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THE GLOBE

Rising Burden of Cancer - Prevention the Key

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World Cancer Report 2014
Rising Burden of Cancer - Prevention the Key

Derek Rutherford reviews the World Cancer Report 2014.

In a Foreward to the Report Dr Margaret Chan, WHO Director General, writes: "The rising burden of cancer and other NCDs places enormous strain on the health care systems of developing countries, many of which are ill equipped to cope with the escalation in the number of people with cancer. Developing countries find themselves in the grip of cancers from two vastly different worlds. The world of poverty and the world of plenty."

The Report has had 254 contributors. It is a very comprehensive covering of the issue with sections on etiology, biology, organ sites in 630 pages. This review concentrates on the sections dealing with alcohol consumption and advocacy.

Incidence of cancer has increased from 12.7 million in 2008 to 14.1 million in 2012, an 11% increase. It is expected to rise by a further 75% over the next two decades bringing the total number of cancer cases to 25 million.

The greatest impact will be in low and middle income countries. The need to elucidate the causes and devise effective prevention strategies are essential to cancer control according to Dr Christopher P. Wild, Director, IARC, "We should put out the fire while it is still small….. Prevention must be writ large in cancer control plans if we are to defy the dark prediction of the statistics."

With 14 million new deaths and 8 million cancer-related deaths in 2013 affecting population in all countries and regions, it is a major cause of morbidity and mortality. Age standardised incidence and mortality rates of 182 and 102 per 100,000 respectively. Among men the five most common sites are: Lung 16.7%; Prostate15.0%; Colorectum 10%; Stomach 8.5%; Liver 7.5%. Among women: Breast 25.2%; Colorectum 9.2%; Lung 8.7%; Cervix 7.9%; Stomach 4.8%.

For all cancers the highest incidence rates (excluding non-melanoma cancer) – are the high income countries of N. America, Western Europe, Japan, Republic of Korea, Australia and New Zealand.

More than 60% of the world's cases occur in Africa, Asia Central and South America and account for 70% of cancer deaths.

Alcohol Consumption

In 2010 the number of deaths caused by malignant neoplasm attributable to alcohol consumption were 337,400 (91,500 of women and 245,900 of men) and disability adjusted life years lost were 8,670,000 (2,252,000 for women and 6,418,000 for men). The relationship between alcohol consumption and cancer has been known since the beginning of the 20th century. Alcoholic beverages were declared 'carcinogenic to humans' by the IARC Monograph programme in 1988; 2007; 2008.

People who were more likely to consume alcohol (those involved in alcohol distribution, production), had a higher risk of head and neck cancers than abstainers. Abstainers also had a markedly lower risk of these cancers compared with the population as a whole.

Cancer deaths attributable to alcohol in the top five regions of the world are as follows:

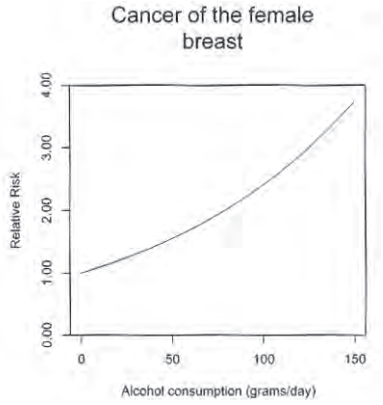
Deaths per 1000,000 people	
	Male
Europe Eastern	12.9
Asia East	11.8
Europe Central	11.2
Europe Western	8.2
Asia Pacific (high income)	8.1
	Female
Europe Eastern	5.7
Europe Western	4.8
Oceana	4.6
Latin America Southern	4.4
Australasia	4.1

Regions based on the WHO Global Burden of Disease.

The region with the lowest rate is North Africa/Middle East for both male and female 0.8 and 0.5 respectively.

Cancers where alcohol consumption may be a component cause:

Causally related: cancers of oral cavity and pharynx; larynx; oesophagus; colorectum; liver and female breast. Relationship between average daily alcohol consumption and risk of mortality from cancers of the upper digestive tract and female breast is exponential; cancers of the lower digestive tract, mouth and oral cavity is linear.



Former drinkers, people who had not consumed alcohol within the previous year but who had consumed in their lifetime, are found to have a higher risk of cancer compared with lifetime abstainers.

Evidence suggests a synergistic effect of tobacco smoking and alcohol consumption on cancer risk of oral cavity, pharynx, larynx and oesophagus and very high risks in individuals who are both heavy drinkers and heavy smokers.

Elizabeth A. Montgomery writes: "Alcohol consumption and tobacco smoking and chewing are the strongest risk factors for the development of oesophageal squamous cell carcinoma."

Lester D.R. Thompson writes: "If there were total abstinence from drinking and smoking (or quid chewing) worldwide, the risk of oral, pharyngeal and laryngeal cancers would be extremely low."

Alcohol consumption shows a strong multiplicative effect with tobacco, perhaps related to acetaldehyde, an intermediate metabolite of ethanol and a known carcinogen. Avoidance of cigarettes and alcohol could prevent up to 80% of oral cancer and up to 90% of laryngeal.

Table 1 on page 5 shows the percentage of deaths and disability life years lost from various forms of cancer attributable to alcohol in 2010.

The report points out that the 2010 data reflects the level of drinking in the early 1990's due to the long time it takes for cancer to develop.

The burden of alcohol attributable to cancers can be reduced through alcohol policy measures such as reduction of availability, increase in price and marketing bans.

Pekka Puska in his contribution on 'Prevention strategies common to noncommuncable diseases' maintains that population based prevention is the most effective public health approach. He confirms the need to address tobacco use; unhealthy diet; physical inactivity and harmful use of alcohol through an integrated NCD prevention perspective. Puska writes:

"Influencing the behavioural risk factors common to several major NCDs in the general population is a cost effective and sustainable public health approach immediately relevant to cancer prevention."

Whilst recognizing that several other measures can substantially contribute to cancer prevention: screening programmes; measures to control certain infectious diseases; action to prevent skin cancer and lung cancer "the prevalence of harmful use of alcohol is closely related to the level of alcohol consumption in the general population. Accordingly interventions should not be confined to 'high risk intervention' among problem users but should address general alcohol policy and be population based interventions."

Table 1

Percentage of deaths from various forms of cancer attributable to alcohol consumption, in 2010									
	Mouth cancer	Cancer of the nasopharynx	Cancer of other part of pharynx and oropharynx	Oesophageal cancer	Cancers of the colon and rectum	Liver cancer	Laryngeal cancer	Cancer of the female breast	All cancer deaths
Total	27,8%	29,3%	26,7%	19,4%	5,5%	10,7%	21,5%	8,8%	4,2%
Women	11,6%	12,6%	9,3%	8,3%	5,2%	6,4%	7,9%	8,8%	2,7%
Men	37,0%	36,3%	32,5%	23,8%	5,8%	12,7%	23,5%		5,4%
Percentage of disability-adjusted life years (DALYs) lost from various forms of cancer attributable to alcohol consumption, in 2010									
	Mouth cancer	Cancer of the nasopharynx	Cancer of other part of pharynx and oropharynx	Oesophageal cancer	Cancers of the colon and rectum	Liver cancer	Laryngeal cancer	Cancer of the female breast	All cancer deaths
Total	28,9%	29,3%	27,4%	20,4%	5,6%	11,2%	22,5%	9,0%	4,6%
Women	11,8%	12,7%	8,9%	8,5%	5,3%	6,4%	8,2%	9,0%	2,8%
Men	37,5%	36,1%	33,9%	24,8%	6,0%	13,0%	24,6%		6,0%

"There is consensus about effective intervention to reduce alcohol consumption – price and availability being the most effective; other interventions limit drink driving and mini intervention in health services." These are outlined in the 2010 WHO Global Strategy to Reduce Alcohol Related Harm.

Puska goes on "Marketing policies should be aimed at reducing the impact of advertising and other marketing; particularly as these matters affect young people. Frameworks should be established to regulate the nature of, and amount of expenditure on, marketing and sponsorship."

Need for Advocacy

The Report calls for the need for effective health advocacy to raise political awareness and influence public policy decision-making.

The 2011 UN General Assembly High Level Meeting on the Prevention and Control of NCDs provides the opportunity to position cancer as a global health and development issue.

Only 43% of low-income countries reported having operational National Cancer Control Plans. Even in countries with cancer plans programmes are not always supported with the necessary funding.
The percentage of populations covered by a cancer registry is 95% in N America; 42% in Europe but only 6% in Latin America and Asia; and 2% in Africa.

The World Economic Forum identified NCDs as the second greater risk to global economic growth.

One half of those who die from NCDs are in their most productive years – consequently social and economic costs of lost productivity are considerable.

The cost of cancer alone is estimated to reach $458 billion by 2030, yet WHO estimates that a package of cost-effective strategies to address the commonest risks - alcohol consumption, unhealthy diet and physical inactivity would only cost $2 billion a year.

Less than 3% of $22 billion of overall development assistance for health was allocated to NCDs in 2007, despite 80% of preventable deaths from such diseases occurring in developing countries.

Poster from the 2012 Government of Western Australia campaign on alcohol and cancer risks.

From local action to global change

Øystein Bakke writes:

The Global Alcohol Policy Conference (GAPC) was hosted by Sahmyook University together with the Global Alcohol Policy Alliance (GAPA), South Korean Ministry of Health and Welfare and Seoul Metropolitan Government. The World Health Organization (WHO) and FORUT were among the many co-sponsors. The organisers had put together a comprehensive programme under the topic "Alcohol; Civil Society and Public Health – From Local and National Action to Global Change". The objective was to promote evidence based alcohol policy through cross sector participation free from commercial interest.
More than 850 participants from 55 countries attended the conference. Low- and middle income countries in Asia and Africa were well represented.

Dag Rekve from WHO set the stage in the first plenary session by presenting the WHO efforts to implement the Global strategy to reduce the harmful use of alcohol. Says Rekve: "We have the instruments – there is no excuse for inaction anymore."

In the next presentation Dr Thaksaphon Thamarangsi, Director of Health Promotion Policy Research Center in Thailand, drew up the picture by bringing in personal stories from his time as a doctor in the rural areas of Thailand as illustrations of the broader topic of alcohol's harm to others.

The presentations covered a wide range of topics, but all contributed to bringing science together with action and advocacy for alcohol policy and reduced alcohol related harm. The conference is unique in that it is an opportunity for collaboration, networking and mobilization of stakeholders from three sectors: civil society, academic and policy makers.

The Seoul Declaration agreed by the conference, states that "Evidence-based and cost-effective interventions exist to reduce alcohol-related harm at global, national and local levels. These interventions, when implemented and enforced, could have profound health, social and economic benefits throughout the world."

The Declaration calls on intergovernmental agencies, NGO networks, national and local governments, academia, civil society, professional organizations, communities, and individuals, at all levels to take action. Included in these calls are:

- Integrating into national development agendas the evidence-based interventions outlined in the Global Strategy;

Members of GAPA Board at the Reception

- Increasing budgetary allocations for reducing alcohol-related harm;

- Establishing the strongest possible statutory restrictions on alcohol marketing of all kinds;

- Strengthening efforts of civil society groups and organizations to reduce alcohol-related harm;

The first Global Alcohol Policy Conference (GAPC) was held in Syracuse in the state of New York, USA, in 2000. The second conference in Bangkok was held in March 2012. The next GAPC conference will be in Edinburgh, Scotland in 2015 and will be hosted by Alcohol Focus Scotland.

The next GAPA Board meeting to discuss GAPC will be held in São Paulo from the 16 - 18 May 2014 at the invitation of Professor Ronaldo Larajneira.

Global Alcohol Policy Conference

"From Local and National Action to Global Change" Seoul, Korea, 7-9 October, 2013

DECLARATION

PREAMBLE

We, the participants of the second Global Alcohol Policy Conference "From Local and National Action to Global Change", gathered in Seoul, Korea on 7-9 October 2013.

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;

Reaffirm the overarching principles of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020 adopted at the World Health Assembly in May 2013, particularly the importance of empowerment of peoples and communities, evidence-based strategies, multisectoral action, and the management of real, perceived or potential conflicts of interest; as well as the need to reduce modifiable risk factors for noncommunicable diseases and underlying social determinants through creation of health-promoting environments; the voluntary global target of achieving at least a 10% relative reduction in the harmful use of alcohol within each national context; and the adoption of the indicators of total (recorded and unrecorded) per capita consumption (aged 15+ years old) consumption within a calendar year in litres of pure alcohol; age-standardized prevalence of heavy episodic drinking among adolescents and adults; and alcohol-related morbidity and mortality among adolescents and adults, all as appropriate within the national context;

Recall and reaffirm the Statement of Concern signed by more than 500 individuals and organizations from around the world, calling on alcohol companies to refrain from further lobbying against effective public health measures, and from further engagement in health-related prevention, treatment, and traffic safety activities;

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 organizations, researchers and community leaders from all over the world to promote and support action to continue 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 fifth leading risk factor for death and disability, the third leading risk factor for males and the twelfth leading risk factor for females. Alcohol is the leading cause of death and disability among persons aged 15 to 24 in every region of the world except the Eastern Mediterranean. While alcohol's burden is greater in better-resourced countries, it is also clear that harmful use of alcohol and related consequences tend to rise with national incomes and national development and thus the development of strong alcohol control policies are an essential task in low- and middle-income countries.

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 recognized the critical importance of reducing the harmful use of alcohol as part of the global response to noncommunicable diseases.

Alcohol-related injuries, including those resulting from road traffic crashes and interpersonal violence, cause a significant public health burden. In addition, evidence continues to mount documenting the role of harmful use of alcohol in infectious diseases such as HIV and TB. 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 three "best buys" controlling physical availability, restricting marketing, and raising the price of alcohol, 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, 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 other unhealthy products and establishing a health promotion agency to carry out research and public health advocacy in support of cost effective interventions to reduce harmful use of alcohol and to identify and treat those with alcohol use disorders.

3. Establishing the strongest possible statutory restrictions on alcohol marketing of all kinds, in recognition of the growing body of literature linking youth exposure to alcohol marketing with increased

likelihood of early initiation of alcohol use, which in turn is linked to greater likelihood of adverse consequences of alcohol use including injury and dependence.

4. 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 organizations 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.

5. 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 such as adult per capita alcohol consumption, recognizing that such systems and measures 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:

6. 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.

7. 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.

8. 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.

9. Ensuring that global economic agreements do not undercut, invalidate or in other ways limit national efforts to establish and enforce evidence-based policies to reduce the harmful use of alcohol, including government monopolies on alcohol distribution, minimum pricing and health-oriented taxation, and restrictions on physical availability and marketing;

10. 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.

11. 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.

12. 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.

13. 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 and revision of the Millennium Development Goals.

Alcohol Advertising and Youth Alcohol Consumption: The case grows stronger
Professor David Jernigan

In the U.S., we have a history of court cases providing strong protections for "commercial speech" that has the effect of leaving most restrictions on alcohol advertising in the hands of alcohol companies themselves, in the form of industry self-regulation.

However, this leaves regulation of alcohol advertising in the hands of an entity - the industry - that consistently denies that alcohol advertising has any relationship with alcohol consumption. Leading alcohol industry spokespersons tend to rely on two arguments to support their position. First, they point out that alcohol advertising spending has increased but U.S. per capita consumption of alcohol has declined since 1977. In recent years (since the mid-1990s), alcohol consumption in the U.S. has been rising, so the industry points to youth consumption, which is dropping, and makes a similar argument, referring to population-based approaches such as advertising and marketing restrictions as "'sky is falling' rhetoric and misguided policy prescriptions of anti-alcohol advocacy groups" that are "unfounded and not evidence-based."(Distilled Spirits Council of the United States, 2013)

If one of our public health students made the industry's simplistic argument that, since advertising spending is rising and consumption is falling, the two are unrelated, he or she would fail basic statistics. There are many reasons why companies advertise, and there are many factors besides advertising that influence per capita alcohol consumption. For instance, the population as a whole tends to drink less during recessions (Harhay et al., 2013, Nandi et al., 2013). When the population is drinking less, it is conceivable that companies might advertise more rather than less, in an attempt to reverse the negative trend in consumption. Companies often advertise heavily to introduce new products, and these products often fail in the marketplace – just try to remember Ice Beer and wine coolers. In short, as a commentator in Forbes magazine recently wrote, "tracing sales to ad spend is nearly impossible." (Kelly, 2010)

What about the industry's argument that because youth consumption is dropping, therefore alcohol advertising does not influence young people's drinking? There are similar general problems with this position: many factors influence consumption, including advertising, and just because ad spending is rising and consumption is falling does not mean the advertising has no impact. Our most reliable body of evidence to date that alcohol advertising does influence youth drinking comes from longitudinal studies that have followed groups of young people, measuring their advertising or media exposure as well as their drinking behavior over time. There are now at least 15 such studies in the published, peer-reviewed literature (Anderson et al., 2009, Grenard et al., 2013), and they have generally found that the greater their exposure to alcohol advertising or marketing, the more likely young people are to start drinking or, if already drinking, to drink more.

Research on the association between youth advertising exposure and drinking behaviors is growing stronger. Some of the existing studies measured media exposure by asking young people if they usually watched a group of television programs that contained alcohol advertising, and then assuming exposure to the advertising based on young people's responses. Others have used estimates of media spending in a young person's media market (a measure with the limitations discussed above about media spending). The studies have also generally looked at exposure to alcohol advertising overall, as opposed to advertising for particular alcohol brands.

Similarly, when looking at youth alcohol consumption, some studies have broken it down by alcohol type but they have

not looked at consumption by brand. There are approximately 900 alcohol brands fairly widely available in the U.S. alcohol marketplace. Some of these brands advertise very little, and some advertise a lot. Some appeal to older drinkers; others are very clearly targeting younger ones, or women, or racial or ethnic groups. When, as most studies have done, researchers use overall alcohol consumption as the main outcome variable, they run the risk of washing out the effects of individual brands' advertising behavior on youth consumption of those brands.

At the Center on Alcohol Marketing and Youth at the Johns Hopkins Bloomberg School of Public Health, we use the same data as most advertisers to measure exposure: commercial sources such as Nielsen that measure exposure at the population level. On the consumption side, with colleagues at Boston University we recently completed the first-ever national survey of youth alcohol consumption by brand. More than 1,000 youth answered an on-line survey about nearly 900 brands.

We are now incorporating those data into studies of the relationship between alcohol marketing and youth drinking behavior. Early results lend further support to the hypothesis that there is a relationship between alcohol marketing and youth alcohol consumption. A cursory look at the beverages most popular among youth in the past 30 days shows that youth are neither drinking the cheapest brands nor the ones most popular with adults. Alcopops like Smirnoff Ice and Mike's Hard Lemonade are in the top ten (Siegel et al., 2013), and none of the top 25 brands among youth are among the 25 cheapest brands on the U.S. market (DiLoreto et al., 2012).

Future analyses will match our commercial exposure data with the youth alcohol consumption data by brand. Based on preliminary results, we anticipate they will strengthen the evidence that advertising does indeed influence youth alcohol consumption, and thus buttress the case for greater action to reduce youth exposure to that advertising.

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Obvious: Booze Advertising is Designed to get People Drinking

Professor Gerard Hastings

Of course advertising works

We in public health spend a lot of time proving the self-evident. It's nearly three decades since I first started researching the link between alcohol advertising and young people's drinking and I have lost count of the times friends, colleagues and complete strangers have looked at me sideways and said some variation on 'but surely it's obvious; booze advertising is designed to get people drinking, and they wouldn't spend all that money on it if it didn't work'. Sadly, however, common sense counts for little in the policy arena, so studies had to be done. And they were; hundreds of them: thousands of interviews, focus groups and real world observations. These required tens of thousands of words to explain the methods, detail the analyses and draw the conclusions. And this wasn't just done for the alcohol market[i], but for the food[ii] and tobacco[iii] sectors as well. All to establish that when powerful, well-resourced and fearfully skilful multinational corporations set about influencing our behaviour, they succeed; especially with children. To prove what Basil Fawlty would call the bleeding obvious.

Hunting in packs

This focus on the axiomatic not only wastes time, it distracts attention from wider concerns. Advertising is just one weapon in the corporate alcohol marketing arsenal, which also includes pricing, point of sale promotion, ubiquitous distribution, packaging and new product development. Each of these levers is a powerful influencer in its own right; in combination they are overwhelming. Price, for example, has a massive impact on what we buy. Think of all the special offers, from BOGOFs to multipacks, in your local supermarket and remember how susceptible we all are to them. That is why minimum unit pricing is such an effective policy measure; and why corporate alcohol is doing so much to fight it here in the UK.

Similarly new product development has had a monumental impact on UK alcohol consumption in the last twenty years. It began with the introduction of alcopops and designer drinks by small operators. When no one objected to this unholy melding of child centred sodas with an addictive drug, the multinationals moved in and gentrified the market. Corporate alcohol never talks about alcopops; the name has been excised from their language and replaced by the much more respectable sounding 'Ready to Drink' or simply RTD. Brand leaders like Bacardi Breezer and Smirnoff Ice have been kitted out in the sophisticated guise of pseudo-cocktails. And the RTD sector is now sufficiently respectable for a company of Diageo's blue chip standing to boast that 'the RTD sub-category continues to provide a strong platform for new innovations' and that 'Diageo GB will continue to develop innovations to drive category growth'[iv]. Meanwhile the small operators carry on producing their disgraceful test-tube drinks, one serving shots and 'Dragon's Soop' (combining energy drink stimulants like taurine and guarana with 8.5% alcohol) (see Figure 1). Such is the mind-numbing strength of this last offering that it is known in the West of Scotland vernacular as 'wreck the hoose juice'.

Meanwhile advertising has itself become hydra-headed. The once omnipotent television commercial is now combined with countless other conventional media from press and cinema to merchandising and sponsorship deals. As a result, in the UK, alcohol promotion has become a sort of cultural wallpaper, colouring all aspects of our lives. No wonder a UK brewer boasts that young men 'think about 4 things' and 'we brew 1 and sponsor 2 of them'[v]; no wonder 96% of thirteen year olds are aware not just of the occasional ad, but alcohol promotion in more than five different media (Figure 2).

Since this boast and this study, digital media have exploded on

Figure 1: A selection of alcoholic drinks currently available in the UK

to the scene. As the Health Select Committee enquiry of 2011 warned us it would, marketing spend in hyperspace is now outstripping that in the real world. This is not only exposing children to an alcohol suffused alternate reality, it is actually recruiting them into the marketing team. Kathy Parker, Diageo's senior vice-president of global marketing and innovation summed up the strategy as follows: "Facebook are working with us to make sure that we are not only fan collecting but that they are actively engaged and driving advocacy for our brands. We are looking for increases in customer engagement and increases in sales and [market] share."[vi] Kids are not just being sold alcohol, they are selling it to each other.

Stakeholder marketing

But corporate alcohol is not satisfied with getting children to do its dirty work, it also wants to co-opt leaders in politics, policy making and public health. Marketers are well aware that our individual consumption decisions are greatly influenced by policy measures such as taxation, licensing and marketing restrictions, so they are just as assiduous in their attempts to influence our leaders' behaviour, as they are that of their potential customers. And in the UK this 'stakeholder marketing' is causing just as much alcohol harm as consumer marketing. Two text book examples have just unfolded in the last few weeks.

First in September 2013 a bit of good journalism had revealed the shocking fact that nearly 300 children aged 11 or under had been admitted to hospital emergency rooms over the last year because they had drunk to excess. The BBC turned to the Drinkaware Trust (DAT) for a public health comment. The fact the DAT is wholly funded by the alcohol industry was never even mentioned. The resulting interaction is presented in Figure 3; unsurprisingly the DAT comment echoes the well-rehearsed industry line – this is a problem caused by peer pressure, weak parenting and the younger generation's unfortunate social networking habits. No mention is made of any industry responsibility whatsoever – not even the infamous deal with Facebook.

The second example is UK's Responsibility Deal Alcohol Network (RDAN), an attempt by the Health Ministry to work collaboratively with industry and public health. This also has to be seen through a stakeholder marketing lens. Alcohol companies earned their place at the table by making certain pledges – to introduce more responsible labelling for example, or boost the production of lower alcohol products. The quid pro quo for making these promises is an opportunity to build relationships with ministers, enhance corporate reputations and fend off unwanted regulatory measures. The RDAN is for them a monumental networking opportunity.

The danger for us in public health is that we focus our evaluation efforts on the pledges. Are, for instance, the new labels actually being introduced and if they are, what impact are they having on drinking behaviour and ultimately public wellbeing? This is our bread and butter; it calls for logic models, intricate diagrams and complex studies. It's what we do. But it misses the point.

Any public health gains from the pledges have to be balanced against industry gains from this stakeholder marketing. Properly implemented labelling improvements may result in measurable benefits, but these would be more than wiped out if industry's RDAN-energised relationship with Government enabled it to encourage the abandonment of much stronger evidence-based measures like Minimum Unit Pricing (MUP). And there is strong evidence that it has; as one of the public health representatives on the RDAN said in his resignation letter:

'I have sat with representatives of the alcohol industry in Responsibility Deal meetings for the last two years. Over this period I have seen the Deal turned by industry into a tool to avoid actions that would improve people's health. At the last meeting an industry representative even made it clear that their continued contributions to the Deal were dependent on a minimum unit price not being implemented.'[vii]

Figure 2: UK Children's exposure to alcohol advertising[ix]

Type of advertising	13 year olds (2006)	15 year olds (2008)
Sample size	*920*	*636*
	%	*%*
TV/Cinema	77	76
Sports Sponsorship	61	76
Clothing (sports tops)	66	73
Music Sponsorship	34	43
Sponsorship of TV & Film	30	32
Social networking sites	12	*34
Mobile communications	24	*21
Websites	14	*7
Any channel	**96**	***97***
Number of channels	**5.5**	***6.0***

*note: question wording changed between stages

Figure 3: Stakeholder marketing in action

On the 30th of September 2013 the news broke that a record number of children under the age of 12 had been admitted to hospital emergency rooms in a state of excessive drunkenness. Ordinarily this would be a big PR problem for corporate alcohol, and an independent public health expert would be on air calling for tighter controls on alcohol pricing, availability and marketing, each of which the evidence base shows affords powerful protections, especially to the young. Instead the Drinkaware Trust got the chance to explain the problem on the BBC[x], without any mention of the fact that it is entirely funded by industry.

The interviewer began by suggesting that it is 'really worrying that kids of 9, 10 or 11 are getting drunk, so drunk that they have to go to hospital.'

After calling for *'a little bit of perspective'* because overall *'the [teen drinking] trends are in the right direction'* the DAT spokesperson blames peer pressure, parents and social networking: *'there's enormous peer pressure on getting young people to drink; there's enormous peer pressure on parents to provide alcohol for teenage parties or sleepovers, or whatever. Our guidance to parents is talk to your child ... because as parents we're setting the norms in the home ... So boundary setting is important. ... But it's not just parents. We know from our research that 40% of children aged 10-17 who were using social networking sites tell us they see images of their friends drunk online. So we're beginning to get a normalisation of excessive drinking to the point of drunkenness that is really influencing our children, and parents need to feel equipped to have that conversation with them as well.'*

Not a word about the £800m being spent every year in the UK promoting drinking, much of it on social networking campaigns. No mention of cheap alcohol, minimum unit pricing or ubiquitous distribution. Complete silence regarding infantilising new product development.

And this is supposedly the public health response.

Shortly after this meeting the Cameron Government abandoned MUP[viii]. In these circumstances focusing on individual pledges would be like the Trojans rejoicing that they had got their hands on some nice timber when they discovered the wooden horse.

The Devil you know

The one thing that can be said in favour of alcohol advertising is that we know it is there. It might distract us into doing axiomatic studies, but at least we can spot it. The rest of corporate alcohol's marketing effort, however, keeps its head down. The point of sale display that triggers an impulse purchase, the test-tube drink that never appears in respectable bars and the peer to peer Facebook campaign that parents will never see can easily slip under our radar. This marketing savvy, however, takes on a truly sinister cloak when it is targeted at our leaders.

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x On the Today Programme: the UK's premier radio news source

Drink dangers in pop music

Pop music contains increasing numbers of references to alcohol and these could undermine public health messages to children and young people, according to researchers at John Moores University in Liverpool in the UK.

The researchers examined the lyrics of Top 10 UK singles in 1981, 1991, 2001 and 2011 for references to alcohol. They found that the prevalence of alcohol references increased sharply between 2001 and 2011, when almost one in five (18.5%) songs referred to alcohol and one in eight (12.6%) to heavy drinking. Up to 3.0% of songs contained branded alcohol references.

Urban music genres (R&B/Rap/Hip-Hop) and artists from the USA were particularly likely to include alcohol references.

While this was a UK study, the global market for popular music gives it international significance.

The grounds for concern were that alcohol-related references were often positively framed, linking alcohol use to valued attributes, for example, confidence, gregariousness or physical attractiveness, and favourable outcomes, such as wealth, success or sexual activity, whilst largely neglecting the negative impacts that alcohol consumption can have on health and wellbeing. In this way, they suggest, the inclusion of alcohol references in popular music can be more than just a portrayal of drinking behaviour, but also a form of advertising and marketing for alcoholic products.

The researchers say that further research should identify the impacts of alcohol references in lyrics on drinking attitudes and behaviours, and that health and other professionals should recognize increased alcohol promotion in popular music and ensure this does not reinforce binge drinking culture or contribute to already high burdens of alcohol on young people.

Global reach

The authors emphasise that though their analysis was limited to songs appearing in the UK charts, its findings may have global relevance as both US and British songs are pervasive in popular music throughout the world. For example, the 2011 single "Last Friday Night" by the US artist Katy Perry - describing a night of drinking "too many shots" and engaging in a range of risky and anti-social behaviours; with the intention to do it all again the following week - achieved a Top 10 position not only in the USA and the UK, but also in Australia, Austria, Canada, Croatia, Czech Republic, Hungary, Ireland, Italy, Lebanon, Netherlands, New Zealand, Poland, Slovakia, Spain and Venezuela. An analysis of charts in the Netherlands, Germany and France over 4 decades (1965–2006) found that US and British artists accounted for 53.4% of the most popular songs in the Netherlands, 41.6% of those in Germany and 21.7% of those in France. While public health concerns are already focused internationally on the impacts of alcohol advertising on the drinking behaviours of young people, the growing references to alcohol in popular music could mean that positive alcohol promoting messages are reaching much larger audiences; regardless of restrictions on direct advertising.

Trends in alcohol portrayal in popular music: A longitudinal analysis of the UK
http://pom.sagepub.com/content/early/2013/09/18/0305735613500701

The online version of this article can be found at: DOI: 10.1177/0305735613500701 published online 30 September 2013 Psychology of Music Katherine A. Hardcastle, Karen Hughes, Olivia Sharples and Mark A. Bellis charts

Challenge to claim that abstainers lose out on protective effect of alcohol

The notion of the J-shaped curve – the claim that both lifetime abstainers from alcohol and heavy drinkers have an increased risk of heart disease compared with light drinkers - has been challenged by a team of US researchers. The crux of the argument is that abstainers are a diverse group, and what applies to some may not apply to all.

It is frequently suggested that the increased mortality found among nondrinkers could be attributable to a protective effect of light drinking in relation to heart disease.

But researchers at the US University of Colorado Boulder, working with colleagues at the University of Colorado Denver, decided to examine whether characteristics of different subgroups of nondrinkers could explain the increased mortality risk.

"Among nondrinkers, people have all sorts of background reasons for why they don't drink," said sociology Professor Richard Rogers, Director of CU-Boulder's Population Program in the Institute of Behavioral Science. "We wanted to tease that out because it's not really informative to just assume that nondrinkers are a unified group."

For the new study, published in the journal Population Research and Policy Review, Rogers and his colleagues relied on data collected in 1988 by the National Health Interview Survey about the drinking habits of more than 41,000 people from across the United States. The researchers also had access to information about which respondents died between taking the survey and 2006.

During the survey, nondrinkers were asked to provide their reasons for not drinking. Possible answers ranged from "don't socialize very much" to "am an alcoholic" to "religious or moral reasons."

The research team divided nondrinkers into three general categories: "abstainers", or people who have never had more than 12 drinks in their lives; "infrequent drinkers", or people who have fewer than 12 drinks a year; and "former drinkers." Each category was further divided using a statistical technique that grouped people together who gave similar clusters of reasons for not drinking.

The team then calculated the mortality risk for each subgroup compared with the mortality risk for light drinkers, and they found that the risks varied markedly.

Abstainers who chose not to drink for a cluster of reasons that included religious or moral motivations, being brought up not to drink, responsibilities to their family, as well as not liking the taste, had similar mortality risks over the follow-up period to light drinkers.

"So this idea that nondrinkers always have higher mortality than light drinkers isn't true," Rogers said. "You can find some groups of nondrinkers who have similar mortality risks to light drinkers."

The other subgroup of abstainers - whose largest reason for not drinking appeared to be a dislike of the taste and to a lesser degree family responsibilities, religious or moral motivations or upbringing - had a 17 percent higher mortality risk over the follow-up period compared with light drinkers.

The scientists also found that infrequent drinkers generally had a slightly higher mortality risk than light drinkers. Former drinkers, however, had the highest mortality risk of all nondrinkers. Former drinkers whose cluster of reasons for not drinking now included being an alcoholic and problems with drinking, for example, had a 38 percent higher mortality risk than light drinkers over the follow-up period.

By comparison, people who drink between one and two drinks per day, on average, have a 9 percent higher mortality rate than light drinkers, while people who drink between two and three drinks per day have a 49 percent higher mortality. People who consume more than three drinks per day had a 58 percent higher mortality risk over the follow-up period compared with light drinkers.

Despite confirming that some subgroups of nondrinkers have a higher mortality rate than light drinkers, it doesn't necessarily follow that those people's mortality rates would fall if they began drinking, Rogers said. For example, people who were problem drinkers in the past might increase their mortality risk further by starting to drink again.

Also, people who don't drink at all, as a group, have lower socioeconomic characteristics than light drinkers, which could be one of the underlying causes for the mortality differences, Rogers said. In that case, starting to drink without changing a person's socioeconomic status also would not likely lower mortality rates.

"I think the idea that drinking could be somewhat beneficial seems like it's overstated," Rogers said. "There may be other factors that lower mortality for light drinkers. It's not just the act of drinking."

Irish Government announces introduction of minimum pricing of alcohol

Regulation of advertising and sponsorship also to be provided for in a Public Health Bill

The Irish Cabinet has approved an extensive package of measures to deal with alcohol misuse, to be incorporated in a Public Health (Alcohol) Bill. The main measures include:

- Minimum unit pricing for retailing of alcohol products
- Regulation of marketing and advertising of alcohol
- Enforcement powers will be given to Environmental Health Officers
- Structural Separation of alcohol from other products in mixed trading outlets
- Regulation of sports sponsorship

Announcing the new measures, Primary Care Minister Alex White said, "this is a landmark day. It is the first time alcohol misuse has been addressed as a public health issue. The Government has recognised the severe consequences of the misuse of alcohol – including deaths, injuries and social and financial problems – and has determined to take action to address this problem. The package of measures to be implemented is the result of intensive discussions across Government departments, and will include provision for minimum unit pricing for alcohol products and the regulation of advertising and marketing of alcohol."

Primary Care Minister Alex White

Continuing, Minister White said, "to implement this range of measures, the Government approved the drafting of the first ever piece of public health legislation to address the problem – the Public Health (Alcohol) Bill." The package of measures is based on the 2012 Substance Misuse Report. "The Report correctly identified that the misuse of alcohol could only be addressed through a range of complementary measures, rather than through any one single initiative", said the Minister.

Welcoming the Government decision Minister for Health Dr James Reilly said, "alcohol misuse in Ireland is a serious problem with two thousand of our hospital beds occupied each night by people with alcohol related illness or injury. This impacts on families and individuals at every level of society. It's deeply worrying too that young people are starting to drink earlier and to drink more. The average Irish person over the age of 15 is consuming the equivalent of a bottle of vodka a week. The Government is committed to tackling these problems and this week's decision marks a significant further step in that direction to create an

Minister for Health Dr James Reilly

environment where responsible consumption of alcohol is the norm."

The measures:

1) Minimum unit pricing for retailing of alcohol products
   - MUP sets a minimum price for per gram of alcohol in the product
   - It will target alcohol cheap relative to strength-particularly low cost products in the off-trade especially supermarkets
2) Regulation of marketing and advertising of alcohol, specifically to:
   a) Limit advertising of alcohol on television and radio from 2016 to evening hours
   b) Limit advertising of alcohol in cinemas to films classified as over 18s
   c) Restrict advertising of alcohol in outdoor media from 2018 with a statutory code

of practice to govern such advertising in the interim· Work will be undertaken with relevant government departments to put in place a process which will identify the forms, frequency and prevalence of outdoor media advertising to be either encompassed or exempted from any restrictions

d) Advertising of alcohol in print media will be regulated by way of a statutory code

e) Set limits on how alcohol is portrayed in advertisements (e.g. prowess or sexual content)

3) Enforcement powers will be given to Environmental Health Officers in relation to

a) Regulations relating to the sale, supply and consumption of alcohol products under section 16 of the Intoxicating Liquor Act 2008

b) Structural separation of alcohol from other products under section 9 of the Intoxicating Liquor Act 2008 which may be commenced

c) Any provision(s) of the Public Health (Alcohol) Bill which require enforcement measures

4) Structural Separation

The Departments of Justice and Equality and Health have agreed a 3-step approach to provide for the structured separation of alcohol from other products in mixed trading outlets. This involves replacing the current voluntary code with a statutory code under Section 17 of the Civil Law (Miscellaneous Provisions) Act 2011 and after 2 years both Departments will review its effectiveness in achieving the policy objectives of Section 9 of the Intoxicating Liquor Act 2008.

5) Regulation of sports sponsorship

The government recognises the public health concerns associated with alcohol sponsorship of sport and the potential impact of any regulatory measures on funding for sports organisations

a) The existing voluntary code that governs sports sponsorship will be placed on a statutory footing

A working group chaired by the Department of An Taoiseach will report within 12 months on

i) The value, evidence, feasibility and implications (including the public health consequences for children and young people) of regulating sponsorship by alcohol companies of major sporting events

ii) Its consideration of financial implications and alternative sources of funding for sporting organisations to replace potential lost revenue arising from any such regulation

6) Health labelling of alcohol products which will see:

a) Health warnings and advice (including for pregnancy) on all alcoholic drink containers (bottles, cans etc.) and on promotional materials;

b) The amount of pure alcohol as measured in grams and the calorie count contained in each container/measure on the label/container.

OTHER MEASURES AGREED BY GOVERNMENT

1) Public health messaging relating to alcohol will be based on grams of alcohol and that weekly low-risk drinking guidelines should be 168 grams (17 standard drinks) and 112 grams (11 standard drinks) for men and women respectively

2) The other measures (eg for the HSE, professional bodies etc) set out in the National Substance Misuse Strategy, upon which provide the recommendations and evidence for today's decision, are endorsed and are to be progressed by the relevant departments and organisations as set out in that report.

Photographs of Primary Care Minister, Alex White, and Minister for Health, Dr James Reilly, courtesy of the Department of the Taoiseach http://www.taoiseach.gov.ie/eng/Taoiseach_and_Government/List_of_Ministers_Ministers_of_State/

Alcohol consumption responsible for nearly 80,000 deaths per year in the Americas

New study reveals "a continuing public health disaster"

A new study published in the scientific journal Addiction by the Pan American Health Organization, a branch of the World Health Organization, has measured the number and pattern of deaths caused by alcohol consumption in 16 North and Latin American countries. The study reveals that between 2007 and 2009, alcohol was a 'necessary' cause of death (i.e. death would not have occurred in the absence of alcohol consumption) in an average of 79,456 cases per year. Liver disease was the main culprit in most countries.

According to the authors, Dr Vilma Gawryszewski and Dr Maristela Monteiro, "The mortality rates found in this study reveal the tip of the iceberg of a broader problem. There is a wide range of diseases and conditions linked to alcohol use, including tuberculosis, heart disease, stroke, epilepsy, falls, suicides, transport-related injuries, and interpersonal violence, among others. Our study simply shows how many deaths are wholly attributable to alcohol consumption. The number of deaths for which alcohol consumption is a significant contributing factor is likely to be much higher."

The highest death rates from alcohol consumption occurred in the Central American countries of El Salvador (averaging 27.4 out of 100,000 deaths per year), Guatemala (22.3), and Nicaragua (21.3). These were also three of the four countries in which the most commonly consumed alcoholic beverage was spirits; Cuba was the fourth.

Men accounted for 84% of all deaths in which alcohol was a necessary cause. However, the ratio male/female varied widely among countries. The risk of a man dying from an alcohol fully-related cause in El Salvador was 27.8 times higher than that of a woman, 18.9 in Nicaragua and 14.8 in Cuba. On the low end of the scale, the male mortality risk was 3.2 times higher than the female mortality risk in Canada and the USA, and 4.3 in Peru.

The risk of dying from alcohol consumption also differed by age group. In Argentina, Canada, Costa Rica, Cuba, Paraguay and the USA, the highest mortality rates were seen among those aged 50-69 years. In Brazil, Ecuador and Venezuela, the rates started increasing from 40-49 years of age, remained stable, and then dropped after age 70. Mexico showed a different pattern, the risk of death escalating throughout life and reaching its peak after age 70. Each of those countries has a life expectancy of over 70 years.

Higher than expected alcohol deaths in US

Disorders related to the abuse of alcohol contribute more than previously believed to the burden of disease in the U.S., finds a new study in *Alcoholism: Clinical and Experimental Research.* Researchers estimated that in 2005, about 53,000 men and 12,000 women died from issues related to alcohol use disorders (AUD).

The results of the meta-analysis were surprising, said lead author Jürgen Rehm, Ph.D., Director of Social and Epidemiological Research at the Centre of Addiction and Mental Health at the University of Toronto in Canada. "We had done meta-analyses on AUD before and knew it would be higher than previous literature, but we did not expect the burden for disease to be so high."

To quantify the influence of alcohol use on the burden of disease, researchers analyzed information from the National Epidemiologic Survey on Alcohol and Related Conditions and the burden of disease study of the National Institutes of Health and found that AUD was linked to three per cent of all deaths in adults 18 and older in the U.S.

Alcohol use disorders contributed even more significantly to a measure of disease burden known as years lived with disability (YLD), with 1,785,000 YLD for men and 658,000 YLD for women in 2005.

Reducing the burden of AUD on society needs to have a multi-pronged approach, said Rehm, and prevention cannot be delivered by health care policy makers alone. "There needs to be restrictions on the availability of alcohol. Increases in taxation or bans of advertisements are not part of health care, and this is part of the problem."

Canadian Province of Ontario urged to improve Alcohol Policy

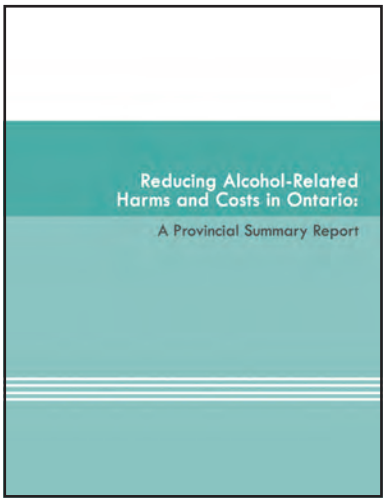
The Centre for Addiction and Mental Health (CAMH), based in Toronto, has released a Provincial Summary report outlining policy strategies to reduce the harms related to alcohol.

In the report titled *'Reducing Alcohol-Related Harms and Costs in Ontario: A Provincial Summary Report,'* CAMH Senior Scientist Norman Giesbrecht outlines Ontario's policy strengths and provides recommendations to help decrease the $2.9 billion attributed annually to the direct and indirect costs of alcohol use in Ontario.

"While there are policy measures in place, there is still work to be done in various areas, such as alcohol pricing and advertising in order to address drinking behaviours that can be harmful," said Dr Giesbrecht. "For instance, we know that more than 75 per cent of Ontarians consume alcohol, and that approximately 22 per cent of Ontarians drink above the recommended drinking guidelines."

Positioning alcohol use as a public health matter, Dr Giesbrecht is recommending 10 policy improvements:

- Adjusting alcohol prices to keep pace with inflation, preventing alcohol prices from becoming cheaper relative to other goods over time.



- Maintain government run monopolies which regulate access to alcohol by maintaining effective alcohol control strategies such as enforcement of the legal drinking age, the regulation of pricing, and hours and days of sale.

- Consider increasing the minimum legal drinking age to 21 years of age.

- Limiting the availability of alcohol by reducing the hours of operation, starting with LCBO licensed agency stores in smaller rural communities.

- Strengthening drinking and driving regulations by lengthening license suspension periods, particularly for repeat offenders, and impounding vehicles during suspension.

- Prohibiting the advertisement of price or sales incentives by all alcohol retailers and tightening restrictions on sponsorship, specifically those targeting youth and young adults.

- Ontario is encouraged to support a consistent physician screening, referral and brief intervention protocol by implementing a fee for service code that is specific to these activities.

- The Smart Serve Responsible Beverage Service program is encouraged to incorporate scenario-based activities into its training program and to require periodic retraining.

- Implement mandatory alcohol warning labels on alcohol packaging that include topics relevant to alcohol use such as drinking and driving, the risks of underage drinking, and chronic diseases.

- Develop a provincial alcohol strategy that emphasizes alcohol specific policies and interventions that have been recommended by the World Health Organization.

"In order to refine and implement these recommendations it will require leadership, commitment to reducing alcohol-related harms and a spirit of collaboration among key stakeholders," said Dr Giesbrecht.

Australian Medical Association calls for national alcohol summit

The Australian Medical Association (AMA) has called on the Federal Government of Australia to convene a National Summit to assess the evidence and develop effective national solutions to the epidemic of alcohol misuse and harms afflicting local communities right across the nation.

"We have a major national problem that requires a major national solution," Dr Hambleton said.

"The mood of the Australian community on this issue warrants a broad discussion that can introduce solutions that governments need to act on as soon as possible.

Dr Hambleton said that the extent of alcohol-related harms is placing enormous strain on the frontline health system and emergency services.

"One in seven emergency department visits on a Saturday night are alcohol related, and in some areas the rate is as high as one in three.

"On average, one in four hospitalisations of young people aged 15-24 years occurs because of alcohol.

"One in five Australians aged 14 years and above drink at a level that puts them at risk of harm from alcohol-related disease or injury over their lifetime.

"One in three 14 to 19 year olds drink alcohol in a way that places them at risk of an alcohol-related injury from a single drinking occasion at least once a month."

Dr Hambleton concludes: "Young Australians are exposed to an unprecedented level of alcohol marketing and promotions, and there is strong evidence that the more young people are exposed to alcohol advertising, the earlier they start drinking, the more they drink, and the more alcohol-related harm they experience."

South Australia: Fewer drunks presenting to hospital emergency department since late night alcohol crackdown

Meanwhile, some Australian States are already taking their own action to reduce alcohol harm. In South Australia the number of early morning alcohol related presentations to the Royal Adelaide Hospital (RAH) has sunk by almost a third since the introduction of a new package of alcohol reforms in 2013.

There were 108 alcohol related presentations to the RAH between midnight and 6:59am during October and December 2013, compared to 152 over the same period in 2012 - a drop of 29%.

Attorney General John Rau said that the drop in alcohol related ED presentations is further evidence of the effectiveness of the Government's crackdown on alcohol related harm.

"Violent behaviour is not the only reason why people wind up in the emergency department after a night of drinking - the excessive consumption of alcohol is also a key factor," Mr Rau said.

"We already know that there has been a 25 percent reduction in violence and other bad behaviour in the city since the introduction of the late night crackdown, now we are observing a positive turnaround in the number of drunks winding up in the emergency department."

New South Wales

The Government of New South Wales has also announced a wide-ranging series of initiatives to tackle drug and alcohol related violence. The initiatives are a response to a number of highly publicized incidents of alcohol-related violence occurring in central entertainment districts, such as in the Kings Cross area of Sydney. For these areas the initiatives include:

- The introduction of 1.30am lockouts and 3am last drinks across an expanded precinct to include Kings Cross to Cockle Bay, The Rocks to Haymarket and Darlinghurst.
- Free buses running every ten minutes from Kings Cross to connect with existing NightRide services on Friday and Saturday nights;
- Enabling Police to impose an immediate ban of up to 48 hours for trouble-makers;
- A precinct-wide freeze on liquor licences for new pubs and clubs;

There will also be stricter Liquor Licensing controls, including the introduction of a periodic risk-based licensing scheme with higher fees imposed for venues and outlets that have later trading hours, poor

compliance histories or are in high risk locations. There will also be a new state-wide 10pm closing time for all bottle shops and liquor stores.

Penalties for alcohol and drug related criminal offences will also be tougher. There will be an eight year mandatory minimum sentence for those convicted under new 'one punch' laws where the offender is intoxicated by drugs and/or alcohol, plus new mandatory minimum sentences for violent assaults where intoxicated by drugs and/or alcohol. On-the-spot fines will be increased to A$1,100 for continued intoxicated and disorderly behaviour disobeying a police move-on order an increase of more than five times.

Exposed: 'Alcohol Industry's Tobacco Tactics'

The alcohol industry is using measures straight out of big tobacco's playbook in order to delay the introduction of mandatory warning labels in Australia, according to a paper published in the international scientific journal, Addiction.

The paper warns that the alcohol industry's false claims, fear mongering and 'undue political influence' continue to undermine alcohol control policy in Australia.

The first detailed analysis of its kind, the paper found the alcohol industry is now employing exactly the same strategies big tobacco used to delay the introduction of health warning labels.

Strategies include falsely disputing the evidence and rationale for labelling, outrageous and alarmist claims of negative impacts on public health and the economy, and lobbying and seeking political influence through large political donations.

Foundation for Alcohol Research and Education Chief Executive Michael Thorn says aggressive campaigning by the alcohol industry was instrumental in delaying the introduction of mandatory alcohol health warning labels in Australia.

"What we are seeing from the alcohol industry is a pattern of obstruction, falsehood and outrageousness copied straight from big tobacco's playbook. When it recognised government might still move ahead on warning labels, it quickly rallied its own front organisation, DrinkWise, to counter with their own weak and ineffective consumer messages in the hope that it could block the introduction of an effective Government mandated scheme," Mr Thorn said.

Years earlier, the tobacco industry manoeuvred in an identical fashion in an attempt to weaken the text on tobacco warning labels and strenuously avoid disease specific warnings, as made clear in correspondence between British American Tobacco and British Tobacco Australia: "Obviously no one in the industry would favour the introduction of warnings… A vague statement such as 'Cigarette smoking may be harmful to health' is a lot easier to live with than something more specific such as 'Excessive cigarette smoking is associated with an increased risk of death from lung cancer."

Article lead author, Rebecca Mathews, says there is a history of alcohol industry opposition to effective policy.

"This is not the first time the industry has opposed effective health policy measures, it campaigned against Random Breath Testing in the 1970's, and more recently, opposed the introduction of a minimum price on alcohol," Ms Mathews said.

Mr Thorn says the Addiction article catalogues the alcohol industry's success, in delaying effective alcohol policy and highlights the significant deficiencies of industry self-regulation.

"The alcohol industry has made it clear by its actions that it has no genuine interest in promoting a healthier and safer Australia. Using the same dirty tricks as big tobacco, it has up until now, been successful in opposing and obstructing effective policies that would save lives and reduce harms, in order to protect sales and profits. The alcohol industry's behaviour can't be allowed to continue," Mr Thorn said.

Mathews R, Thorn M, and Giorgi C. Is the alcohol industry delaying government action on alcohol health warning labels in Australia?. Addiction, 108: doi:10.1111/add.12338

Alcohol Action Plan Launched by The Australian National Council on Drugs

An alcohol action plan for Australia has been launched by The Australian National Council on Drugs (ANCD), the body established in 1998 as the principal advisory body to the Prime Minister and the Federal Government on drug and alcohol policy.

Dr Herron, Chairman of the ANCD, said "The level of alcohol related damage occurring in our communities is simply appalling".

Some of the issues of concern considered by the ANCD in developing their plan included research showing:

- 25% of Australians report having been a victim of alcohol-related verbal abuse
- 21% of Australians under the age of 18 report having been harmed by another's drinking
- 8% of Australians report having been a victim of alcohol-related physical abuse
- 3.2% of the total burden of disease in Australia is related to alcohol use
- Hazardous and harmful alcohol consumption results in costs of more than $15.3 billion a year
- It is estimated that local governments spent nearly $800 million on public order and safety
- Insurance administration costs related to alcohol were at least $185 million in 2004–05

Among the ANCD Alcohol Action Plan Recommendations are:

Increase informed public engagement with the harms associated with alcohol, by:

- Promoting public understanding of the range of evidence-based options to prevent and respond to alcohol-related harm.
- Promoting better public understanding of the harms to others caused by alcohol consumption
- Encouraging States and Territories to ensure that liquor licensing legislation across all jurisdictions gives prominence to public health and safety considerations.
- Recognise the critical role of regulating the availability of alcohol in reducing alcohol-related harms, by:
    - Give further consideration to implementing the recommendations regarding alcohol taxation made in the Australia's Future Tax System review.
    - Developing liquor licensing procedures that consider outlet density, closing hours, and related risks and harms, drawing on local evidence and with the input of the local community.
- Regulate alcohol advertising, promotions and sponsorship, by:
    - Initiating a parliamentary review of the impact of alcohol advertising, promotions and sponsorship on young people.
    - Give further consideration to establishing an independent or government body to review, adjudicate and regulate alcohol advertising and promotions.
- Address alcohol-related problems among older Australians, by:
    - Undertaking further research into alcohol use among Australians aged over 65, including identifying patterns of use, age-specific risks and harms, and implications for prevention and treatment.
    - Developing an evidence base that enables the development of alcohol consumption guidelines for older Australians.
    - Introducing strategies to alert health professionals and older Australians themselves to the risks associated with alcohol among older people as well as appropriate interventions.
- Address alcohol consumption and harms among young people, by:
    - Encouraging informed community debate on the minimum legal purchase age for alcohol.
    - Encouraging broad prevention strategies such as increasing school engagement and awareness of the role families and parents can have in reducing alcohol-related harm, and investing in strategies consistent with this role.

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