found by the researchers included drink-driving prevention campaigns, environmental protection initiatives and disaster relief.

Focus groups were conducted with young people aged 15-24, living in Bangkok, to gain insight into their perceptions of the alcohol industry and the CSR activities. News articles and promotional materials from CSR initiatives were discussed and the young people were asked their

views. The focus groups showed a difference of opinion between young people who drank alcohol and those who did not; drinkers saw the CSR initiatives in a more positive light than non-drinkers. Professor Sthapitanonda explained:

“The young people who claimed to be light, moderate or heavy drinkers felt the alcohol beverage companies’ corporate social responsibility activities had positive results, returning a portion of their gains to society. They reported CSR activities would assist communities and could help reduce the burden on the government. Furthermore, these young drinkers also felt that these activities were good for an alcohol beverage company’s public relations as the public would know the brand better and see how it works to help society. The young non-drinkers felt that the alcohol beverage companies conducted their CSR activities to promote their brand image and not to really help society.”

Professor Sthapitanonda argued that the results of this study show how the alcohol beverage industry is able to gain publicity and increase brand recognition amongst young people through CSR initiatives, despite restrictions on marketing in place through the Alcohol Control Act. She calls for the Thai Government to recognize

CSR activities as an extension of marketing practice, thus subject to strict regulations:

“The goal of CSR is purely economical, i.e. they want to profit from the investment. Therefore, these activities aim at building corporate image and reputation, which will impress consumers and could ultimately lead to increased sales.

“A major concern has been the alcohol industry organizing CSR activities that would attract Thai youth, such as sports and music entertainment related activities. This research shows that young drinkers see CSR initiatives in a positive light, providing evidence that CSR can achieve similar aims of marketing such as brand loyalty, which ultimately can impact sales.

“This is a danger that relevant government agencies must be aware of and must develop preventative measures and regulations to control the alcohol beverage industry and their CSR activities that are being used to target young people as potential consumers.”

Free trade agreements “threaten public health”

Negotiations are under way behind closed doors for a far-reaching new trade and investment agreement, labeled the Trans-Pacific Partnership Agreement (TPPA), which threatens to give transnational corporations greater power in the public health policymaking process.

This was the argument presented by Professor Jane Kelsey, from the University of Auckland, who gave GAPC delegates a preview of a paper soon to be published in the scientific journal *Addiction*, about the impact a new generation of trade agreements will have on alcohol policies.

The TPPA is currently being negotiated between Australia, Brunei, Chile, Malaysia, New Zealand, Peru, Singapore, United States and Vietnam, with Canada, Japan and Mexico ‘in the wings’. Professor Kelsey argues the agreement aims to set a ‘gold standard’ for removing barriers to the global alcohol and tobacco industries and to

give them greater leverage over domestic policy decisions. The goal is to produce a state-of-the-art agreement that other states in the Asia Pacific Economic Cooperation (APEC) grouping will adopt, culminating in a Free Trade Area of the Asia Pacific.

The draft TPPA text is secret, aside from chapters and background documents that have been leaked. Despite the secrecy, Kelsey says it is clear that the cumulative effect of its substantive rules and procedural requirements would shift the balance of policy-making power firmly in favour of transnational corporate interests. By ensuring that domestic alcohol and tobacco policy and regulation pose minimal impediments to global strategies, and that industry has a role in writing them, the draft TPPA threatens progressive public health policies. At its core, the TPPA threatens sovereignty and democratic governance. The problem is with the agreement itself.

TPPA negotiations are not going forward unopposed. The American Medical Association has already called for the exclusion of measures affecting the supply, distribution, sale, advertising, promotion or investment in tobacco products and alcoholic beverages from trade agreements. Tobacco control advocates are well advanced in their campaign, bringing pressure at the national level and at the stakeholder programmes held on the margins of the formal TPPA negotiating rounds.

In Australia, The Public Health Association of Australia (PHAA) is working with other health, medical and fair trade organisations to lobby the Australian government to ensure that it refuses investor-state dispute settlement provisions applying to Australia and that it insists that public health and access to medicines are not compromised in the developing countries party to the agreement. The PHAA has also organised

discussions between public health experts and Australia's trade negotiators, written to politicians, issued press releases, and organised several public events to raise awareness in the public health community about the risks to health associated with the TPPA, including during the negotiations in Melbourne.

But Kelsey asserts that there is danger in focusing on issue silos.

Beyond alcohol and tobacco are other public health concerns, such as Pharmaceutical Benefits Schemes, and beyond public health is a multitude of other negative impacts, from mining and sustainable livelihoods to indigenous rights and culture. These trade agreements represent a major public health challenge which requires action from people interested in reducing

the harm from addiction and substance use around the world.

Professor Jane Kelsey's paper, 'New generation free trade agreements threaten progressive tobacco and alcohol policies' will be published in *Addiction* vol 107, issue 5



Photo courtesy of Patrick - André Jacquet (p.jacquet@gmail.com)

Closing Ceremony at GACP Conference

At the closing ceremony in Bangkok on 15 February, Dr Apichai Mongkol, Deputy Permanent Secretary of the Thai MOH, passed the GACP flag to Dr Sungsoo Chun, Institute of Alcohol Problems, Seoul. South Korea will host the next Global Alcohol Policy Conference which will be held in Seoul, from 7-9 October 2013.

Global Alcohol Policy Alliance Board meet in Thailand

From left to right: Miss Katherine Brown, Assistant to the UK Chairman of GAPA, Dr S Arulraj (India), Professor Isidore S Obot (Nigeria), Mr Derek Rutherford (UK Chairman), Mr Sven-Olov Carlsson (Sweden), Professor Udomsil Srisangnam (Thailand), Professor Sungsoo Chun (Korea), Mr Øystein Bakke, Secretary (Norway), Professor Sally Casswell, Chairperson Scientific Advisory Panel (New Zealand), Associate Professor David Jernigan (USA), Mr George Hacker (USA), Sally Liggins, Assistant to the Chairperson Scientific Advisory Panel (New Zealand) and Professor Charles Parry, South Africa



Photo courtesy of Patrick - André Jacquet (p.jacquet@gmail.com)

Global Alcohol Policy Conference
“From Global Strategy to National and Local Action”
Nonthaburi, Thailand, 13 – 15 February 2012

DECLARATION

PREAMBLE

We, the participants of the first Global Alcohol Policy Conference "From Global Strategy to National and Local Action", gathered in Nonthaburi, Thailand, on 13-15 February 2012,

Reaffirm that the WHO Global Strategy to Reduce the Harmful Use of Alcohol endorsed by the World Health Assembly in May 2010 is the main policy framework in setting forth principles and priority areas for action at global level and providing a portfolio of policy options and measures that could be considered for implementation at national and local levels, in accordance with World Health Assembly resolution 63.13;

Recall that in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, Heads of State and Government committed to advance the implementation of multisectoral interventions by, inter alia, promoting the implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol, while recognizing the need to develop appropriate domestic action plans, in consultation with relevant stakeholders, including taking into account the full range of options as identified in the Global Strategy, as well as raise awareness of the problems caused by the harmful use of alcohol, particularly among young people, in accordance with General Assembly resolution 66/2;

Express good will and strong commitment to support the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol at all levels;

Recognize that the Global Strategy provides the opportunity for sustained action in implementation of effective and evidence-based strategies to reduce the alcohol-related health and social burden throughout the world;

Note that the Conference has mobilised representatives of governmental sectors, non-governmental organisations, researchers and community leaders from all over the world to promote and support action to fulfil the Global Strategy's vision of improved health and social outcomes for individuals, families, communities and societies at large by reducing the harmful use of alcohol.

RATIONALE FOR ACTION

Globally, alcohol consumption is the third leading risk factor for death and disability. It is estimated that in 2004, the harmful use of alcohol, as defined in the WHO Global Strategy, accounted for 2.3 million deaths (about 3.8% of all deaths in the world). Equally important, an estimated 4.5% of the global burden of disease - as measured in disability adjusted life years (DALYs) lost - is caused by the harmful use of alcohol. Harmful use of alcohol is also the leading risk factor for both death and disability for young people between 15 and 29 years of age.

More than half of deaths due to the harmful use of alcohol occur from noncommunicable diseases, including cancers, cardiovascular diseases, liver cirrhosis and alcohol dependence. The Political Declaration of the High-level Meeting of the UN General Assembly on the Prevention and Control of Noncommunicable Diseases recognizes the critical importance of reducing the harmful use of alcohol as part of the global response to noncommunicable diseases.

A significant public health burden is caused by alcohol-related injuries, including those resulting from road traffic accidents and domestic violence. In addition, the role of harmful use of alcohol in infectious diseases such as HIV and TB has, in recent years, become increasingly recognised. There is a growing world wide concern and urgent need for action regarding the increasing culture of drinking and heavy episodic drinking among young people and women of childbearing age.

Alcohol is a psychoactive substance with a potential for abuse comparable to that of other dependence-producing substances under international control, and its consumption may lead to a range of negative health effects, including life-threatening intoxication, teratogenic effects and alcohol dependence. Alcohol is increasingly recognized as a commodity that requires appropriate consideration by parties in international, regional and bilateral trade negotiations to account for public health concerns.

Harmful use of alcohol leads to increased burden on individuals, families and communities, including impoverishment of women and men from treatment and care costs, loss of productivity and household income, loss of decent work and employment, thus making the harmful use of alcohol a contributing factor to poverty and hunger, which may have a direct impact on the achievement of the internationally agreed development goals, including the Millennium Development Goals.

Evidence-based and cost-effective interventions exist to reduce the harmful use of alcohol at global, national and local levels. These interventions, when implemented and enforced, could have profound health, social and economic benefits throughout the world. Examples of cost-effective interventions to reduce the harmful use of alcohol, which are affordable in low-income countries, include measures to raise taxes on alcohol, restrict access to retailed alcohol, and enforce bans and restrictions on alcohol advertising and marketing. These "best buys" have significant public health impact, and are highly cost-effective, inexpensive and feasible to implement.

Particular attention should be paid to pricing policies and the potential to increase taxation on alcohol: these reduce consumption, prevent ill-health and increase the resources governments can specifically designate for health and prevention and treatment of alcohol use disorders.

CALL TO ACTION

We, therefore, call on intergovernmental agencies, NGO networks, national and local governments, academia, civil society, professional organizations, communities, and individuals, at all levels to take action by:

At the national and local level:

1. Supporting, strengthening and integrating into the national development agenda the evidence-based interventions outlined in the Global Strategy, and especially the cost-effective interventions mentioned above, in order to make our communities safer and individuals healthier, and to protect those at risk from harmful use of alcohol by others.
2. Increasing, prioritizing and supporting budgetary allocations for reducing the harmful use of alcohol at the national level, according to national priorities and taking into account domestic circumstances and the reduction of social disparities, and exploring the provision of adequate, predictable and sustained financial resources for preventing and reducing the harmful use of alcohol and associated public health problems through domestic innovative financing mechanisms, including raising excise taxes or establishing an additional surcharge on alcoholic beverages and allocating a portion of the proceeds to program activities to reduce harmful use of alcohol, and to the prevention and treatment of alcohol use disorders.

3. Strengthening efforts of civil society groups and organizations in reducing the harmful use of alcohol and implementation of the Global Strategy at the national and local level. Civil society organisations that are independent from the alcoholic beverage industry and free from conflict of interest have an important role to play in engaging with governments and advocating for effective alcohol control policies.

4. Establishing and strengthening country-level surveillance and monitoring systems using indicators, definitions and data-collection procedures compatible with WHO information systems on alcohol and health, including periodic national surveys that are integrated into existing national health information systems and include measures of alcohol consumption and alcohol-related harm, recognizing that such systems are critical for advocacy, policy development and evaluation purposes. Results of monitoring and evaluation should be made available to the general public in order to sustain and advance public health agendas on reducing harmful use of alcohol at national and local levels.

At the international level:

5. Exploring the provision of adequate, predictable and sustained resources for implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol at the global level through bilateral and multilateral channels, including traditional and voluntary innovative financing mechanisms.

6. Supporting collaboration of WHO, as the lead United Nations specialized agency for health, with countries in scaling up implementation of the Global Strategy at all levels and strengthening national efforts to reduce the harmful use of alcohol as well as in assessing and monitoring progress made.

7. Developing effective global governance for reducing the harmful use of alcohol in the context of implementation of the Global Strategy at all levels taking into consideration current experience in addressing other risk factors for noncommunicable diseases including tobacco use, unhealthy diet and lack of physical activity.

8. Mobilizing global social movements and support of civil society groups and organizations bringing together alcohol policy activists, youth and youth related agencies, professionals, scientists, consumers and others for joint advocacy activities in support of effective alcohol control policies and implementation of the Global Strategy to reduce the harmful use of alcohol.

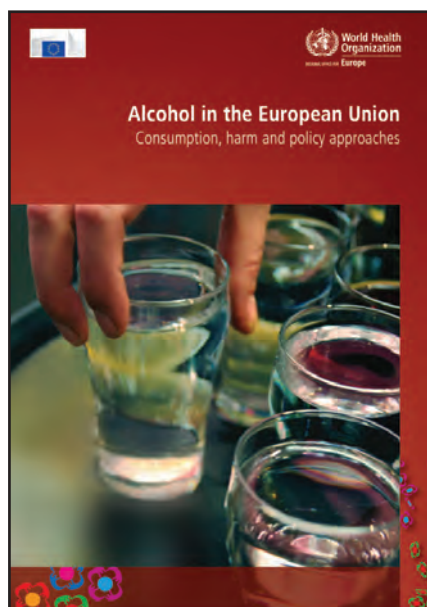
9. Calling upon the Global Alcohol Policy Alliance (GAPA) and its regional affiliates, as well as other relevant international associations and organizations to strengthen the networking, information sharing and collaboration among civil society and professional organizations for reducing the harmful use of alcohol in line with the aims, objectives and the guiding principles of the Global Strategy.

10. Acknowledging the contribution of international cooperation and assistance in reducing the harmful use of alcohol and, in this regard, encouraging the inclusion of the goal of reducing harmful use of alcohol in development cooperation agendas and initiatives, including initiatives to fight poverty, build democratic societies, halt and reverse the spread of HIV and TB, empower women, reduce crime and violence, grow national capacities, address noncommunicable diseases, and improve road safety.

11. Including prevention and control of noncommunicable diseases and their risk factors, including the harmful use of alcohol, in discussions of the substantive process that will lead to the definition of a United Nations development agenda post-2015.

Adults in Europe consume three standard alcoholic drinks per day on average

New report on alcohol in European Union



People in Europe consume more alcohol – 12.5 litres of pure alcohol equivalent per year on average – than in any other part of the world. How frequently, where and in what context alcohol is consumed influence the effect it has on health. “Alcohol in the European Union”, a new report by WHO co-sponsored by the European Commission, reveals significant subregional patterns of consumption and health effects across the European Union (EU).

“Alcohol in the European Union”

The report analyses alcohol consumption patterns, the harm this causes to the health of both drinkers and non-drinkers, and what can be done to improve the health of Europe’s population. A number of cost-effective policies have proven that increased

taxes, decreased availability and restrictions on marketing are effective in reducing the harmful use of alcohol. The policy options are all described in the report.

“Europe’s dubious honour of having double the global average alcohol consumption has clear, recognized health consequences for drinkers, those around them and society,” said Zsuzsanna Jakab, WHO Regional Director for Europe. “Yet the take home message from this new report is that the alcohol-related burden on health in Europe is avoidable. For every facet of alcohol consumption, this report provides evidence-based conclusions for policy and practice, and I urge countries to review it carefully.”

Regional patterns

Social, cultural, geographic and economic variations in the countries of the EU have



Zsuzsanna Jakab, WHO Regional Director for Europe

led to four distinct country groupings – central-eastern and eastern Europe, central-western and western Europe, the Nordic countries, and southern Europe – with different alcohol consumption patterns and trends.

Total consumption and the indicators of hazardous drinking

Although high in all cases compared to the global average, the breakdown of alcohol consumption by sub-region reveals the highest consumption in central-eastern and eastern Europe (14.5 litres of pure alcohol per adult, per year), compared to 12.4 litres in central-western and western Europe, 11.2 litres in southern Europe and 10.4 litres in the Nordic countries.

When, however, these figures are weighted against the indicators of hazardous drinking – the proportion of drinking outside mealtimes, drinking in public places and irregular, heavy (binge) drinking – they reveal a different picture. The Nordic countries have a hazardous drinking score of 2.8 (from a range where 1 is least detrimental and 5 is most detrimental), compared to an only slightly higher score of 2.9 for central-eastern and eastern Europe, and significantly above central-western and western Europe (1.5) and southern Europe (1.1).

Consumption levels over time

Although European consumption of alcohol per capita has remained nearly constant over the past decade, at a subregional level, the Nordic countries and eastern Europe have seen an increase in adult consumption, while this has decreased in western and southern Europe.

Deaths from alcohol

The standardized alcohol mortality rate per 100,000 population across the EU was 57 for men and 15 for women in 2004. Yet sub-regional mortality rates varied widely, from 129 (men) and 27 (women) per 100,000 in central-eastern and eastern Europe, to the lowest rate of 30 (men) and 10 (women) in southern Europe.

In addition to these general differences, specific drinking tendencies in the sub-regions influence the causes of death. Deaths from cardiovascular diseases (excluding ischaemic heart disease) and injuries are proportionally higher in central-eastern and eastern Europe, owing to the high overall volume consumed in these countries, together with irregular heavy drinking sessions. In the Nordic countries, deaths from mental and neurological disorders are proportionally higher, owing to the high prevalence of alcohol dependence and alcohol-use disorders. Cancer is proportionally higher in southern Europe, as consumption levels were considerably higher two decades ago and cancer often takes a long time to develop.

Harm to others from alcohol consumption

As well as doing harm to drinkers themselves, alcohol consumption affects others. Again, reviewing data from 2004, over 5500 deaths in men of all ages in the EU and over 2000 deaths in women were attributable to drinking by others. By far the greatest number of deaths and harm were the result

Alcohol consumption by adults over 15 years in the EU is more than double the world average. It is the equivalent of 12.5 litres of pure alcohol a year, 27g of pure alcohol per day, or nearly 3 drinks daily.

There are over 40 recognized alcohol-use disorders and conditions, including alcohol dependence and the harmful use of alcohol, alcoholic liver disease, alcohol-induced chronic pancreatitis, accidental alcohol poisoning, and fetal alcohol syndrome. There are many more health conditions where alcohol is a contributory cause, such as injuries and deaths from road traffic crashes.

One in 10 cancers in men and 1 in 33 cancers in women are alcohol related.

In the EU, 11.8% of all deaths in 2004 among those aged 15–64 were due to alcohol, the equivalent of 1 in 7 deaths in men and 1 in 13 deaths in women.

A total of 3.3% of all deaths in 2004 among those aged 15–64 were due to alcohol consumed by others.

of transport injuries, followed by violence as a distant second cause. Southern Europe shows the greatest proportion of harm to others compared to the total alcohol-related harm for that subregion, as measured by deaths. In central-eastern and eastern Europe, however, calculations indicate that a greater proportion of motor vehicle crashes, attributable to alcohol, harm the drunk drivers themselves.

European action plan on alcohol

The European action plan to reduce the harmful use of alcohol 2012–2020, endorsed by the 53 Member States of the WHO European Region in September 2011, is the latest Region-wide policy response to reduce the health burden caused by alcohol. It gives a comprehensive overview of the problem and provides policy options proven to reduce alcohol-related harm. Policies such as regulating alcohol pricing, targeting drink-driving, and restricting alcohol marketing are known to be effective.

Irish Health Committee supports strong alcohol policy framework

In its report on alcohol and substance misuse issues, the Health and Children Committee of the Irish parliament has come out in favour of tough restrictions on alcohol advertising, minimum unit pricing of alcohol and other control measures.

The report was welcomed by Alcohol Action Ireland, the leading alcohol policy advocacy body in the Republic, but it cautioned that political action was needed to make the recommendations a reality.

Committee on Health and Children

A ban on all retail advertising relating to the discounting of alcoholic products, a ban on the advertisement of alcoholic products on television before 9pm and a ban on the advertisement of alcohol products on social networking websites should be explored by the Government to help deal with the misuse of alcohol and drugs in Ireland, according to the report by the Committee on Health and Children.

The report, *The misuse of alcohol and other drugs*, also recommends that the Government end VAT refunds on below-cost sales of alcohol and that the Government prohibit the practice of retail deliveries of alcoholic products directly to consumers' homes.

The majority of the members of the Committee supported the introduction of minimum pricing in respect of alcoholic drinks in a forthcoming public health bill. However, there was a divergence of views within the committee on this matter with a minority supporting, as an alternative, an increase in either or both alcohol expenditure taxes (with the additional revenue generated being ring-fenced for preventative education and the provision of alcohol addiction services).

Other key recommendations are:

That the Government consider how a programme of new, preventative, educational initiatives, aimed at the public in general, could be devised and implemented. The aim of this programme would be to highlight the implications and dangers of alcohol and drug misuse, and to influence the prevailing cultural attitudes, particularly in relation to the use of alcohol.

That the Committee are extremely concerned about the proliferation of outlets which sell alcoholic products and the presentation of such products therein. The Committee recommends that legislation

be introduced which would ban the presentation and sale of alcoholic products alongside groceries, confectionery and fuel. Consideration should also be given to an outright ban on the sale of alcohol in certain outlets in the longer term.



Jerry Buttimer

That funding under the medical card should cover rehabilitation treatment for alcohol addiction.

Committee Chairman, Jerry Buttimer TD said: "The overarching aim of this report is to highlight the prevalence of alcohol and other drugs in society and to emphasise the misuse of alcohol in particular, this being the most commonly used drug - what some have called the 'national drug'."

The report hopes to bring about a change in attitudes towards the misuse of alcohol by illustrating the huge personal and economic costs caused by hazardous drinking.

It is the Committee's belief that there is no single measure which will solve the problem of alcohol misuse. Rather, a package of measures is needed to change our attitudes towards, and behaviour regarding, the consumption of alcohol. The Committee is aware that alcohol consumption per capita is an indicator for alcohol-related harm in any country. Noting the lower levels of total alcohol consumption per capita in 1960's Ireland, the Committee wishes to see the implementation of measures which will bring about a significant reduction in the overall consumption of alcohol per capita in the coming years."

Health Committee recommendations welcome - but political action needed to make them a reality

Alcohol Action Ireland, the national charity for alcohol-related issues, welcomed the Dail Health Committee's recommendation backing minimum pricing and a raft of other measures on alcohol



Left: Norah Gibbons, Chair, Alcohol Action Ireland/Director of Advocacy Barnardos with Fiona Ryan

availability and marketing but urged political action to make the recommendations a reality.

Director Fiona Ryan said: "The Health Committee has shown real leadership in the debate on alcohol consumption and harm and the fact that these measures have all party support is very welcome since it shows increased recognition for the fact that we in Ireland have real problems with alcohol consumption and it is costing us in terms of health, crime and finances, with the latest estimates putting the figure at €3.7 billion.

"There have, however, been other worthwhile reports on alcohol that have made similar recommendations. What is now needed in order to make a real difference is political will and political action to follow through on these recommendations."

In relation to minimum pricing she said: "We hope that a minimum price for alcohol – a floor price below which alcohol cannot be sold – will now be considered and taken on board as a realistic option for reducing alcohol consumption. At the moment, we have alcohol for sale in shops and supermarkets which can work out cheaper than a bar of chocolate in the same shop."

Ms Ryan also singled out the recommendation from the committee to restrict alcohol marketing through a 9pm TV watershed and a ban on alcohol marketing on social networking sites: "Mass marketing of alcohol is a concern because alcohol marketing influences young people's drinking behaviour.

Alcohol education in schools or government can never hope to counter existing levels of commercial alcohol marketing.

"The committee was right to highlight digital marketing and particularly alcohol marketing via social networking sites, since the current voluntary codes are so inadequate it is effectively unregulated. A survey we commissioned showed that 30% of 16 to 17-year-olds with a social networking page had received an unsolicited alcohol ad or alcohol pop-up.

"How can the current voluntary codes on alcohol marketing be achieving their stated aim of reducing young people's exposure to alcohol marketing when this is happening? We don't even have a baseline figure on the extent of overall alcohol marketing young people are being exposed to."

Alcohol Action Ireland's call for minimum pricing is being backed by the following organisations: Barnardos, The ISPCC, Foroige, the National Youth Council of Ireland, The No Name Club, St Vincent De Paul, Focus Ireland, Faculty of Public Health Medicine, Royal College of Physicians, The Irish Medical Organisation, Rape Crisis Network Ireland, The Irish Cancer Society, The Irish Heart Foundation, The North West Alcohol Forum and the Ballymun Local Drugs Taskforce.

UK to introduce Minimum Unit Pricing of alcohol

UK Prime Minister David Cameron has announced that a central plank of his government's new alcohol harm reduction strategy will be the introduction of minimum unit pricing of alcohol (MUP). A law will be passed making it illegal to sell any alcoholic beverage below a fixed price per standard unit. This is the principal alcohol policy measure for which the public health community in the UK have been campaigning, and one to which the Scottish government was already committed.

MUP is designed to reduce alcohol consumption and harm by making alcohol less affordable, and, in particular, to tackle the problem of cheap off-sales of alcohol from supermarkets. In the UK, the long-term trend has been for the traditional British pub to lose out against competition from the supermarkets selling cheap alcohol for home consumption. A particular issue to emerge has been the practice of supermarkets attracting customers by using alcohol as a 'loss leader', retailing alcohol at below cost price. It is believed that cheap alcohol from the supermarkets is one of the main drivers of increased alcohol consumption and in the growth of modern 'binge drinking'.



David Cameron

(Photograph courtesy of Dods Parliamentary Communications)

Announcing the move, Mr Cameron said:

“Binge drinking isn't some fringe issue, it accounts for half of all alcohol consumed in this country. The crime and violence it causes drains resources in our hospitals, generates mayhem on our streets and spreads fear in our communities. My message is simple. We can't go on like this. We have to tackle the scourge of violence caused by binge drinking. And we have to do it now.

“So we're going to attack it from every angle and that means coming down hard on cheap alcohol. When beer is cheaper than water, it's just too easy for people to get drunk on cheap alcohol at home before they even set foot in the pub.

So we are going to introduce a new minimum unit price - so for the first time it will be illegal for shops to sell alcohol for less than this set price per unit. We're consulting on the actual price, but if it is 40 pence that could mean 50,000 fewer crimes each year and 900 fewer alcohol related deaths per year by the end of the decade.”

So far as is known, no other country has introduced a fully-fledged system of MUP, so there is no direct experience to judge how successful the policy is likely to be. However, in the debate on the issue in the UK, the experience of Canada with a similar though not identical system was frequently cited.

Professor Tim Stockwell gave evidence to the Scottish Health and Sport Committee on the issue, and the findings of a paper published in the scientific journal 'Addiction' are summarised on page 17.

Minimum Pricing works in Canada

The minimum prices set by the British Columbia Liquor Distribution Branch have helped curb drinking in the province, researchers from the University of Victoria's Centre for Addictions Research of BC (CARBC) have concluded.

The research report 'Does minimum pricing reduce alcohol consumption? The experience of a Canadian province', published in the international journal 'Addiction', is the first to examine the effectiveness of setting minimum prices as a means of curbing alcohol consumption.

In a study based on 20 years of data on sales and liquor prices, the University of Victoria team found a 10% increase in minimum prices of all alcoholic drinks led to a 3.4% reduction in consumption. And because heavy drinkers favour cheaper alcohol, the findings have important health implications, said Tim Stockwell, CARBC Director.



Professor Tim Stockwell

"This is significant information for policies to prevent the substantial toll of death, injury and illness associated with hazardous alcohol use," says Stockwell. "Our results support having a standard minimum price per standard drink for all alcoholic beverages as a cornerstone of alcohol problem prevention."

"Further research will assess which drinkers and which alcohol-caused harms respond most to minimum prices," added Chris Auld, a co-author in the study, "yet our initial results suggest minimum pricing effectively reduces drinking. Higher minimum prices may also permit lower taxes on higher priced drinks without increasing associated harms."

In practice, British Columbia has allowed minimum prices of beer, wine and coolers to go down over time and only the minimum prices for spirits have kept pace with inflation. "If minimum prices were today what they were in 1987, alcohol consumption would be about 4% lower than it is now," noted Auld.

Minimum prices in British Columbia vary by alcohol type. Current pricing rules mean that, for example, one 341 ml bottle of beer with 8% alcohol content may not be sold for less than \$1.21 in a government



Dr Chris Auld

liquor store—or 75 cents for one Canadian standard drink.

The study is the first report from a program of research funded by the Canadian Institutes of Health Research (CIHR) being conducted by an international consortium led by Stockwell with collaborators at the Centre for Addiction and Mental Health, Ontario; the Alcohol Research Group, California; and the School of Public Health, University of Sheffield, UK.

Forthcoming papers from this CIHR-funded program will focus on the impacts of minimum pricing in several Canadian provinces on both consumption patterns and levels of alcohol-related harm.

Minimum Pricing is available at the Addiction website: <http://onlinelibrary.wiley.com/>

Alcohol and your heart: friend or foe?

A meta-analysis done by the Canadian Centre for Addiction and Mental Health (CAMH) into the relationship between alcohol consumption and heart disease provides new insight into the long-held belief that drinking a glass of red wine a day can help protect against heart disease.

“It’s complicated,” says Dr Jürgen Rehm, Director of Social and Epidemiological Research at CAMH. Dr Rehm’s paper, co-authored by Michael Roerecke, was recently published in the journal *Addiction*. “While a cardio-protective association between alcohol use and ischaemic heart disease exists, it cannot be assumed for all drinkers, even at low levels of intake,” says Dr Rehm.

Ischaemic heart disease is a common cause of illness and death in the Western world. Symptoms are angina, heart pain, and heart failure. Based on 44 studies, the analyses used 38,627 ischaemic heart disease events (including deaths) among 957,684 people.

“We see substantial variation across studies, in particular for an average consumption of one to two drinks a day,” says Dr Rehm. The protective association may vary by gender, drinking patterns, and the specific health effects of interest. Differential risk curves were found by sex, with higher

risk for morbidity and mortality in women.

Moreover, for any particular individual, the relationship between alcohol consumption and ischemic heart disease should not be isolated from other disease outcomes. Even at low levels, alcohol intake can have a detrimental effect on many other disease outcomes, including on several cancers.

“Even one drink a day increases risk of breast cancer, for example,” says Dr Rehm. “However, with as little as one drink a day, the net effect on mortality is still beneficial. After this, the net risk increases with every drink.”

“If someone binge drinks even once a month, any health benefits from light to moderate drinking disappear.” Binge drinking is defined as more than four drinks on one occasion for women, and more than five for men.

Given the complex, potentially beneficial or detrimental effects of alcohol on ischaemic heart disease in addition to the detrimental effects on other disease categories, any advice by physicians on individual drinking has to take the individual risk constellation (such as familial predisposition for certain diseases and behavior with respect to other risk factors) into consideration.

“More evidence on the overall benefit-risk ratio of average alcohol consumption in relation to ischaemic heart disease and other diseases is needed in order to inform the general public or physicians about safe or low-risk drinking levels,” the study concludes. “Findings from this study support current low-risk drinking guidelines, if these recognize lower drinking limits for women.”

The Centre for Addiction and Mental Health (CAMH) is Canada’s largest mental health and addiction teaching hospital, as well as one of the world’s leading research centres in the area of addiction and mental health. CAMH combines clinical care, research, education, policy development and health promotion to help transform the lives of people affected by mental health and addiction issues.

CAMH is fully affiliated with the University of Toronto, and is a Pan American Health Organization/World Health Organization Collaborating Centre.

Michael Roerecke and Jürgen Rehm. The cardioprotective association of average alcohol consumption and ischaemic heart disease: A systematic review and meta-analysis. *Addiction* 107: doi: 10.1111/j.1360-0443.2012.03780.x

New Zealand report looks at deadly impacts of alcohol on children and young people

A New Zealand report has highlighted the strong contribution of alcohol to the dramatic increase in that country in the rate of death by injury after the age of fifteen, with many young people becoming victims of their own drinking or the drinking of others.

The Child and Youth Mortality Review Committee (CYMRC) special report into the role of alcohol in the deaths of children and young people in New Zealand reviews the deaths of children and young people aged from 28 days to 24 years old.

The report considers 357 deaths from injury, during the years 2005 to 2007, of children and young people aged between 4 weeks and 24 years. In 87 of these, the death was attributable to alcohol or alcohol clearly contributed to the death. Of these 87 deaths, 49 involved a motor vehicle, 16 involved assault and 11 were due to drowning. The majority of these deaths related to young people 15 to 24 years.

CYMRC Chair Dr Nick Baker says there is a dramatic increase in death and injury rates from the age of 15, often related to adolescent risk-taking behaviour for which alcohol is a precipitating factor.

“For instance, we see deaths and injuries sustained by teenagers who drive while drunk, get

into cars driven by other people who are drunk, or suffer fatal assault while under the influence themselves or where the assailant has been drinking.

“Binge drinking is a particular problem when added to the natural tendency of this age group to take risks, contributing to many deaths in young people.”



Dr Nick Baker

Dr Baker says alcohol and motor vehicles are a lethal mixture.

“We need to put as much separation as possible between the processes of young people learning how to drink alcohol responsibly and learning how to drive safely. This is why CYMRC expressed support for the recent introduction of a zero blood-alcohol limit for teenage drivers, and enforcement of legislation to prevent young people from breaching the conditions of their driving licences.

“The report also highlights that females and younger males most frequently die because of other people’s drinking. This is a very important message for young people who want to keep themselves safe and for parents

and caregivers so they can support their young people to stay safe.”

Dr Baker says the report recommends limiting the availability of alcohol and making it less attractive, asking communities to consider establishing liquor bans in some areas, and extending ‘host responsibility’ and health promotion messages.

An important part of making alcohol less attractive to young people is reducing the sponsorship and advertising that creates close links between sport, sporting role models and alcohol, he says.

The report notes that there is very little information about the impact of alcohol on the supervision and care of infants and children.

“Police do not have a mandate to test for alcohol-related impairment whenever a child is injured or dies.”

He says every infant and child needs a sober caregiver, and anyone who drinks to the point of impairment needs a sober friend to help keep them safe.

The report - The involvement of alcohol consumption in the deaths of children and young people in New Zealand during the years 2005 – 2007 - is available on the Health Quality & Safety Commission’s website (www.hqsc.govt.nz) and the CYMRC website (www.cymrc.health.govt.nz)

Australian Health experts call for state-wide review of closing hours

The Australian Alcohol Policy Coalition (APC) has called for the State of Victoria to conduct a state-wide review of closing hours for licensed premises.

The prompt for the call was the Victorian Government's new Chapel Street planning reforms, which include limits on new late-night licenses in the area.

"The peak hours for alcohol-related casualties are between midnight and 6am on weekend nights, as shown in the ambulance attendance data", said Professor Robin Room, Director for the Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre. "Research shows that with extended trading hours of licensed outlets, there is a direct increase of alcohol-related problems in the community."

The APC states that the Victorian community is concerned about unrestricted availability of alcohol, such as 24-hour bottle shops and late night venues. Melbourne is a 24 hour city so it is natural for people to be out late at night. However, the APC says, late-night activities should not be fuelled by alcohol. "Emergency doctors and nurses, the ambulance service, the police, and others who pick up the pieces all can tell of the tragic consequences", Professor Room added.

He continued:

"The APC proposes that nightclubs and other late-night venues should stop serving alcohol at 3am. They can stay open later, but without adding more alcohol to the mix. To avoid "preloading", "side-loading" and "post-loading", bottle-shops need to close at 11pm. We call for a state-wide review to consider these and other proposals for reducing the harm from late-night drinking."



Professor Robin Room

The APC argues that with every additional liquor shop, the rates of assault and chronic disease go up. This is particularly problematic because it is known that most (75%) of the alcohol sold in Victoria comes from bottle shops or liquor barns. The number of packaged liquor outlets in Victoria has more than doubled in the last two decades. Studies in Melbourne have shown that with a greater number of bottle shops, the surrounding

community sees a rise in rates of street violence and alcohol-related chronic disease.

Alcohol remains a major cause of preventable death and illness across the state. It hospitalises 24,700 Victorians and kills more than 750 every year. Alcohol-related harms cost Victorian taxpayers more than \$4billion every year. This is something we have the power to prevent. Alcohol-related harms to Victorians have increased dramatically in the last two decades as the number of alcohol stores has gone up. The number of drunken 16-17 year olds presenting to emergency rooms has increased by 33% for males and 66% for females since 1999.

Opinion surveys show that an increasing number of people think that Australians have a problem with excess drinking or alcohol abuse (80%), up from 73% in 2010. The majority of Australians (82%) believe that more needs to be done to address alcohol-related harms.

The Alcohol Policy Coalition is a collaboration of health agencies – Australian Drug Foundation, Turning Point, Alcohol and Drug Centre and VicHealth – with shared concern relating to the misuse of alcohol and its health/social impacts on the community.

For more information visit www.alcoholpolicycoalition.org.au

FIFA colludes with Drinks Industry to change Brazilian Law

Brazil is the country of soccer. But, for many years now, there has in several states been a ban on alcohol in sports stadia because of the violence associated with matches. The ban was enacted into law in the city of Sao Paulo. Besides banning the sales of alcoholic beverages in stadia this law also bans sales in the surrounding area two hours before and one hour after sports events. The prescribed penalty is confiscation of the product being sold plus a fine of approximately \$555 U.S. dollars. A second offence doubles the penalty, and a third one may lead to a loss of the commercial license. This has been a successful history of alcohol policy, resulting in a significant drop in violent events, and everybody was happy with this situation until FIFA stepped in.

FIFA are imposing the lifting of the ban on sales of alcoholic beverages in soccer stadia during the 2014 world cup matches. FIFA's actions are linked to a multimillion dollar contract that the organization has with



Budweiser, and which is in force until 2014. The indication is that, as in the 2010 world cup in South Africa, only Budweiser will be sold during the games. Corporate interests are trumping the public health and safety interests of Brazilians.

While most in Brazil believe that the ban will be lifted no matter where games are played and no matter what types of laws mandate the ban, the political debate is not yet over, and very recently it took a new twist. First, on March 28, 2012, the bill "Lei Geral da Copa" (Cup General Law), which provides a legal framework regulating the cup in Brazil, was approved by the lower chamber in the Brazilian Congress (Camara dos Deputados or the Deputies Chamber). The bill is to be debated by the senate side of the Brazilian congress in May 2012. Several deputies and senators are openly against the lifting of the ban, and even public opinion clearly shows the same feeling. However, the force of corporate FIFA and the threat of taking the World Cup elsewhere can become too strong an argument for our politicians, and at the end the most likely outcome is that Brazil will surrender its sovereignty to the interest of the alcohol industry having FIFA defending their interest.

Professor Dr Ronaldo Laranjeira
Professor of Psychiatry – Federal
University of São Paulo - Brazil

Globe Comment:

This is not the first time that Anheuser-Busch (a USA-based company) has aggressively lobbied against the alcohol control policies of other nations. In 1997 the American brewer, a major sponsor of the World Cup, attempted to thwart France's alcohol advertising ban (Loi Evin) in order to advertise Budweiser in French stadia.

The French Government was not prepared to yield and, as a consequence, Anheuser-Busch sold its billboards.

The Alcohol Industry knows only too well the potential of sponsoring and advertising during the World Cup and other international sporting events. Such investment is repaid many times over with increased sales. Alcohol and sport is a mismatch. It sends the wrong message to young people and circumvents the Drinks Industry's own self-regulatory codes. It is time for FIFA and other sports organisations to recognise this and, at least, to support the national alcohol control policies that have proven to be effective in protecting the young and helping to curtail violence and other alcohol-related harm.

Binge drinking endemic in Chinese culture

Highest prevalence in middle aged

A nationwide study published in the journal *Addiction* confirms that binge drinking has reached epidemic proportions in China, and argues that efforts to tackle the problem must address the country's unique drinking culture.

In this study, binge drinking was defined as consuming 50g or more pure alcohol in one day for men (about five 330ml tins of beer), and 40g or more for women. The study found that, of the almost 50,000 people surveyed across China, 55.6% of men and 15% of women were current drinkers, having had at least one drink in the previous twelve months. Among current drinkers, men averaged a daily intake of 47.8 grams of pure alcohol, with a median of 5.6 binges per year. Women fared a bit better, with an average daily intake of 19.1g and a median of 2.4 binges per year. 26% of male drinkers and 8% of female drinkers were classed as 'frequent drinkers', drinking 5-7 days per week.

So among Chinese people who drink, the average man regularly drinks to just below binge level and has a true binge about once every two months. The average woman drinks to excessive levels (above 15g per day) and binges about once every 5 months.

What makes China unique among other heavy drinking

countries, the authors say, is that drinking frequency, quantity, and binge drinking increase with age. The heaviest Chinese drinkers are middle-aged or beyond, while drinking levels in other countries tend to peak in people's late teens and early twenties.

There is a cultural basis for this difference: Chinese youth are expected to concentrate on education and avoid alcohol, while older people are encouraged to drink during social occasions to enhance friendships and build relationships with business partners. Entrenched drinking customs in China also contribute to the problem, such as frequent dining out, drinking with business partners, toasting (urging one another to drink), and popular drinking games such as 'Wager' that encourage excessive drinking.

China's drinking problem is exacerbated by the overwhelming popularity of spirits over wine. Spirits have much longer history in China than wine and are more accessible, especially in rural areas or undeveloped regions.

The lead author of this study, Yichong Li, says that if the China wants to curb its national drinking levels it must develop culturally specific interventions. "The Chinese mass media, especially the mainstream media, is awash with ads for alcoholic beverages. And there are no

regulations for access to alcoholic beverages, so people of any age can buy alcohol. Frequent moderate drinkers in China are very likely to be binge drinkers, because they are often urged to drink at special occasions, and may need more alcohol than usual to reach a higher mood. Given these characteristics, the most effective interventions for China would be to limit alcohol commercials, increase alcohol taxes, restrict availability and, most importantly, change Chinese people's entrenched attitudes toward drinking by persistently informing current and future generations about healthy drinking habits."

The Chinese government already recognises that the nation's drinking levels are too high. China's newly amended Road Traffic Safety Law addresses the increasing problem of drunk driving-related deaths across China. The amended law says drunk drivers can face criminal punishment or be banned from driving for life.

Li Y., Jiang, Y., Zhang, M., Yin, P., Wu, F., and Zhao, W. Drinking behaviours among men and women in China: The 2007 China Chronic Disease and Risk Factor Surveillance. *Addiction*, 106: doi:10.1111/j.1360-0443.2011.03514.x

Movies encourage teenage drinking



Young teenagers who watch a lot of movies featuring alcohol are twice as likely to start drinking, compared to peers who watch relatively few such films, reveals research published in the online journal *BMJ Open*. And these teenagers are significantly more likely to progress to binge drinking, the study shows.

The findings prompt the researchers to suggest that Hollywood should adopt the same restrictions for alcohol product placement as it does for tobacco.

They base their findings on a representative sample of more than 6500 US teenagers between the ages of 10 and 14, who were regularly quizzed about their consumption of alcohol and potentially influential factors over the last two years. These factors included movie viewing and marketing, the home environment, peer behaviour, and personal rebelliousness.

The teenagers were asked which randomly selected 50 movies they had seen from among the top 100 US box office hits in each of the preceding five years, plus 32 films grossing more than US \$15 million in the first quarter of 2003 - the year of the first survey.

The number of seconds of on-screen alcohol use, including product placement, in each of these 532 films was measured by trained coders. Given the movies

they reported seeing, adolescents had typically seen an estimated 4.5 hours of on-screen alcohol use and many had seen in excess of eight hours.

Around one in 10 of the teenagers (11%) said they owned branded merchandise, such as a T-shirt or hat with the name of a beer/wine/spirit on it. And nearly one in four (23%) said their parents drank alcohol at least once a week at home; 29% said they were able to get hold of alcohol at home.

Over the course of the two years, the proportion of teenagers who started drinking alcohol more than doubled from 11% to 25%, while the proportion who began binge drinking - defined as five or more drinks in a row - tripled from 4% to 13%.

Parents who drank at home, and availability of alcohol in the home, were associated with taking up drinking, but not progression to binge drinking. Exposure to alcohol in movies, owning branded merchandise, having friends who drank, and rebelliousness were associated with both.

After adjusting for factors likely to influence the results, teenagers who watched the most movies featuring alcohol were twice as likely to start drinking as those who watched the least. And they were 63% more likely to progress to binge drinking.

Alcohol in movies accounted for 28% of the proportion of teens who started drinking between surveys and for 20% of those who moved on to binge drinking.

The association was seen not only with movie characters who drink, but also with alcohol product placement, suggested the authors.

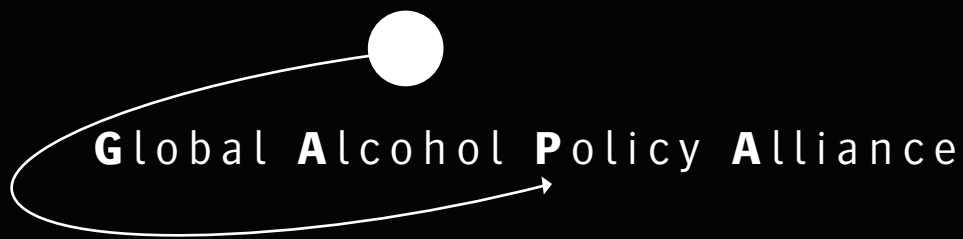
“Product placement in movies is forbidden for cigarettes in the USA, but is legal and commonplace for the alcohol industry, with half of Hollywood films containing at least one alcohol brand appearance, regardless of film rating,” they write.

They point out that the depiction of smoking in movies has fallen since it became a public health issue and the subject of industry monitoring, and suggest that alcohol in movies “may deserve similar emphasis”.

Hollywood has responsibilities further afield, given that half its movie revenues come from overseas, they add.

“Like influenza, images in Hollywood movies begin in one region of the world then spread globally, where they may affect drinking behaviours of adolescents everywhere they are distributed,” they write.

Comparing media and family predictors of alcohol use: a cohort study of US adolescents doi: 10.1136/bmjopen-2011-000543]



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