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Alcohol: No Ordinary Commodity

Global Alcohol Policy Alliance

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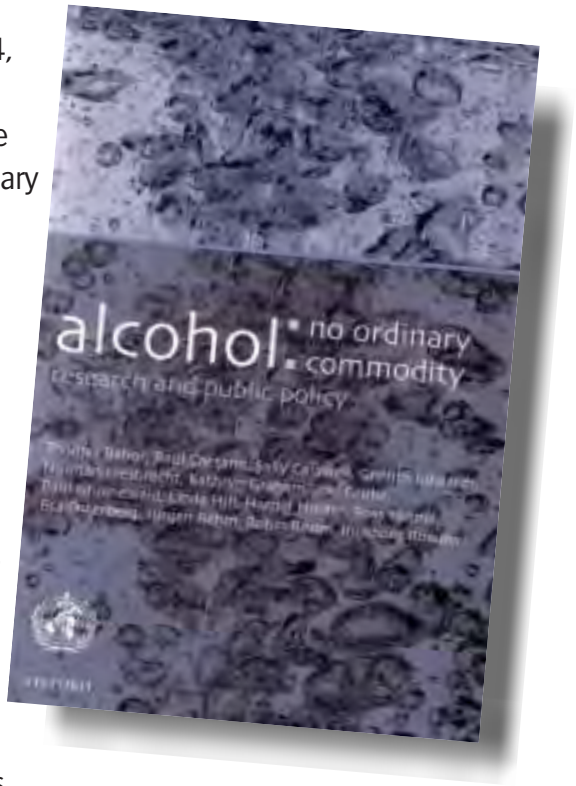
Alcohol: **No Ordinary Commodity.** A summary of the book

Alcohol & Public Policy Group



Alcohol Policy and The Public Good, published in 1994, was a modern landmark in alcohol policy. Here, with the kind permission of the editor of the journal Addiction, we reproduce a summary of its successor, Alcohol: No Ordinary Commodity — Research and public policy (Babor et al. 2003). The first part of the book describes why alcohol is no ordinary commodity, and presents epidemiological data on the global burden of alcohol-related problems. The second part of the book reviews the scientific evidence for strategies and interventions designed to prevent or minimise alcohol-related harm: pricing and taxation, regulating the physical availability of alcohol, modifying the drinking context, drinking-driving counter measures, regulating alcohol promotion, education and persuasion strategies and treatment services. The final section considers the policy making process on the local, national and international levels, and provides a synthesis of evidence-based strategies and interventions from a policy perspective.

Setting the policy agenda

The purpose of this volume is to describe recent advances in alcohol research that have direct relevance to alcohol policy on the local, national and international levels. Alcohol policies serve the interests of public health through their impact on drinking patterns, the drinking environment and the health services available to treat problem drinkers. Public health concepts provide an important vehicle to manage the health of populations in relation to the use and misuse of beverage alcohol by helping communities and nation states to design better preventative and curative services. Alcohol policies have been implemented throughout history to minimise the effects of alcohol on the health and safety of the population but only recently have these strategies and interventions been evaluated scientifically.

No ordinary commodity

In many countries, the production and sale of alcoholic beverages generates profits for farmers, manufacturers, advertisers and investors. Alcohol provides employment for people in bars and restaurants, brings in foreign currency for exported beverages and generates tax revenues for the government. Alcoholic beverages are, by any reckoning, an important, economically embedded commodity.

Alcohol: No Ordinary Commodity. A summary of the book

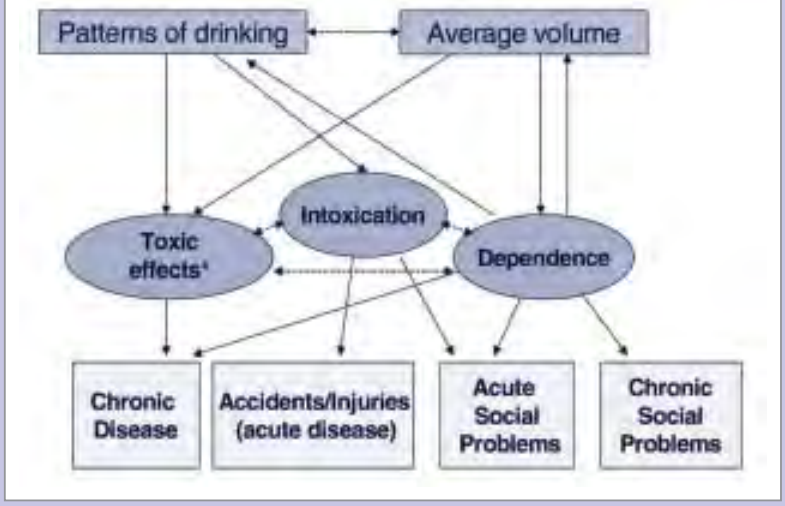


Figure 1: Why alcohol is no ordinary commodity. Relationships among alcohol consumption, mediating factors and alcohol-related consequences (reprinted with permission from Babor et al. 2003)

However, the benefits connected with the production, sale and use of this commodity come at an enormous cost to society. Three important mechanisms explain alcohol's ability to cause medical, psychological and social harm:

(1) physical toxicity

(2) intoxication and

(3) dependence.

Alcohol is a toxic substance in terms of its direct and indirect effects on a wide range of body organs and systems. Paradoxically, the main cause of alcohol-related harm in the general population is alcohol intoxication.

The link between intoxication and adverse consequences is clear and strong, especially for violence, traffic casualties and other injuries. Alcohol dependence has many different contributory causes including genetic vulnerability, but it is a condition that is contracted by repeated exposure to alcohol: the heavier the drinking, the greater the risk.

As illustrated in Fig. 1, the mechanisms of toxicity, intoxication and dependence are related closely to the ways in which people consume alcohol, called 'patterns of drinking'. Drinking patterns that lead to rapidly elevated blood alcohol levels result in problems associated with acute intoxication, such as accidents, injuries and violence. Similarly, drinking patterns that promote frequent and heavy alcohol consumption are associated with chronic health problems such as liver cirrhosis, cardiovascular disease and depression. Finally, sustained drinking may result in alcohol dependence. Once dependence is present, it impairs a person's ability to control the frequency and amount of drinking. For these reasons, alcohol is not a run-of-the-mill consumer substance. Public health responses must be matched to this complex vision of the dangers of alcohol as they seek better ways to respond to population-level harms.

Alcohol consumption trends and patterns of drinking

Alcohol consumption varies enormously, not only among countries, but also over time and between different population groups. Variations in these drinking patterns affect rates of alcohol-related problems, and have implications for the choice of alcohol policy measures. Two aspects of alcohol consumption are of particular importance for comparisons across populations and across time.

First, total alcohol consumption in a population is an important indicator of the number of individuals who are exposed to high amounts of alcohol. Adult per capita alcohol consumption is, to a considerable extent, related to the prevalence of heavy use, which in turn is associated with the occurrence of negative effects. Secondly, the relationship between total alcohol consumption and harm is modified by the number of drinkers in a population and by the way in which alcohol is consumed.

Recorded alcohol consumption is highest in the economically developed regions of the world. In contrast, recorded consumption is generally lower in Africa and parts of Asia, and is particularly low in Moslem states and the Indian subcontinent. Western Europe, Russia and other non-Moslem parts of the former Soviet Union now have the highest per capita consumption levels, but Latin American levels are not far behind.

Sales data from established market economies show a slight overall decrease in alcohol consumption in recent years, as well as converging trends in traditional high-consumption and low-consumption countries. This is particularly the case in the wine-producing countries in Europe, such as France, Italy and Portugal, where the decrease is due mainly to reductions in wine consumption. Of particular concern, however, is the increasing consumption in some of the emerging economies of the developing world, such as China and Thailand, given that drinking appears to be concentrated in a

smaller fraction of the population in these countries.

There are striking gender differences in whether a person drinks, with men more likely to be drinkers and women abstainers. Among drinkers, men drink 'heavily' (i.e. to intoxication, or large quantities per occasion) much more often than women. Abstinence and infrequent drinking are more prevalent in older age groups, and frequent intoxication is more prevalent among young adults.

Most of the alcohol in a society is consumed by a relatively small minority of heavy drinkers. When alcohol consumption levels increase in a country, there tends to be an increase in the prevalence of heavy drinkers. Countries vary in the extent to which drinking to intoxication is a characteristic of the drinking pattern. They also differ in how intoxicated people become, and how people behave while intoxicated. In the southern European countries, approximately one in 10 drinking occasions lead to a state of intoxication among adolescents, whereas the majority of drinking occasions in the most northern European countries result in intoxication.

The global burden of alcohol consumption

According to the World Health Organization, in 2000 alcohol-related death and disability accounted for 4.0% of the global burden of disease, ranking as the fifth most detrimental risk factor of 26 examined. Alcohol accounts for about the same amount of disease as tobacco. In developed countries, alcohol was the third most detrimental risk factor, accounting for 9.2% of all burden of disease. In emerging economies such as China, alcohol was the most detrimental risk factor. Overall, injuries accounted for the largest portion of alcohol-attributable disease burden, which ranged from close to zero among females in the predominantly Moslem Eastern Mediterranean regions to more than 20% for males in Eastern Europe.

The volume of drinking is linked to most disease outcomes through specific dose–response relationships. These relationships can at the individual level be linear (as in the case of breast cancer or suicide), accelerating (as in the case of liver cirrhosis or motor vehicle accidents) or J-shaped (as in the case of heart disease or all-cause mortality). Patterns of drinking also play an important role in the disease burden, being linked to coronary heart disease, motor vehicle accidents, suicide and breast cancer.

Moderate drinking has positive as well as negative health effects. It has been linked to an increased risk of cancer and other disease conditions. For coronary heart disease (CHD), studies indicate a cardioprotective effect of regular, light and moderate alcohol consumption at the level of the individual drinker. This effect applies mainly to the age group of 40 years and older, where the overwhelming majority of CHD occurs. This effect explains the lower death rate of light drinkers relative to abstainers. However, aggregate-level studies suggest that there may be no net protective effect at the population level from an increase in the level of consumption, and even a detrimental effect in societies with heavy episodic drinking patterns.

Although public discussion has often concentrated on alcohol-related problems connected with disease and other medical conditions, alcohol is also linked to consequences in the social realm, which has been called 'the forgotten dimension'. Clearly, alcohol is related to many social problems, especially violence.

In summary, alcohol accounts for a significant disease burden worldwide and is related to many negative social consequences.

Strategies and interventions to reduce alcohol-related harm

The differences among countries in per capita consumption, patterns of drinking and alcohol-related problems suggest that alcohol policies may have to be tailored to fit the needs of each society. Alcohol policy is defined broadly as any purposeful effort or authoritative decision on the part of governments or non-government groups to minimise or prevent alcohol-related consequences. Policies may involve the implementation of a specific strategy with regard to alcohol problems (e.g. increase alcohol taxes), or the allocation of resources that reflect priorities with regard to prevention or treatment efforts. Policies that increase harm unintentionally are also examined in this book, thus providing insight into the public health risks associated with ill-advised policy decisions.

Pricing and taxation

Evidence suggests that alcohol prices have an effect on the level of alcohol consumption. Consumers of alcoholic beverages increase their drinking when prices are lowered, and decrease their consumption when prices rise. Heavy or problem drinkers appear to be no exception to this rule. Moreover, economic studies demonstrate that increased alcoholic beverage taxes and prices are related to reductions in alcohol-related problems.

Despite these findings, the real price of alcoholic beverages has decreased in many countries over the last 50 years, even as many other alcohol control measures have been liberalised or abandoned completely. A major reason for the price decline has been the failure of governments to increase tax levels

in accordance with inflation. Alcohol taxes are thus an attractive instrument of alcohol policy because they can be used both to generate direct revenue and to reduce alcohol-related harm. The most important downside to raising alcohol taxes is the possibility of smuggling or illegal in-country alcohol production. The net effects of taxation and price increases, however, are to reduce alcohol use and related problems.

Regulating the physical availability of alcohol

The physical availability of alcoholic beverages refers to the accessibility or convenience of obtaining and consuming these products. Most countries have restrictions on who may buy and sell alcohol, primarily because of social concerns about health, safety and public order. Experience has shown that extreme restrictions on alcohol availability, such as the banning of all alcohol sales (i.e. total prohibition), can lower drinking and reduce alcohol problems. Yet these restrictions often have adverse side effects, such as the criminality associated with illicit markets.

Research on limiting alcohol availability demonstrates that reductions in the hours and days of sale, numbers of alcohol outlets and restrictions on access to alcohol are associated with reductions in both alcohol use and alcohol-related problems. Laws that raise the minimum legal purchasing age reduce alcohol sales and problems among young drinkers.

Regulations directed toward commercial vendors of alcohol who sell to minors and ignore other restrictions can also be effective, provided the system has the power to suspend or revoke a licence in the case of selling infractions. The evidence suggests that making available and promoting beverages of low alcohol content can be an effective strategy. Such a strategy has the potential to reduce the level of absolute alcohol consumed and associated intoxication and impairment.

One means to regulate alcohol availability in a comprehensive way is through government-owned alcohol outlets. There is strong evidence that off-premise monopoly systems limit alcohol consumption and alcohol-related problems, and that elimination of government off-premise monopolies can increase total alcohol consumption.

In general, changes in availability can have large effects in nations or communities where there is popular support for these measures. The cost of restricting the physical availability of alcohol is cheap relative to the costs of health consequences related to drinking, especially heavy drinking. The most notable adverse effects of availability restrictions include increases in informal market activities (e.g. home production, illegal imports). Nevertheless, informal market activities are generally not sufficient to replace formal production and have not produced equivalent levels of alcohol-related problems.

Modifying the drinking context

Many prevention measures seek to limit drinking in the contexts or environments where alcohol is typically sold and consumed. The most effective options involve enforcement of serving regulations and the legal liability of bar staff and owners for the actions of those they serve. Responsible Beverage Service (RBS) programmes focus on attitudes, knowledge, skills and practices of people involved in serving alcoholic beverages on licensed premises.

If supported by actual changes in the serving policies of licensed establishments and reinforced by local police, RBS training can reduce heavy consumption and high risk drinking. Beyond programs aimed at serving practices, there is increasing evidence that staff training in techniques for managing problem behaviour can reduce aggression and violence in licensed premises.

Community mobilisation has been used to raise public awareness of problems associated with on-premise drinking, develop specific solutions to problems and pressure bar owners to recognise that they have a responsibility to the community in terms of such bar-related issues as noise level and patron behaviour.

Community mobilisation can be highly successful at reducing aggression and other problems related to drinking in licensed premises, but the long-term sustainability of these efforts remains to be demonstrated.

Other approaches include general safety measures that have particular relevance to intoxicated people and modifying the potential behaviour of bystanders or victims. Research shows that the adoption and enforcement of policies to make licensed premises safer are associated with lower levels of intoxication and problems. A number of communities, most notably in Australia, have implemented voluntary codes of practice among local bar owners to limit the major risk factors for violence and other alcohol-related problems.

Drinking-driving counter measures

Traditionally, law enforcement directed at drinking-driving has been designed to catch offenders, on the assumption that such practices will prevent or deter people from driving after drinking. Punishment for a drinking-driving conviction has been increased typically either by changing the maximum penalties or by introducing mandatory minimum penalties.

There is limited evidence to support the positive impact of these laws. 'Celerity', or swiftness of punishment, is related to the proximity of punishment to the drinking-driving event.

The one punishment that seems to have a consistent impact on drinking-driving offences is administrative licence suspension. Licence loss can be effective for both alcohol-involved and non-alcohol- involved accidents.

One strategy for increasing certainty of apprehension and punishment is to increase the frequency and visibility of drinking-driving enforcement. The traditional way of producing a higher perceived probability of apprehension is simply to intensify police enforcement through such measures as sobriety or selective checkpoints.

A more effective approach is through random breath testing. Motorists are stopped at random by police and required to take a preliminary breath test, even if they are in no way suspected of having committed an offence or been involved in an accident. The evidence is quite strong that highly visible, non-selective testing can have a sustained effect in reducing drinking-driving and the associated crashes, injuries and deaths.

Combined with enforcement, national and state laws lowering the legal limit of the driver's blood alcohol concentration (BAC) have been a successful way to reduce drinking-driving. The evidence indicates that setting a reasonably low level of BAC (e.g. 0.08) significantly reduces alcohol-related driving fatalities.

Treatment programmes have also been used in many countries to provide a therapeutic or educational alternative to punishment. Evidence from some countries supports the effectiveness of comprehensive treatment including counselling or therapy plus licence suspension in reducing recidivism.

Successful programmes are well structured, go beyond information provision to address alcohol abuse, are conducted for more than 10 weeks and have rules of attendance enforced by a court.

Another approach for high-risk repeat offenders is to use ignition interlock devices that prevent a vehicle from being started until the driver passes a breath test. These devices have been very effective for many alcohol-impaired drivers, but have not been tested widely in countries other than Canada and the United States.

In general, young drivers (adolescents between 16 and 20 years of age) are at higher risk for traffic accidents, especially alcohol-involved crashes, as a result of their limited driving experience and their tendency to experiment with heavy or binge drinking.

Traditional counter measures such as driver training and school-based education programmes are either ineffective or have yielded mixed results. One effective measure is the use of graduated licensing for novice drivers, which limits the time and other conditions of driving during the first few years of licensing.

In summary, the evidence suggests that drinking-driving counter measures consistently produce long-term problem reductions of between 5% and 30%. Deterrence-based approaches, using innovations such as random breath testing, yield few arrests but substantial accident reductions. The persistent delinquency of some impaired drivers and their consistent contribution to the fatality statistics should not detract from the enormous achievements of recent decades.

Regulating alcohol promotion

The marketing of alcohol is a global industry. Alcohol brands are advertised through television, radio and print, point-of-sale promotions and the internet. Exposure to repeated high-level alcohol promotion inculcates pro-drinking attitudes and increases the likelihood of heavier drinking. Alcohol advertising predisposes minors to drinking well before legal age of purchase. Indeed, advertising has been found to promote and reinforce perceptions of drinking as positive, glamourous and relatively risk-free.

Legislation restricting alcohol advertising is a well-established precaution used by governments throughout the world, despite opposition from the alcoholic beverage industry. Some bans are partial, applying only to spirits, to certain hours of television viewing or to state owned media. These bans often operate alongside codes of self-regulation that govern permitted forms of alcohol advertising.

Although many countries have restricted alcohol advertising to various degrees, the evaluation findings suggest that while the restrictions have not achieved a major reduction in drinking and related harms in the short term, countries with greater restrictions on advertising have less drinking and fewer alcohol-related problems.

Despite industry claims that they adhere to codes of responsible advertising, the detrimental influences of marketing practices are not addressed adequately by industry self-regulation. Self-regulation tends to be fragile and largely ineffective. These codes may work best where the media, advertising and alcohol industries are all involved, and an independent body has powers to approve or veto advertisements, rule on complaints and impose sanctions. Few countries currently have all of these components.

Education and persuasion strategies

School-based alcohol education programmes have been found to increase knowledge and change attitudes toward alcohol and other substances, but actual substance use remains unaffected. Approaches that address values clarification, self-esteem, general social skills and 'alternative' approaches that provide activities inconsistent with alcohol use (e.g. sports) are equally ineffective. Many contemporary school-based programmes include both resistance skills training and normative education, which attempts to correct adolescents' tendency to overestimate the number of their peers who drink. Scientific evaluations of these programmes have produced mixed results with generally modest effects that are short-lived unless accompanied by ongoing booster sessions.

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

Public service announcements (PSAs) are messages prepared by non-governmental organisations, health agencies and media organisations that deal with responsible drinking, the hazards of drinking-driving and related topics. Despite their good intentions, PSAs are an ineffective antidote to the high-quality pro-drinking messages that appear much more frequently as paid advertisements in the mass media.

Counter-advertising involves disseminating information about a product, its effects and the industry that promotes it in order to decrease its appeal and use. Tactics include health warning labels on product packaging, such as those that explain that alcohol may cause birth defects when consumed during pregnancy. Although a significant proportion of the population reports seeing these warning labels, research indicates that exposure produces no change in drinking behaviour per se. In sum, the impact of education and persuasion programmes tends to be small, at best. When positive effects are found, they do not persist.

Treatment and early intervention services

In addition to its value in the reduction of human suffering, treatment can be considered as a form of prevention. Treatment for alcohol problems typically involves a set of services, ranging from diagnostic assessment to therapeutic interventions and continuing care. Researchers have identified more than 40 therapeutic approaches, called treatment modalities, which have been evaluated by means of randomised clinical trials. These modalities are delivered in a variety of settings, including freestanding residential facilities, psychiatric and general hospital settings, out-patient programmes and primary health care.

There is no consistent evidence that intensive in-patient treatment provides more benefit than less intensive out-patient treatment, although residential treatment may be indicated for patients who:

1 are highly resistant to treatment;

2 have few financial resources;

3 come from environments that are not conducive to recovery; and

4 have more serious, coexisting medical or psychiatric conditions. Regarding specific treatment modalities, the weight of evidence suggests that behavioural treatments are likely to be more effective than insight-orientated therapies. Recent research also indicates that Twelve-Step Facilitation, which is based on the principles of Alcoholics Anonymous (AA), is as effective as more theory-based therapies. In general, when patients enter treatment, exposure to any treatment is associated with significant reductions in alcohol use and related problems, regardless of the type of intervention used.

Interest on the part of the pharmaceutical industry in medications to treat alcohol dependence has increased in the past decade, and several compounds are now available in the United States and Europe. In the 1990s naltrexone, an opioid antagonist, became available for medical management of alcohol dependence, following positive studies showing incremental benefits of psychotherapy combined with this medication. Acamprosate (calcium acetylhomotaurinate), an amino acid derivative, has also shown positive effects in the prevention of relapse.

Although mutual help societies composed of recovering alcoholics are not considered to be formal treatment, they are often used as inexpensive substitutes, alternatives and adjuncts to treatment. Mutual help groups based on the Twelve Steps of AA have proliferated throughout the world. Research suggests that AA itself can have an incremental effect when combined with formal treatment, and that AA attendance alone may be better than no intervention at all.

In contrast to treatment provided in specialised settings, brief interventions consist of one to three sessions of counselling or advice delivered in general medical settings. The cumulative evidence of randomised controlled trials

(conducted in a variety of settings) indicates that clinically significant changes in drinking behaviour and related problems can follow from brief interventions with non-alcoholic heavy drinkers.

The international context of alcohol policy

In a world of increasing trade globalisation, national and local alcohol policies, predicated on the extraordinary nature of alcohol, have come under pressure increasingly at the international level.

The last 50 years have seen a convergence in alcohol policies in Europe. There have also been converging trends with regard to taxing alcoholic beverages, although excise duties are still clearly lowest in wine-producing countries and highest among the Nordic countries, Ireland and the United Kingdom.

In North America, there has been a gradual decline in alcohol control in most jurisdictions in recent decades, with more dramatic changes such as privatisation of alcohol retail sales. Alcohol taxes have not been raised to match inflation. In contrast, there have been extensive education and law enforcement efforts to control drinking-driving.

Similar developments have taken place in other parts of the world. For instance, the collapse of the communist system in the former Soviet Union and Eastern Europe has meant that alcohol control, especially the control of alcohol availability, has lost much of its effect in these countries.

On the other hand, in the 1990s, under the impetus of the European Alcohol Action Plan, many Eastern European countries adopted national alcohol programmes or participated in projects aimed at strengthening local alcohol control.

In many developed countries, general alcohol policies affecting the whole population and orientated to the collective good have been weakened or dismantled, often under pressure from the 'structural adjustment' programmes of international development agencies. Policies remaining from the past have been gradually eroded (e.g. privatisation of monopolies, erosion of taxes by inflation, extension of closing hours).

At the same time, however, popular concern about alcohol-related problems has risen, although it has found only fitful political expression. In many countries there has been an increase in educational programmes, despite research on their lack of effect, along with some interventions to curtail drinking-driving. One factor behind the weakening of national and local alcohol policies has been the impact of international trade agreements and common markets. To the extent that alcohol is considered to be an ordinary commodity, these agreements and treaties often become severe obstacles for conducting purposeful and efficient alcohol control policies.

The policy arena

Who makes alcohol policy? The answer differs among countries and between different levels of government within countries. Within each jurisdiction of the policy arena, there is an interplay of different interest groups.

A national level legislative and regulatory framework is essential to the promotion of effective measures to curtail alcohol-related problems. Federal and national laws often establish the legislative mandate for prevention and treatment policies.

In many nations there is a vacuum in advocacy for the public interest, leaving members of non-governmental organisations as the most likely candidates to represent the public. These have occasionally involved interest groups representing victims of alcohol-related harm, such as Mothers Against Drunk Driving. More recently, alcohol issues have increasingly become the concern of health professionals.

The mass media can have a significant influence on the policy debate at the national and local levels, given their dominant role in contemporary culture. Media coverage influences whether policy makers perceive a problem and how salient that problem is. This is an 'agenda-setting' function.

Groups involved in for-profit production and sales are often key players in policy debates. Supported by free market values and concepts, the alcoholic beverage industry has become increasingly involved in the policy arena in order to protect its commercial interests. In some countries, the industry is the dominant non-governmental presence at the policy making table. Although the alcoholic beverage industry is not monolithic in terms of its motives, power or operations, its commercial interests often come into conflict with public health measures.

An appreciation of the various players in the alcohol policy arena can heighten our understanding of the following fundamental conclusion: alcohol policy is often the product of competing interests, values and ideologies. The process of alcohol policy creation needs to be better understood, more transparent and more responsive to the needs of the citizens who are the end consumers of emerging policies.

Alcohol policies: a consumer's guide

The difference between good and bad alcohol policy is not an abstraction, but very often a matter of life and death. Research has the capacity to indicate which strategies are likely to succeed in their public

health intentions, and which are likely to be less effective or even useless, diver sionary and a waste of resources. Building on previous work in this area, we rated 32 policy options reviewed in previous chapters of the book according to four major criteria: (1) evidence of effectiveness; (2) strength of research support; (3) extent of testing across diverse countries and cultures; and (4) relative cost in terms of time, resources and money.

In general, effectiveness is strong for the regulation of physical availability and the use of alcohol taxes. Given the broad reach of these strategies, and the relatively low expense of implementing them, the expected impact of these measures on public health is relatively high. Most drinking-driving counter measures received high ratings on effectiveness as well. Not only is there good research support for these programmes, but they also seem to be applicable in most countries and are relatively inexpensive to implement and sustain.

In contrast, the expected impact is low for school-based education and for public service messages about drinking. Although the reach of educational programmes is thought to be excellent (because of the availability of captive audiences in schools), the population impact of these programmes is poor. Similarly, while feasibility is good, cost–effectiveness and cost–benefit are poor.

Treatment and early intervention strategies have, at best, medium effectiveness. At the population level, their impact is limited, because specialised treatment for alcohol problems can benefit only the relatively small fraction of the population who come to treatment. While treatment provision is an obligation of a humane society, its effect on the actual drinking problem rates of the population at large is necessarily limited.

Strategies directed at altering the drinking context are applicable primarily to on-premise drinking in bars and restaurants, which limits somewhat their public health significance. In most developed countries, only a minority of drinking is conducted on-premise, although frequently this drinking is trouble-prone. One recurring theme in this literature is the importance of enforcement.

The following 10 policy options stand out as 'best practices': minimum legal purchase age, government monopoly of retail sales, restrictions on hours or days of sale, outlet density restrictions, alcohol taxes, sobriety checkpoints, lowered BAC limits, administrative licence suspension, graduated licensing for novice drivers and brief interventions for hazardous drinkers.

Alcohol policies can be effective at both the community level and the national level. Within each of these levels, policies can be targeted at the general population, at high-risk drinkers and at people already experiencing alcohol-related problems.

Alcohol policies rarely operate independently or in isolation from other measures. Complementary system strategies that seek to restructure the total drinking environment are more likely to be effective than single strategies. Full-spectrum interventions are needed to achieve the greatest population impact.

In sum, opportunities for evidence-based alcohol policies that serve the public good are more available than ever before. However, policies to address alcohol-related problems are informed too seldom by science, and there are still too many instances of policy vacuums filled by unevaluated or ineffective strategies and interventions. Because alcohol is no ordinary commodity, the public has a right to expect a more enlightened approach to alcohol policy.

Note on authorship

The Alcohol and Public Policy Group consists of Thomas Babor, Raul Caetano, Sally Casswell, Griffith Edwards, Norman Giesbrecht, Kathryn Graham, Joel Grube, Paul Gruenewald, Linda Hill, Harold Holder, Ross Homel, Esa Österberg, Jürgen Rehm, Robin Room and Ingeborg Rossow.

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Reference

Babor, T. F., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Österberg, E., Rehm, J., Room, R. & Rossow, I. (2003) Alcohol: No Ordinary Commodity—Research and Public Policy. Oxford and London: Oxford University Press.

Advocates meet in Cambridge

Leading advocates in the field of alcohol policy from around the world came together at a series of meetings in Cambridge in September. Ideas and news were exchanged between members of Eurocare, the organisation of groups working towards the prevention of Alcohol Related Harm in Europe, and GAPA, the Global Alcohol Policy Alliance.

One meeting was led by WHO (World Health Organization). Leanne Riley, a WHO scientist, and Dr Pekka Puska, the Director of Non-Communicable Disease Prevention and Health Promotion at WHO, presented a picture of current projects and spoke about issues relating to alcohol advertising and promotion, especially their impact on global health.

In this issue of The Globe we publish papers by three of the delegates to the Cambridge Conference, which was held in Westminster College, from Spain, Canada, and Brazil.

Challenges to reducing drinking-related harm through social policies

Dr Norman Giesbrecht

In 1960 John Seeley, the then Director of Research at the Addiction Research Foundation in Toronto, published a paper which demonstrated that, as real price of alcohol dropped in Canada, alcohol consumption rates and liver cirrhosis mortality rates increased. At a seminar in December 2002 researchers showed that a rise in total consumption in Canada was associated with an increase in total mortality, alcohol-specific mortality, liver cirrhosis deaths, traffic fatalities, suicide and violent deaths.

Their focus was on five decades between 1950 and 2000. Despite differences in methods and time frame there is nevertheless a striking similarity in conclusions reached almost 40 years apart. Total consumption and drinking patterns do have a significant bearing on rates of drinking-related damage, and the evidence is becoming stronger.

Challenges to reducing drinking-related harm through social policies

Dr Norman Giesbrecht

There may be some methodological comfort in the consistency of the findings stretching over several decades. However, what is particularly troubling is that the lessons emerging from research in Canada in the 1960s and 1970s has had so little bearing on policy-making in this country in recent decades. Not only were the policy implications of this work often ignored, but more recent developments with regard to alcohol policy seem to run contrary to the public health and safety messages emerging from this research. It is feasible that several decades from now, another research team will examine associations between alcohol promotion and access to alcohol, consumption rates and indicators of damage, focusing, for example, on the period 2000 and 2035. Will they again find evidence of such associations? Will they also find that the burden of disease, violence, social problems and death from alcohol in Canada was unnecessarily elevated by policy decisions? A critical first step to proposing more effective and appropriate policies is to consider several challenges.

Alcohol control systems

Although all Canadian provinces, except Alberta, have liquor boards that manage a large share of retail alcohol sales, there is a gradual and persistent drift toward privatization, sometimes by stealth, In Ontario, British Columbia, Nova Scotia and Saskatchewan there have been consideration of this option. In principle, a private alcohol retailing system can serve harm reduction and control agendas as effectively as a public one. In practice, however, it is likely that a change to privatization will include much higher outlet density, longer hours of sale and lower vested interest among low-paid staff to curtail sales to minors or intoxicated patrons. Furthermore, a powerful lobby group, namely an alcohol retailers association, will enter the policy arena and will very likely place commerce and marketing agenda above harm reduction and public health considerations.

However, the government run liquor management systems have also shown remarkable innovations on the marketing front in recent years. With the threat of privatization, and the mandate to generate revenues for their provincial governments, they have also become more customer-oriented using highly sophisticated measures to promote themselves, their outlets and their products through on-site innovations and multi-media advertisements.

The goals appear to be that of offering excellent service to their best customers, introducing new customers to their products and encouraging consumers to link alcohol use with many social events and occasions. While social responsibility is a mandate, there appears little official concern about the impact of state-of-the-art marketing on the drinking rates and possible risks associated with a rising rate of consumption.

Therefore, a major challenge in this domain is that of making the policy-makers and public aware of the risks associated with privatization. Also, there needs to be increased vigilance of both the

unintended and intended consequences of alcohol management decisions where revenue generation and increased sales seem to be more important than controlling damage at the population level.

Alcohol marketing and promotion

The most important developments with regard to alcohol marketing, sponsorship and promotion appear to mirror those in Europe and the United States. There are several signals that controls of a few decades ago have been eroded. Alcohol sponsorship is extensively linked with events -- such as car races, rock concerts, skiing to mention a few -- where many under-age adolescents are participants. The federal committee associated with Canadian Radio and Television Commission (CRTC) no longer directly oversees proposed alcohol advertisements. This is now handled by a private group. Spirits advertising has been allowed on television and radio since the late 1990s. Despite several attempts, efforts to place warning labels on alcoholic products have been successfully blocked. Alcohol can be ordered by telephone or arranged for home delivery, and recently it became feasible to have Canada Post deliver alcohol. There are occasional counter-advertisement campaigns. However, in contrast to the many sophisticated and attractive messages that promote alcoholic beverages and drinking events, these health and safety messages are significantly under-funded and strongly overshadowed by those promoting alcohol and drinking.

There are at least three challenges with regard to alcohol promotion and marketing. Stronger guidelines about alcohol marketing and sponsorship need to be developed which have significant input from health and safety personnel and include effective mechanisms for their monitoring and enforcement. Curtailing the extensive promotion of alcohol by private and government-run systems is another challenge. Attention should be given to piloting warning labels and other forms of counter-advertising in order to determine which combinations, if any, are likely to have the greatest impact in raising awareness of the risks associated with alcohol. Finally, there needs to be attention to raising public awareness about how alcohol marketing techniques influence public views of drinking and decisions about alcohol use.

Popular perspectives on alcohol problems and prevention

There is growing awareness of the range of risks of drinking and extensive awareness of certain problems, such as alcohol dependence and drinking and driving, to mention two. However, it is uncommon to see media coverage that takes a population-based perspective and associates alcohol promotion, drinking rates and drinking-related damage. The media stories tend to focus on the deviant individual or the high-risk user, and seldom do they consider the potential role of alcohol management at the societal level with regard to problem enhancement or harm reduction.

This narrow focus is in line with other aspects of the current popular framing of alcohol problems and their prevention. By dividing the world into problem drinkers and normal drinkers, it is easier for retailers, alcohol system managers or alcohol industries to conclude that extensive marketing of alcohol is not inconsistent with prevention agendas. The marketing of alcohol is framed as intended for those who do not have a problem with alcohol. Furthermore, the alcohol industries are assumed to be legitimate players in prevention. However, estimates that up to 50% of their products are consumed by the 10% that drink the most suggest that they are not likely to be supportive of the most effective control interventions. Social responsibility is mainly and narrowly defined as offering education and information and generally, given lower priority in contrast to marketing and promotion agendas. It appears, also, that the recent rise in the rates of alcohol consumption in several Canadian provinces is not of concern among those who manage alcohol distribution.

The main challenge here is that of making policy-makers more aware of the association between policy decisions and their impacts on drinking rates and damage at the population level. This population-based orientation is now widely accepted in other domains, for example, with regard to environmental pollution. However, in the alcohol arena there is still a long way to go to raise awareness that how alcohol is distributed and sold has a bearing on drinking rates and risks for populations, communities and populations. Among the many players that need to rise to this challenge, the media has special potential to present this message in a way that is both clear and convincing, to point out, for example, that what is reported on the business page has a bearing on health and crime stories related to alcohol, and vice versa.

An evidence-based perspective

A noteworthy finding by Babor et al. is that some of the more popular prevention strategies are the least effective. They noted that

Challenges to reducing drinking-related harm through social policies

informational and educational campaigns seldom demonstrated any impact on drinking rates among those who were the foci of such campaigns. Some of the more effective measures, such as raising the price of alcohol or having government-run liquor systems oriented to controlling problems, or having a ceiling on the density of outlets, are often unpopular. The term "evidence-based" may be a popular one but it does not typically influence practice. Unevaluated measures are promoted, and attempts to evaluate them, such as server intervention measures, are at times thwarted. With the exception of campaigns to prevent drinking and driving, there is not a strong current pattern to use demonstrated effectiveness as a basis for implementing a policy or prevention strategy. Furthermore, changes such as higher density of outlets, longer hours of sale, more extensive promotion of alcohol, to mention a few, are driven by commercial and revenue-generating agendas, and evidence of their benefits in reducing drinking-related harm.

A first challenge is to promote greater awareness of what types of policies and prevention strategies have the greatest potential to reduce the harm from alcohol. Second, there needs to be a better match between the scale of the problem that is addressed and the harm reduction potential of the intervention that is used to reduce it. Finally, their needs to be a greater willingness to using evidence to inform decisions and assess their impact.

Policy-making protocols

How are alcohol policy decisions made? There is considerable variation on this topic, and in some instances, such as with regard to drinking-driving arena, there are cases of careful assessment of the options, consultation with a wide range of knowledgeable players and consideration of the costs and benefits. On other topics, the health and safety advocates might be consulted literally just a few days before a decision is finalized, and with insufficient time to offer a detailed response that has much hope of influencing the outcome.

There are at least three challenges with regard to using alcohol policy to manage alcohol problems. First, deliberations on alcohol policy are typically not transparent and public debate and input is uncommon, even though a decision will have implications for their health and safety. Second, the alcohol industry is a central player in deliberations leading up to many decisions and the outcome, not surprisingly, is often very close to their interests and agendas. The challenge for public health and safety advocates is to get a place at the table, as an equal partner, and at a stage in deliberations when there is still enough time to influence the outcome. Third, social and health impact assessments are uncommon prior to the policy change. This tradition, common when it comes to proposed changes in transportation, land-use or the environment, needs to become that standard approach in the alcohol arena as well.

Public health and safety response

A final topic is that of the challenges faced by the public health and safety communities that devote some time to alcohol issues. Some of their challenges are similar to those noted earlier, including, for example, a media that is not oriented to thinking about alcohol issues in global terms, control systems that place product promotion above harm reduction, and policy-makers that are often strongly influenced by commercial interests.

They also have unique challenges. Their resources are limited and they are often over-extended with regard to seeking to tackle multiple agendas in the health area. There are constraints related to funding. If some resources come from government then advocacy may be considered out-of-order or unwise. If some resources come from the alcohol industry, then this might influence their stated views on which interventions to support or be cool towards.

Finally, in the hope of demonstrating some progress, there may be a tendency to focus on interventions that are popular and flashy, such as information campaigns, but where there is little evidence of impact in reducing drinking or harm associated with alcohol consumption.

This report has summarized challenges to reducing drinking-related harm. While the focus has been on Canada, it is likely that some experiences are not dissimilar from those in other places. A future report will focus on current activities and options to address these challenges.

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Getting round the marketing codes of conduct

Alicia Rodriguez-Martos

If we are to believe statements made by the industry and the examples of good will it provides, there should be no need for concern about self-regulation, especially if the controls it has in place both before and after the launch of any marketing campaign are taken into account.

However, daily reality shows that the code of conduct is frequently broken. In addition, too often any complaints are not upheld. As an example, we can quote last spring's campaigns by Ballantines,'GO PLAY and GO SNOW, in Spain. Both are whisky promotional tools and both use amusing puppets which have considerable appeal to children and are likely to catch the underage eye.

The GO PLAY campaign, showing the puppets having fun in different ways, showed the whisky bottle and the warning message of Drink moderately; it's your responsibility. In the case of the GO SNOW, the name Ballantine's was associated with dangerous activities, such as snowboarding and the risky jumping "half-pipe". The GO SNOW advertisements did not show any bottle or warning message, because they allegedly promote just a snowboard championship, legally sponsored by the industry. The puppets design and the name Ballantine's are, anyway, unmistakable. Both campaigns were widely featured on bus-shelters and billboards and were clearly recognisable as whisky advertisements.

SOCIDROGALCOHOL, the Spanish organisation concerned with alcohol and other drug problems, complained on three grounds: the content of the messages which associated alcohol and sport and alcohol with playing in general (alcohol was clearly intended to embody the idea of "play"); the attractiveness of the advertisements to minors; and their placement in places frequented by school-children. The complaint drew attention to the fact that these advertisements broke the articles of the industry's codes of conduct relating to the association of alcohol with sports and success, and to the industry's own recommendation that designs and styles mainly associated underage activities and capable of appealing to underage people should not be used.

The regulatory body disallowed both claims on the grounds that, on the one hand, Ballantines' sponsorship was perfectly legal and that, on the other, the target audience was adult in both cases.

In fact, the youngest participants in the snowboarding championships were eighteen years old. The question is whether this precludes children under that age being attracted by the advertisements.

According to the regulatory body, AUTOCONTROL's, rules, the jury's resolution cannot be published other than in its entirety. Therefore, I am unable to quote selected sentences, but the resolutions are available at this association's web-site and we have them at the disposal for anybody who might be interested. It is, however, true that an image is worth more than a thousand words. Readers can look at those pictures and draw their own conclusions.

Getting round the marketing codes of conduct

Meanwhile, industry gives us more and more examples of its good intentions and its effective code of conduct. Street and magazines advertisements and television spots are repeatedly aimed at young people, constantly using the message of sexual and social success as a positive gain from drinking alcohol.

What is the point of presenting complaints, becoming involved in long, legal procedures, only to have the evidence denied?

Counter-publicity seems a much more direct strategy, at least as a means of opening people's eyes. It might also prove to be more effective in having unethical advertisements removed than formal claims. In Barcelona, the Public Health Agency has produced a series of "free-postcards" alluding to some of the best known advertisements of the summer campaign as part of a prevention community programme of health and leisure, sponsored by the National Plan on Drugs. Again images speak for themselves.

Meanwhile, in June of this year, the brewers of Spain approved a new code of conduct, which, taking into account the principles defined by the Recommendation of June 5th 2001, aims to prevent alcoholic products and their promotion being designed to attract underage drinkers. A special section is devoted to beer and minors, where, in addition to the existing legal limitations, a commitment is made to avoid any type of marketing portraying or aimed at minors. The commitments includes non-alcoholic beers. As far as social responsibility is concerned, a series of limitations should preclude non-ethical practices such as conveying the message that drinking alcohol is a requirement of a successful social life, or that beer can contribute to sexual success or make the drinker more sexually attractive or help overcome shyness. It is further stated that commercial communications cannot be aimed, by any means, at people under eighteen years of age.

Yet every time a young person sees a beer advertisement on television the implication is that all fun, all interaction with the opposite sex, every party or social occasion, is incomplete without a beer.

Young people, experiencing independent leisure time for the first time, pay attention to the messages conveyed by these advertisements on television. The message is: you can not have fun or be sexually interesting if you don't drink.

Will anything change when the new code of conduct comes into force?

We would like to see responsible marketing work. It would be far more preferable to celebrate their ethical behaviour in selling and advertising a legal commodity, than being daily confronted with questionable marketing ploys which forces us to react.

Alicia Rodriguez-Martos
SOCIDROGALCOHOL (Spain)

Alcohol Consumption in Brazil: recent public health aspects

Ilana Pinsky and Ronaldo Laranjeira, Federal University of Sao Paulo

Rising alcohol consumption

According to the World Health Organization, 8-15 per cent of the burden of disease in South America is attributable to alcohol, as compared to 4 per cent worldwide (World Health Report, 2002). Brazil, the largest country in South America and the fifth biggest in the world, provides a number of epidemiological data indicating that the consumption of alcohol by its population has been growing in the last decade.

Specifically, there are several signs of this increasing consumption among the youngsters. Results from school based surveys conducted periodically from 1987 to 1997 have shown that lifetime use of alcohol is above 65 per cent for all school children, with 50 per cent of those aged 10-12 years old having already tried alcohol at least once (Galduróz et al., 1997).

Comparing the four years when the surveys were done, the frequent use of alcoholic beverages (six or more times in a month) has been increasing in six of the ten cities surveyed. In addition, heavy use (defined as use on twenty or more times in a month) grew in eight cities, which is a cause for concern. Regarding alcohol related problems, 28.9 per cent of the school students report at least one lifetime episode of alcohol intoxication. (Galduróz et al., 1997).

Other important pieces of information can be drawn from Brazil's first household surveys, one completed in 1999 (covering 24 cities in the state of São Paulo, the most populated in Brazil) and another conducted in 2001 (covering the 107 largest cities in Brazil). Once again, alcohol stands at the top of the list of drugs used. Among 12-17 year-olds in the São Paulo survey, lifetime alcohol use was 35 per cent and 2 per cent of young people this age admitted to having problems with alcohol (Galduróz et al., 2000).

These frequencies are somewhat lower than the ones presented in the school surveys and may be due to the methodological differences in data collection. The country household survey reported a lifetime consumption of 48 per cent for 12-17 year-olds and 73 per cent for 18-25 year-olds (Carlini et al., 2002). Problems due to alcohol use were reported by 4 per cent of the 12 to 17 year-olds and 10 per cent of the 18-25 year-olds. A paper comparing the two household surveys specifically for the state of São Paulo analysed all the age groups together and concluded that alcohol lifetime use increased during these two years (Galduróz et al., 2003). The same paper suggested that this increase may be related to an aggressive alcohol advertising campaign, especially for beer.

There are other data corroborating these surveys. A study based on data from the Global Status Report on Alcohol suggests that per capita alcohol consumption in Brazil had a 74.5 per cent increase over the period between 1970 and 1996, a situation quite the opposite to many other countries worldwide (Carlini-Marlatt, 2001). In addition, the forecast by the Euromonitor, an organisation monitoring business trends, is that alcohol volume sales are expected to grow by 9 per cent in 2003, especially with the contribution of young Brazilians taken into account (Euromonitor, 2002).

Regarding the kind of alcoholic beverage sold, beer presents the highest volume by far, with an estimated 7.5 billion of litres sold in 1995. This quantity almost doubles the figure for 1985 (Carlini-Cotrim, 1999). In 2001, a representative of the Brazilian beer industry

Alcohol Consumption in Brazil: recent public health aspects

estimated the beer consumption as 8.5 billions of litres per year (SINDCERV, 2001). It is important to point out two important factors related to this increase in beer consumption in Brazil: 1) that it happens in addition to the use of other alcoholic beverages and not in substitution for them (Carlini-Marlatt, 2001) and 2) although drunk by all age groups, beer is the most frequently used alcoholic beverage among young students (Galduróz e cols., 1997).

At his point, it seems fundamental to tackle two main questions concerning this boost in alcohol consumption in Brazil: why is this happening and what is being done to address this situation?

Alcohol policy vacuum

First of all, Brazil has, in effect, few regulations concerning alcohol consumption. The small number of laws that already exists (for example, it is illegal to sell alcohol to minors, to people already visibly intoxicated, in outlets located next to roadways) is rarely enforced.

There are no regulations concerning some vital aspects of alcohol availability, such as hours and days of sale, density of alcohol outlets and specific alcohol licenses. In addition, most alcoholic beverages are extremely cheap and promotions, like "happy hours", are frequent ("Clube das Loiras", VEJA SP, 23/10/02). Concerning alcohol prices, a litre of cachaça (a spirit produced from sugar cane, about 40 per cent ABV) can be bought for less than one US dollar in a supermarket and a 350ml can of beer for 20 cents (as a means of comparison, a 2 litre bottle of soda costs 75 cents).

Secondly, there is an aspect that is considered by many people as intrinsically cultural to Brazil, that is, the extreme tolerance of Brazilian society regarding alcohol consumption and even alcohol abuse. Examples of this include alcohol binge behaviour by young males, even minors, often regarded positively as "macho behavior"; the general disregard for restrictive regulations; and the undisputed presence of alcoholic beverages in the majority of gatherings and festivals such as carnival, soccer games, parties, and similar events.

The lack of a consistent national policy regarding substance abuse prevention is another factor. Recently, the Anti-Drug National Secretariat was formed, and substance abuse public policies, related to both prevention and treatment started to gain some space among Brazil's priorities, but still in a very timid and unorganised way. There are a few school prevention programmes being implemented in the country, some adapted from the US (for example, DARE) and some developed nationally, but most of them are very isolated programmes without much funding or outcome evaluation.

A crucial aspect of the increased alcohol consumption in Brazil is without doubt the high percentage of young people in its population and the fact that the country's economic-political situation is relatively favourable. In this way, Brazil represents a very promising market as far as the alcohol industry is concerned (Euromonitor, 2002).

The industry's interest in Brazil can be seen in their investment in marketing and advertising and by the development of new products. In 2001, $106 million were spent on alcohol advertising in Brazil, around 80 per cent specifically for beer (Pinsky, 2003). Besides, several new products, focusing specially on young consumers, have been created. Some examples are the alcopops , light beer and "caipirinha" (a mixture of cachaça and lemon juice). There has been serious investment in alcopops in Brazil. For instance, the producer of only one of these drinks spent around $5 million to promote it in the space of one year (Istoé dinheiro, 15/05/2002). The market leader, Smirnoff Ice, surpassed its expected sales by 10 million bottles and "increased by 10 per cent the vodka Smirnoff's sales, that had been stagnating for years" (Istoé dinheiro, 15/05/2002).

Top: Sao Paulo

Second from top: A bar in Rio

Bottom two pictures: The Rio Carnival

What is being done?

Brazil seems to be at a pivotal moment in its acknowledgement of

Alcohol Consumption in Brazil: recent public health aspects

alcohol-related problems as a significant matter that needs to be addressed. For instance, a few Brazilian cities have experimented recently with a local regulation restricting hours for selling alcohol. In addition, the new health minister has been portraying himself as a tough opponent of the alcohol industry, and recently co-ordinated the creation of an inter-ministerial group (GTI) responsible for setting guidelines for a policy concerning alcohol related problems (Newspaper "O Estado de S.Paulo, 14/05/2003).

The GTI, that is at the moment still concluding its work, is going to offer suggestions regarding promotion, selling points, taxes and prevention. Nevertheless, there are doubts as to whether these recommendations are actually going to be put into action.

The alcohol and advertising industries, however, are not taking any chances. It is necessary to provide here a little background on other recent developments related especially to alcohol promotion. In Brazil there is a federal law, dating from 1996, that regulates alcohol advertising in Brazil, as well as tobacco and a few other products. Among other things, alcohol beverages may only advertise before 6 am and after 9pm.

However, alcohol beverages, in the definition of the 1996 law, means solely those products with an alcohol content higher than 13ABV, thus excluding beer and wine. In 2000, the former health minister banned all kinds of tobacco advertising, except within points-of-sale. Since then, more than seventy new laws were proposed suggesting further restrictions on alcohol advertising. The advertising industry, trying to anticipate and avoid further outside regulation, in September 2003 approved revisions to its self-regulation code (Brazilian self-regulated publicity code: www.conar.org.br).

Among other modifications, these restrict the use of sexual content and cartoons, both regularly employed in advertisements, to promote alcohol beverages. In addition, models featured in the advertisements should be and appear to be older than twenty-five and people should not be portrayed drinking. In this new version of the code, alcoholic beverages are actually separated into three categories: those above 13 ABV, alcohol and wine, and alcopops.

Some sections of the alcohol industry, especially those representing the beer producers, launched several campaigns intended to improve its "reputation" and avoid being included in the advertising restrictions. For instance, the biggest brewer in Brazil, AMBEV, initiated a well publicised drunk driving prevention campaign, including the donation of 38 breathalyzers to the military police and a partnership with cabs' representatives. The industry has also been lobbying, pressuring politicians and inviting public health representatives for talks.

The newly elected Brazilian government is taking some steps towards a basic alcohol policy. It is very unlikely to succeed. If Brazil is to have some chance of a proper and sustainable policy in relation to alcohol, we need to create a strong advocacy group. The success of the country in the tobacco and HIV area supports this move.

References

Carlini EA et al. (2002) I Levantamento Domiciliar sobre o Uso de Drogas Psicotrópicas no Brasil – 2001. São Paulo, CEBRID.

Carlini-Marlatt,B. (2001). "A população é jovem e o país é quente": estimativas de consumo de álcool e tabaco no Brasil pelos dados das indústrias produtoras. Jornal Brasileiro de Dependência Química, 2(1): 3-8.

Eutomonitor (2002). www.euromonitor.com

Galduróz JCF et al. (1997) IV Levantamento sobre o Uso de Drogas entre Estudantes de 1o. e 2o. graus em 10 Capitais Brasileiras – 1997. São Paulo, CEBRID.

Galduróz JCF et al. (2000). I Levantamento Domiciliar Nacional sobre o Uso de Drogas Psicotrópicas – Parte A: estudo envolvendo as 24 maiores cidades do estado de São Paulo.São Paulo, CEBRID.

Galduróz JCF et al. (2003) Comparações dos resultados de dois levantamentos domiciliares sobre o uso de drogas psicotrópicas no estado de São Paulo nos anos de 1999 e 2001. Jornal Brasileiro de Psiquiatria, 52(1): 43-51.

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1st European Alcohol Policy C larger Europe: Bridging the GA

16-19 June 2004 Hotel Europejski -Warsaw - Poland

Presented by **Eurocare**, in collaboration with The **European Commission**, The **World Health Organisation**, The **European Youth Forum**, The **European Cultural Foundation & The Polish State Agency for Prevention of Alcohol Related Problems**, and in partnership with NGOs and government departments from 27 **European countries**. The conference is co-financed by the European Commission DG SANCO

Aim of Conference

- To bridge the gap between scientifically based evidence, the possible and the practical in the process of alcohol policy-making.
- To inform and enable those involved in making and implementing policies and programmes in public health and social welfare.
- To raise awareness about alcohol related harm and what can be done about it.

Who Should attend?

- National and EU officials involved in issues related to public health, social welfare, road safety and culture.
- Prevention specialists working in governmental and non-governmental organizations at the local, national and European level.
- Health promoters, researchers, clinicians, and addiction service providers in health and other relevant sectors.

Why attend ?

- Simply because it will be the first conference on alcohol policy to be held in the enlarged Europe, creating dialogue, breaking barriers, and bridging the gaps between science, advocacy, and policy.
- Working in public health, you will gain insight into influencing the policy process and best practice.
- Opportunity to learn from eminent international speakers who will be challenged by professional moderators and the audience on the different policy issues.
- Practical workshops and parallel session will give you the opportunity to present your own views and discuss each policy issue further.
- The advocacy tool kit, specifically designed to assist policy makers and programme implementers in their daily work will be presented at the conference.

The old town square in Warsaw

onference in the context of a
.P

- You will be able to practice your presentation skills during the "Test the Tool Kit Sessions" with the help of a professional communicator.
- There will be theatre for and by young people, puppet shows introducing each session, a cartoonist and a professional photographer recording your own words and gestures with a review at the end of each day.

This event is expected to attract much national and international media attention.

The language of the conference will be in English with Translation into Polish.

Programme, Workshops and parallel themes?

The programme will be made available as soon as possible. Please note that, whilst we will do out best to integrate all the proposals in the programme, there might be too many requests to make this possible. The themes are as follows:

- The harm done by alcohol
- Threats to health and alcohol policy
- Marketing and communicating about alcohol
- Success stories from the national to the local, in settings and on the roads
- Public health approach to treating alcohol problems

Aerialview of warsaw

Cost?

- Special reduced conference fees is 200 euros for participants from existing EU Member States , and 50 euros for participants from accession and applicant countries – this fee includes lunch
- The Conference venue is the HOTEL SOFITEL VICTORIA, WARSAW. Rooms have been reserved at the SOFITEL VICTORIA and EUROPEJSKI HOTEL.

What next?

- Write the date in your diary now (16th to the 19th June)
- **Send a message to Florence Berteletti Kemp f.bertelettikemp@ias.org.uk expressing your wish to receive the full programme and your interest**
- **Start thinking about the parallel sessions and send your ideas and proposal to Florence Berteletti Kemp by 31 December 2003**
- Send this message to those you think might benefit from the conference

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European report highlights alcohol danger

Excluding tobacco and caffeine, alcohol is the psychoactive substance used most by young people across the European Union, says the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in its annual report presented to the European Union and its member states.

The report states that the "proportion of 15- to 26-year-old students who have been drunk at some time in their lives ranges from 36 per cent in Portugal to 89 per cent in Denmark (fig 1)." It notes the growing concern about increased levels of drunkenness and binge use of alcohol for recreational purposes and, citing the example of two very different countries, says that between 1995 and 1999 "marked increases in lifetime experience of being drunk occurred in Greece and Norway (Fig 2)".

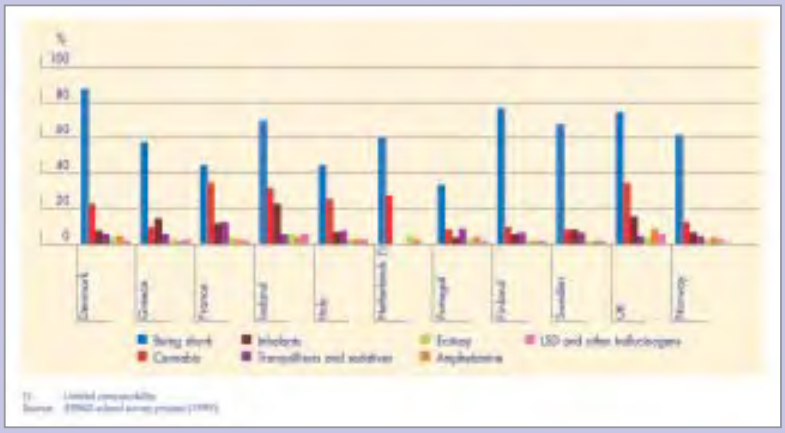


Figure 1: Lifetime prevalence of being drunk and illicit substance use (15- to 16-year-old students)

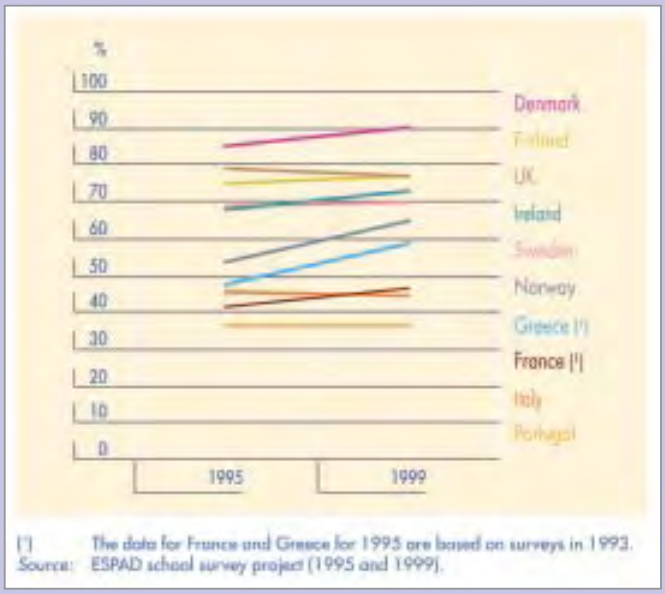


Figure 2: Lifetime prevalence for being drunk

Data are gathered by EMCDDA from all the member states of the EU and Norway. Whilst there are no routinely collected EU data on drug-related hospital emergencies, because of the hidden nature of illicit drug use, the report does note that such data as are available suggest "that alcohol is a greater burden on health services in some Member States than illicit drug use.

WHO estimates that in developed countries alcohol accounts for 10-11 per cent of all illness and death each year."

For example, a Danish study of young people carried out in 2001 found that fewer 17-year-olds had reported hospital attendance for drug-related problems than for alcohol-related problems. "In Ireland," says the report, "a regional study of hospital case notes over a three-month period found that almost all of the 55 hospital admissions among young people aged 10-18 were related to alcohol alone or deliberate self-poisonings."

The EMCCDA Annual Report for 2003 is available online at: http://annualreport.emcdda.eu.int/en/home-en.html

Further publications available from the Institute of Alcohol Studies

Counterbalancing the Drinks Industry

Counterbalancing the Drinks Industry: A Report to the European Union on Alcohol Policy

A response to a report published by the European drinks industry and a defence of the WHO Alcohol Action Plan for Europe.

Alcohol Policy and The Public Good

Alcohol Policy and the Public Good: A Guide for Action

An easy-to-read summary of the book written by an international team of researchers to present the scientific evidence underpinning the WHO Alcohol Action Plan for Europe

Medical Education

Medical Education in Alcohol and Alcohol Problems: A European Perspective

A review of educational programmes on alcohol and alcohol problems in European medical schools, identifying gaps in provision and proposing guidelines for a minimal educational level within the normal curriculum of under- and post-graduate medical students.

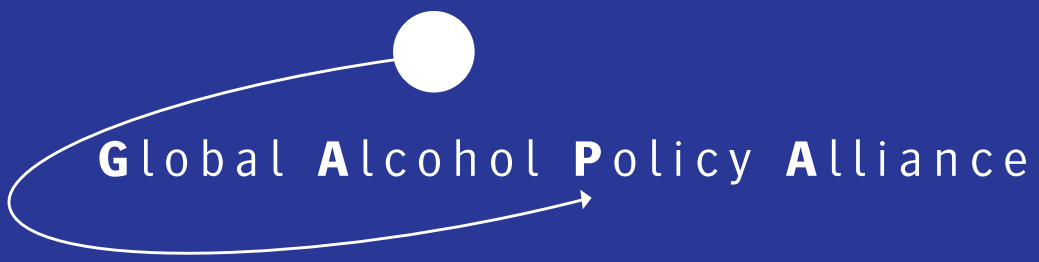
Alcohol Problems in the Family

Alcohol Problems in the Family: A Report to the European Union

A report produced with the financial support of the European Commission describing the nature and extent of family alcohol problems in the Member Countries, giving examples of good practice in policy and service provision, and making recommendations to the European Union and Member Governments.

Marketing Alcohol to Young People

Children are growing up in an environment where they are bombarded with positive images of alcohol. The youth sector is a key target of the marketing practices of the alcohol industry. The booklet depicts the marketing strategies of the industry and shows how advertising codes of practice are being breached.



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