Response to Preventative Health Taskforce discussion paper:  
Cancer Council Australia

Overview

Cancer Council Australia welcomes the opportunity to respond to the three technical papers developed by the Australian Government's National Preventative Health Taskforce and summarised in the discussion paper, *Australia: the healthiest country by 2020*.

As an independent, non-government health policy organisation, Cancer Council Australia emphatically supports the Taskforce’s recommendations – essentially as it appears that the Taskforce, like Cancer Council Australia, draws on the best available evidence to inform the development of policy.

The Taskforce’s work is particularly important to Cancer Council Australia, as the modifiable behaviours subject to the technical papers’ recommendations – smoking, nutrition and physical activity, and alcohol consumption – cause around one third of cancer deaths in Australia.1

In supporting the Taskforce recommendations, Cancer Council Australia provides a number of specific comments in relation to the three technical papers, as set out in the sections that follow. Our response includes Attachment 1, a report on front-of-pack food labelling – an important area of health policy in relation to cancer prevention.

In our view, and on the basis of the evidence, the Taskforce has done a commendable job in scoping and proposing policy options aimed at reducing the preventable burden of chronic disease in Australia. The challenge is for governments in Australia to collectively adopt and implement the Taskforce recommendations, thereby helping the nation achieve its potential to reduce the high level of death and disability caused by chronic diseases such as cancer through effective primary prevention.

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‘Making smoking history’

Cancer Council Australia emphatically supports the tobacco control measures proposed in the Taskforce’s technical paper, *Tobacco control in Australia: making smoking history*.

The proposed measures are consistent with Cancer Council Australia’s own tobacco control policy priorities, published in 2007 in the *National Cancer Prevention Policy 2007-09*.2

The reason for the consistency is that the Taskforce, like Cancer Council, appears to draw on the best available evidence in developing policy.

Of particular importance is the Taskforce’s promotion of a target of no more than 9% of Australians aged 14 and over smoking by the year 2020. This would require reducing the aggregate number of Australians smoking by at least 1 million.

Evidence of the effectiveness of tobacco control shows this target is achievable. The Council of Australian Governments’ (COAG’s) support of such a target would help to ensure that all Australian governments worked together to implement evidence-based measures to reach the target of 9% or less Australian smokers by 2020. Government could openly endorse the target, if there is sufficient political will to support the measures needed to deliver the result.

Reducing smoking prevalence in Australia to 9% would substantially reduce Australia’s cancer burden. Tobacco smoking is the leading preventable cause of cancer; in 2005 there were an estimated 11,308 new cases of cancer and 8,155 deaths from cancer that can be attributed to smoking. This represents over 11% of cases and nearly 21% of cancer deaths. 3 Of particular concern, 2005 saw lung cancer exceed breast cancer as the main cause of cancer death in Australian women.2

**Taskforce recommendations**

**Revenue measures that would reduce the affordability of tobacco products**

1. Increase excise and customs duty on tobacco to discourage smoking and to provide funding for prevention activities, including those in lower socio-economic status groups.

2. Amend customs and excise legislation to implement measures to prevent erosion of prices through the evasion of duties on tobacco.

**Cancer Council Australia comment**

Cancer Council Australia has long supported increased excise and duty to reduce smoking prevalence, in view of longstanding evidence that price control is one of the most effective levers for reducing the death and disease caused by tobacco use.

Our position has for many years been published in our *National Cancer Prevention Policy* and, more recently, in submissions to the “Henry Review” on taxation reform and in our pre-budget submission to Treasury.

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Legislative reforms to address current deficiencies in tobacco regulation – recommendations 3-9

3. Mandate plain packaging of cigarettes and increase the required size of graphic health warnings to take up at least 90% of the front and 100% of the back of the pack.

4. Modernise the Tobacco Advertising Prohibition Act 1992 (Cth) to cover new forms of media and to ban internet sales etc.

5. Establish a national system to review mandated warnings and warn smokers of emerging and new evidence about health effects in a more timely and systematic manner.

6. Establish or nominate a regulatory body with the powers to ban, limit or mandate tobacco product constituents, emissions, additives or design features.

7. Strengthen state and territory legislation to ensure that cigarettes are not sold to children.

8. Extend state and territory laws that protect against exposure to second-hand smoke.

9. Provide commercially realistic funding over a period of several years for a continuing social marketing campaign to be developed by an expert group and run in collaboration with state Quit agencies (include tailored Indigenous component).

Cancer Council Australia comment

Cancer Council Australia has for a number of years promoted increasing the required size of graphic health warnings on tobacco packaging. While the current graphic warnings represented a positive step when introduced in 2005, they remained short of the evidence-based recommendation for adequate warnings on both front and back of the pack. Continued reform in this area is required; the Taskforce recommendations are supported.

In 2003, Cancer Council Australia provided a detailed submission to a parliamentary review of the Tobacco Advertising Prohibition Act, calling for a raft of amendments along similar lines to those proposed by the Taskforce. We publicly expressed our disappointment when the review concluded that there was no requirement to amend the Act. The tobacco industry’s ongoing attempts to use new media and technology to circumvent advertising restrictions, recruit new smokers and retain current smokers, demonstrate the current act’s inadequacy.

As set out in our National Cancer Prevention Policy, and in the inter-governmental National Tobacco Strategy 2004-09, continued monitoring and surveillance of tobacco control and a systematic approach to informing the community about the risks of tobacco-related disease should be part of a strategic approach to reduce tobacco burden in Australia – as promoted in Taskforce recommendation 5.

Regarding regulation, recommendation 6 is urgently required to address an unacceptable anomaly in tobacco sales and marketing. As articulated in Cancer Council Australia’s position statement on “reduced harm cigarettes”, the current level of tobacco regulation is highly inconsistent with a consumer product causing such high levels of death and disability.

Strengthened state/territory legislation to help ensure cigarettes are not sold to children would have a complementary benefit as part of a comprehensive plan to reduce tobacco use in adults, whose influence as role models can encourage smoking in children.

The Commonwealth should lead the states and territories, as part of the proposed Preventive Health Partnerships, in also ensuring best practice is employed in a consistent, national way to eliminating second-hand smoke from public places, as well as protecting children from smoking in cars.

Social marketing is one of the most effective ways to reduce the social and economic cost of smoking, yet Australia has slipped in this area since the success of the National Tobacco Campaign a decade ago.

Indigenous tobacco control, reduced social disparity in tobacco burden – recommendations 10-14

Cancer Council Australia comment

Indigenous Australians are more than twice as likely to die within five years of a cancer diagnosis as non-Indigenous Australians. While the evidence base on cancer in Indigenous Australians is limited, significantly higher smoking rates among Indigenous populations is believed to be a key reason for the disparity in cancer outcomes; cancers attributed to smoking have a generally poorer prognosis and Indigenous communities have far higher smoking rates than non-Indigenous communities.

Reducing smoking rates in Indigenous people is, therefore, one of the most urgent requirements for reducing cancer death and disability in Aboriginal and Torres Strait Islander peoples.

At a national discussion forum on Indigenous cancer convened by Cancer Council Australia in Darwin in 2004, a number of presentations focused on tobacco control in Indigenous Australians, with measures along the lines of the Taskforce recommendations generally endorsed. Cancer Council Australia therefore fully supports recommendation 10 – working in partnership with Aboriginal health organisations to reduce tobacco use in Indigenous Australians.

Re recommendations 11-14, Cancer Council Australia fully supports these recommendations to address the disproportionate tobacco death and disease burden among socially disadvantaged groups. As articulated in our pre-budget submission to Treasury, increased tobacco excise would provide an ideal revenue source to directly address this social disparity in public health outcomes.

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Health system interventions – recommendations 15, 16

**Cancer Council Australia comment**

Quitline services have been shown to be effective as part of a comprehensive approach to tobacco control. If the proposed new approach to the Australian healthcare agreements – i.e. building preventative health into a system that has historically been focused on funding hospital services – is to succeed, integrated funding for important preventative health services such as state/territory Quit programs is essential.

Cancer Council Australia also supports measures to enhance tobacco control capacity in medical practice, as outlined in our submission to the National Health and Hospitals Reform Commission.

Reinvigoration of the Australian National Tobacco Strategy – recommendation 17

**Cancer Council Australia comment**

Reinvigorating the Australian National Tobacco Strategy is clearly a matter of implementation – the current strategy was endorsed by COAG, but lacked an implementation plan and mandatory reporting requirements for jurisdictions. As expressed in Cancer Council Australia’s 2007 election priorities, re-invigorating the strategy, through implementation planning and funding rather than re-drafting, would be pivotal to Australia reaching its potential to reduce the death and disability caused by smoking.

Cancer Council therefore fully supports the Taskforce recommendation 17.

Overseas development – recommendation 18

**Cancer Council Australia comment**

Cancer Council recognises that Australia, as a world leader in tobacco control, has an important role to play in reducing tobacco burden internationally, particularly as the tobacco industry looks increasingly to developing nations for sales.

As a supporter of international tobacco control (e.g. promoting Australia’s ratification of the WHO Framework Convention on Tobacco Control, representation at the subsequent Conference of the Parties, co-hosting international events such as the 2010 Asia Pacific Tobacco Control Conference etc.), the Cancer Council fully endorses the Taskforce recommendations in relation to Australia applying its expertise to reduce tobacco burden in the region.
‘Obesity in Australia – a need for urgent action’

Cancer Council Australia emphatically supports the obesity control measures proposed in the Taskforce’s technical paper, *Obesity in Australia – a need for urgent action*.


The reason for the consistency is that the Taskforce, like Cancer Council, apparently draws on the best available evidence in developing policy. Of particular important is the Taskforce’s promotion of a comprehensive obesity strategy, integrating policy (including food marketing reform), environmental design, research and monitoring with public education and community programs.

Reducing the prevalence of obesity/overweight in Australia will be integral to preventing a significant increase in cancer. (Note that due to the complexity of the debate around obesity control, evidence sourced for this section is comprehensively referenced from page 16.)

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**Cancer Council Australia comment**

Cancer Council congratulates the National Preventative Health Taskforce for its comprehensive recommendations aimed at reducing the burden of disease attributed to obesity and overweight. We are pleased that the strategies extend beyond education and information and, importantly, focus on policy and environmental changes. The proposed strategies are balanced between strategies to improve both dietary intake and physical activity.
Cancer Council strongly supports the proposals of the Taskforce relating to the prevention of obesity, and urges the Australian Government to immediately implement the proposed strategies. These initiatives are consistent with our National Cancer Prevention Policy. It is also imperative that the full range of strategies is implemented to ensure there is a focus on equity in the delivery of the strategies.

In commenting specifically, Cancer Council Australia frames its response in the context of multiple policy priorities for improved nutrition and physical activity already promoted by our organisation through a range of published material.

**Food marketing**

Cancer Council strongly supports a ban on unhealthy food marketing directed at children. We believe this is a very important strategy that will have a significant population health impact.

There is compelling evidence that improved food marketing regulations have the potential to be an important and cost-effective strategy to address childhood obesity in Australia – a necessary ingredient to change. Systematic reviews on food marketing to children show that advertising works. It leads to children preferring advertised foods, requesting their parents purchase the advertised foods and the consumption of more of these foods. As the majority of foods marketed to children are high in fat, sugar, and salt (estimates of unhealthy TV food advertising range from 55-81% of all food ads), this food marketing is detrimental to children’s health and wellbeing.

There is strong community support, particularly among parents, for more effective regulations on food marketing to children. The findings from an independently conducted survey of 400 representative parents across Australia, which has been peer reviewed and published, found:

- 86% of parents supported a ban on advertising of unhealthy foods at times when children watch TV;
- 89% of parents agreed the government should introduce stronger restrictions on food advertising at times when children are watching;
- 75% of parents were concerned about advertising using toys and giveaways to promote unhealthy food to children; and
- 67% of parents were concerned about advertising via the sponsorship of children’s sporting activities to promote unhealthy food to children.

These findings have been supported by more recent research, conducted in March 2008 by the consumer group Choice, which found that 88% of parents think the marketing of foods specifically to children contributes to difficulties ensuring children develop healthier eating habits. The Choice survey also found that 82% of parents were in favour of tighter restrictions over the way unhealthy food is marketed to children in Australia. These results have remained stable since an earlier survey conducted by Choice in 2006, which reported that 82% of respondents were in favour of government regulating the way food and drink is advertised and marketed to children.

As well, the Cancer Council was involved in a grass roots advocacy campaign, *Pull the Plug on TV Food Advertising*, on behalf of the Coalition on Food Advertising to Children (CFAC), whereby 20,521 postcards were collected from Australians supporting the need for better regulations to protect children from food advertising.
It is essential that the Government understands that there is an artificial juncture of children’s TV program classification times and children’s viewing times which has been used effectively to muddy the waters about the efficacy of existing regulations and industry codes of practice. The largest proportion of children watch TV outside of specified children’s periods.

Any imposed TV food advertising restrictions which genuinely aim to protect children, must apply during broadcast periods when the highest numbers of children are watching. Child audience numbers on commercial free-to-air televisions are low at the times Children’s (‘C’) and Pre-school children’s (‘P’) programs are usually broadcast.\(^1^1\) The peak viewing time for 0–14 year olds is in the evening between 7.00 pm and 8.00 pm, with average child audiences close to 500,000. This child viewing audience is six-fold higher than during C periods; with only 80,000 children watching TV between 4.00 pm and 5.00 pm.\(^1^1\) Both the current Children’s Television Standards and industry self-regulatory codes narrowly only make provisions for food advertisements shown during this very restricted C period. For this reason, the Cancer Council urges the government not to be swayed by the food and advertising industries claims that they are able to effectively self regulate to limit children’s exposure to food marketing using the current broadcasting definitions.

New Australian research has found that persuasive marketing techniques, such as the use of premium offers and promotional characters, are more likely to be broadcast during children’s peak viewing times compared to other broadcast periods.\(^1^2\) In this study, during the programs that were most popular with children, the rate of unhealthy food advertisements containing premium offers was more than 18 times higher than during adults' popular programs.\(^1^2\)

Other forms of food marketing

The Discussion paper does not specify if food marketing regulations will be proposed for other non-TV forms of food marketing. These other forms of food marketing contribute substantially to children’s overall exposure to unhealthy food marketing and the Cancer Council recommends that these other forms of food marketing be included in a broader set of regulations which meaningfully limit inappropriate commercial promotions to children.

Australian research has shown that children are frequently targeted with unhealthy food marketing from other non-broadcast (non-TV) media. One study, which looked at the extent of food marketing to children on the Internet, identified a range of marketing techniques used to specifically target children andadolescents. Researchers coded and analysed 315 websites, including 119 food product websites and 196 popular children’s websites (as based on website traffic data). Food marketing techniques on food product websites included branded education (79% of websites), competitions (34%), promotional characters (35%), downloadable items (35%), branded games (29%) and designated children’s sections (22%).\(^1^3\) As such, Internet marketing uses a range of techniques to ensure that children are immersed in product related information and activities for extended periods, thereby increasing brand exposure. Overall, food references on popular children’s websites were significantly skewed towards unhealthy foods (61% vs. 39% healthy food references), with three times more branded food references for unhealthy foods.\(^1^3\) The relatively unregulated marketing environment and increasing use of the Internet by children, point to the potential increase in food marketing via this media.

Research has also been conducted looking at the nature and extent of food marketing in children’s popular magazines.\(^1^4\) A sample of sixteen popular children’s magazine titles reviewed over a 12-month period (n=76 magazines in total sample). Food references were significantly skewed towards unhealthy foods (64% unhealthy vs. 36% healthy food references), and for non-branded items (66% non-branded vs. 34% branded food
The food groups with the highest proportion of branded (paid) food references were ice cream, fast food restaurant meals and high sugar drinks.\(^{14}\) This study showed that despite food industry rhetoric, children are indeed a target for unhealthy food marketing.

Further research also indicates that food marketing in the area surrounding primary schools is high, and is predominately for alcohol and unhealthy foods. In a study which examined outdoor food advertising within a 1km radius of primary schools in the Sydney and Wollongong areas (n=40 schools) food advertisements were skewed towards unhealthy foods (80\% of all food advertisements), and were concentrated in retail areas and in areas close to schools.\(^ {15}\)

Lastly, Australian research examining the extent of supermarket packaging promotions to target children, found that within seven different food categories between 9\% and 35\% of food products used some sort of promotional tactic, such as cartoon and movie character promotions or the use of premium offers, such as giveaways and competitions.\(^ {16}\) Further, 82\% of all food promotions were for unhealthy foods.\(^ {16}\)

In 2007, Cancer Council Australia commissioned a report on the marketing practices of Australian food companies, that described the policies of eight food companies with regard to marketing to Australian children, and compared these policies to their actual marketing activities.\(^ {17}\) This report found that despite having existing policies relating to marketing food products to children, most of the products promoted to children – and recalled by children – were those high in sugar, fat and salt. The report concludes that Australia’s current regulatory arrangements around food marketing are ineffective in helping to control consumption levels of foods that have a negative impact on the health of Australian children.

**Summary:** Cancer Council Australia recommends the Australian Government introduce statutory regulations that significantly reduce children’s exposure to unhealthy food and beverage marketing.

We recommend that statutory regulations related to television food advertising need to apply to broadcast periods when high numbers of children are watching, specifically between 7am to 9am and 4pm to 9pm weekdays and 7am to 9pm on weekends.

Cancer Council recommends that statutory regulations to restrict unhealthy food marketing to children apply across a broad range of broadcast and non-broadcast media.

We support the use of the FSANZ Nutrient Profiling Model to establish criteria for the advertising of healthy foods.

Cancer Council Australia also recommends that these regulations be monitored by an independent statutory body, with clear and transparent monitoring and mandatory enforcement processes.

**Food labelling**

This year, Cancer Council collaborated with other public health and consumer groups to conduct independent research on consumers’ preferences for, and understanding of, different front of pack food labelling systems.\(^ {18}\) The aim of this consumer research was to
determine which front of pack food labelling system would be most appropriate for adoption in Australia.

Four different front-of-pack labelling systems were tested: Traffic Light system ranking levels of total fat, saturated fat, sugar and sodium as either high, medium and low and assigned a red, amber, or green traffic light; Traffic Light + Overall Rating; Monochrome Percentage Daily Intake indicating the percent dietary contribution of energy, protein, fat, saturated fat, carbohydrate, sugar, fibre and sodium; and Colour-coded Percentage Daily Intake. Surveys with 790 consumers were conducted at four shopping centres in NSW with representation from high, medium and low socio-economic areas and one regional area (Newcastle).

Consumers reported strong support for nutritional information to be placed on the front of food packages, particularly for nutrients that should be consumed in limited amounts, including saturated fat, sugar, total fat and sodium. The traffic light system, when compared with other front-of-pack labelling systems, was significantly more effective in assisting consumers to select healthier food products; led to more accurate assessments of nutrient levels; and was easier and quicker to use.

Consumers using the traffic light system were five times more likely to correctly identify the healthier food products compared to the percentage daily intake scheme. Further, people from the lowest socio-economic group were six times less likely to identify healthier food products using the percentage daily intake system than people from higher socio-economic groups.

This research has now been submitted to a peer reviewed journal publication, but a summary of the research is included with this submission (see attachment 1).

**Summary:** Cancer Council Australia supports the Taskforce’s proposal for food labelling to assist Australian consumers to make healthier food choices, and recommends that the Australian Government implement a traffic light food labelling scheme to apply uniformly across all grocery food products.

**Ongoing monitoring and surveillance**

Integral to addressing Australia’s obesity crisis is an ongoing nutrition and physical activity program, as part of biometric monitoring and surveillance of Australia’s population. Research on the social determinants of obesity is essential to promoting healthy weight among Australia’s population.

Cancer Council Australia calls for an ongoing commitment to a national nutrition and physical activity survey program as part of its 2009-10 pre-budget submission to Treasury.

**Summary:** Cancer Council Australia recommends the Australian Government undertake regular monitoring and surveillance on nutrition and physical activity behaviours of both adults and children.

Cancer Council is helping to fund the *National Secondary Students’ Diet and Activity* (NaSSDA survey), an ongoing survey that will aim to:

1) monitor changes in overweight and obesity prevalence, diet and activity over time, at both a state and national level;

Comment [PG1]: And can the food labelling report also be linked here?
2) elucidate potential targets inform program development and evaluation; and
3) provide evidence to inform policy development.

A nationally representative sample of around 20,000 students in school years 8 to 11, from over 200 schools will be surveyed triennially, commencing in 2009. Data on dietary habits and physical activity will be collected via a web-based survey, along with anthropometric measurements (height, weight and waist circumference). Data on the school food and activity environment will also be collected.

A major strength of this study will be the use of a consistent methodology over time. This commitment to ongoing monitoring means that the survey data can be used to determine long-term trends in overweight and obesity, diet and physical activity. This data will be able to be used to inform program development and policy initiatives aimed at obesity prevention at the state/territory level, and to identify potential targets for change (i.e., provide an indication of whether existing programs are working and what might work better).

While the NaSSDA survey will assist in collecting data on children’s weight status, and nutrition and physical activity profiles, obviously funding constraints preclude the collection of data from a wider age range of children and from adults. Such a broad monitoring program is the responsibility of government. Cancer Council recommends the Australian Government take the lead in developing regular adult and children’s nutrition and physical activity surveys.

**Role of the food industry**

Cancer Council Australia recommends the Australian Government develop and adopt clear guidelines for engaging the Australian food industry in the implementation of strategies to prevent obesity. While we fully accept that the food industry needs to be involved in the development and implementation of such strategies, it is imperative that those with vested and commercial interests must not be able to dictate or slow down policy changes.

As the Taskforce’s Discussion Paper points out, reshaping and reformulating the food supply towards healthier products is a key strategy. This must include a strong emphasis on increasing the population intake of fruit and vegetables, especially in disadvantaged communities. Any initiatives to encourage food supply reformulation must not result in the development and promotion of food products that have been "health-ified" through the addition of low quality protein and vitamins and minerals, for which there is no population deficiency requirement. Rather, reformulation must result in real and meaningful improvements to the food supply, including the reduction of total fat, saturated fat, sugar and sodium, and increases in dietary fibre and fruit and vegetable content.

The successes and lessons learnt from those jurisdictions that have developed healthy canteen policies will be useful in looking at the larger food supply and other food service sectors.

Cancer Council is supportive of the FSANZ Nutrient Profiling Criteria for determining which foods are healthy and unhealthy. However, again safeguards must be applied to ensure that the food industry is unable to modify foods with the addition of low quality protein and vitamins and minerals to achieve a more beneficial nutrient profiling score.
‘Window of opportunity’ to reduce alcohol-related cancer

Cancer Council Australia supports the alcohol control measures proposed in the Taskforce’s technical paper, Preventing alcohol-related harm in Australia: a window of opportunity.


The reason for the consistency is that the Taskforce, like Cancer Council, apparently draws on the best available evidence in developing policy.

Alcohol consumption is a major cause of cancer in Australia, with an estimated 2,997 new cases of cancer and 1,376 deaths from cancer attributed to excessive alcohol consumption in 2005. This represents 3.0% of cases and 3.5% of cancer deaths. Changing Australia’s drinking culture has the potential to substantially reduce this country’s cancer burden.

Taskforce recommendation

‘Reshape consumer demand towards safer drinking through managing both physical availability (access) and economic availability (price).

Cancer Council Australia comment

- Cancer Council strongly supports using the economic availability of alcohol to reshape consumer demand towards safe drinking.
- Taxation is an important means of addressing these issues. Raising the real price of alcohol through taxation is one of the most effective ways available to government to influence and moderate alcohol consumption. Revenue raised from taxation can also be used to fund programs that address the social and economic costs of alcohol.
- Ongoing data collection and analysis is essential to ensure the capacity to monitor the impact of changes in alcohol price and any resulting relationship to consumption patterns and associated costs and harms.

Taskforce recommendation

Reshape consumer demand towards safer drinking through addressing the cultural place of alcohol. Social marketing and public education are required, and will be more effective if the marketing of alcoholic beverages is restricted, including curbing advertising and sponsorship of cultural and sporting events.

Cancer Council Australia comment

- Cancer Council strongly supports restrictions on alcohol advertising and sponsorship of cultural and sporting events and a comprehensive, well-resourced social marketing and public education campaign on the harmful effects of alcohol.

• To assist with public education on alcohol, Cancer Council believes that health information and warning labels should be compulsory on all alcohol products, including a full list of ingredients and nutritional information. This will inform consumers about the serious impact alcohol may have on their health and wellbeing.

• These measures should be part of an overall strategy aimed at dealing with and minimising alcohol-related harm in Australia.

• The Cancer Council believes that the Commonwealth Government should regulate Australian alcohol advertising. Industry self-regulation of alcohol advertising is inadequate and not working.

• The Cancer Council recommends the establishment of a comprehensive legislative framework for alcohol advertising that will:
  o cover all forms of alcohol marketing, including point of sale promotions, print and media advertising, packaging, labeling, sponsorship, viral and internet campaigns;
  o provide for the phased introduction of bans on alcohol advertisements. Initially, the ban would apply to the banning of alcohol advertisements during live sporting broadcasts on television and expand, over time, to apply to alcohol advertisements on billboards and public transport infrastructure; in cinema and radio; and the television (free-to-air and pay) and internet;
  o provide for sponsorship bans of all events by alcohol companies and brands in Australia;
  o create an independent body for administering the system with the powers to formally investigate, where appropriate, breaches of the alcohol advertising rules; and
  o create legislative sanctions for parties who do not comply with the system.

Taskforce recommendations

• Reshape supply towards lower-risk products through changes to the current taxation regime that stimulate the production and consumption of low-alcohol products.

Cancer Council Australia comment

• Cancer Council strongly supports changes to the current alcohol taxation regime that stimulate the production and consumption of low-alcohol products.

• Alcohol consumption frequently involves consumption of a number of drinks over a particular timeframe, with drinkers following a repeat pattern of behaviour. On health and safety grounds, it is preferable that alcohol consumers drink lower-strength drinks than the same number of high-strength drinks in any given drinking period.

• As young people are also price sensitive, this policy proposal would steer them towards lower-risk alcohol products, thereby minimising the harm from risky drinking.

• Therefore, Cancer Council believes that the Australian alcohol tax regime should
encourage less harmful consumption by taxing alcohol content progressively with low-strength products taxed at a lower rate than mid or high-strength products.

- Cancer Council believes that the low-strength beer concession (annual cost of $15m) should be retained and should be extended to all other low strength alcohol products.

Taskforce recommendations

Reshape supply towards lower-risk products through improved enforcement of current legislative and regulatory measures (e.g. Responsible Serving of Alcohol, bans on serving intoxicated persons and minors, lowering blood-alcohol content in drink-driving laws).

Strengthen, skill and support primary health care to help people in making healthy choices. Supporting brief interventions as part of routine practice by trusted health professionals and other health workers in primary healthcare settings can assist changes in drinking behaviour and attitudes to alcohol consumption.

Cancer Council comment

- In 2005-06, approximately 88% of the Australian population visited a GP at least once. General practitioners, as a patient’s first point of contact with the health care system, are in a unique position to education and counsel patients on their risky health behaviours before they lead to more serious conditions.

- Brief advice from a general practitioner has been demonstrated to have resulted in a 19–34% reduction in alcohol use.

- The Royal Australian College of General Practitioners (RACGP) states that GPs should ask all patients over the age of 14 years about the quantity and frequency of alcohol intake and number of alcohol free days each week. The RACGP has developed guidelines for GPs to follow if they identify a problem, based on the 5 As model of ask, assess, advise, assist and arrange. The 5 As model works as follows:
  1. **ASK** – identify patients with risk factors
  2. **ASSESS** – level of risk factor and its relevance to the patient in terms of health and the patients willingness to change
  3. **ADVISE** – provide resources, lifestyle prescriptions as well as brief intervention and motivational interviewing
  4. **ASSIST** – prescribe pharmacotherapies and support for self-monitoring
  5. **ARRANGE** – referrals to special services, social support groups, counselling services and a follow up appointment.

- A number of resources may assist GPs to change patients’ drinking behaviour:
  - Lifescrpts, particularly “Your prescription for low-risk alcohol use”
  - Cancer Council Australia’s lifestyle and prevention fact sheets for patients
  - Australia Government Department of Health and Ageing resources on drinking, including an “Alcohol and Your Health” booklet and fact sheets, and the “Drinking decisions” resource
  - Alcohol and Drug Information Services, located in each state and territory.
To assist GPs, Cancer Council Western Australia have developed a summary guide to this model of prevention that incorporates the key parts of the RACGP’s guidelines. This resource is designed to help GPs incorporate more prevention into their consultations with its clear and concise format.

Taskforce recommendation

Close the gap for disadvantaged communities. There is a need for tailored approaches and services to reach Indigenous and other disadvantaged groups.

Cancer Council comment

- The prevalence of high-risk alcohol consumption (defined as the average daily consumption of seven or more standard drinks for men and five or more standard drinks for women) is found to be associated with socioeconomic status, though differences are seen between men and women.
  - Data collected in the 2001 National Health Survey show higher rates of high-risk alcohol consumption in men living in the most disadvantaged areas, while for women the socioeconomic gradient was reversed, with the highest rates found among those living in the least disadvantaged areas.
- Aboriginal and Torres Strait Islander Australians are more likely to abstain from alcohol than the general population, nevertheless, alcohol-related problems are of particular concern for these peoples.
- The most reliable national survey of Aboriginal and Torres Strait Islander drinking levels to date has estimated that about 51% of Indigenous Australians drink at risky or high-risk levels compared to about 11% among the non-Indigenous population.
- Deaths from alcohol-attributable conditions are about two and a half times greater for Aboriginal and Torres Strait Islander peoples when compared to the general population and males tend to have higher levels of consumption than females.
- The consumption of cheap cask wine is of particular concern for Aboriginal peoples living in rural and remote regions.
- Tailored approaches are essential, however singling out those who are experiencing disadvantage for special treatment may broaden the gap unless careful consultation with target communities underpins proposed strategies.
- Options to consider include:
  - The careful incorporation of people from all target groups in any mass media or social marketing interventions
  - Funded community-specific interventions, developed in partnership with clear achievable outcomes measured in time appropriate ways
  - Addressing social disadvantage at its root before attempting specific targeted change i.e. poverty before self medication.
References - obesity control section


11. Australian Communications and Media Authority. Children’s viewing patterns on commercial, free-to-air and subscription television. Australian Communications and Media Authority. 2007.


