EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 23 JUNE 2010

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Mr P. Abetz (Deputy Chairman)
Ms L.L. Baker
Mr P.B. Watson
Mr I.C. Blayney

Hearing commenced at 9.21 am

SLEVIN, MR TONY
Director, Education and Research, Cancer Council WA,
examined:

PRATT, MR IAIN STEPHEN
Dietician, Cancer Council WA,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. You have been provided with a copy of the committee's specific terms of reference. At this stage I would like to introduce myself, Janet Woollard; other members of the committee Mr Peter Abetz, Mr Ian Blayney and Ms Lisa Baker; our principal research officer, Dr David Worth; Michael Barton, who is an acting research officer; and Darby from Hansard.

The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal procedure and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As this is a public hearing, Hansard will be making the transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to your submission and the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

The Witnesses: We have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary inquiry?

The Witnesses: We do.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the details of witness form today?

The Witnesses: We did.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Mr Slevin: Not that comes to mind.

Mr Pratt: No.

The CHAIRMAN: We will start with you, Terry would you please state your full name and the capacity in which you appear before the committee today?

Mr Slevin: My name is Terry Slevin. I am director, education and research, with the Cancer Council Western Australia.

Mr Pratt: Iain Stephen Pratt, nutrition and physical activity manager with the Cancer Council Western Australia.

The CHAIRMAN: Would you like to start, Terry?

Mr Slevin: Yes, but first I will turn off my mobile phone and make sure that does not give me cancer, Janet! It does not; I am only joking.

The CHAIRMAN: And while you are making your presentation are you happy to take interjections as you go, or would you prefer to make a presentation first?

Mr Slevin: Absolutely. The same rule when I speak to university students: please, stick your hand up, interrupt—anything you like, because it far better that you get what you need, rather than me tell you what I want to tell you. Essentially, we have a series of documents, and we have emailed through a submission that I am sure you have not had a chance to read but will be available to you. The prime purpose we are here is to reinforce what is a little known or little accepted fact in our community, which is that alcohol is a known carcinogenic. We have known since 1988 that alcohol contributes to cancer risk. The International Agency for Research on Cancer, which is a World Health Organization body, and which is a primary source of expertise in what we know about cancer, released a report in 1988 that identified alcohol as a contributor to a number of cancers. Since then, as the evidence has unfolded, we have learnt more about the connection between alcohol and cancer, and the news is not going in an encouraging direction for those of us who drink and those people who sell alcohol. The truth is that alcohol is contributing more significantly to the burden of cancer now than we have ever known before. There is convincing evidence that alcohol increases the risk of cancers of the mouth, the pharynx, the larynx, oesophagus, the bowel in men, and breasts in women. It is also probably increasing the risk of cancer of the liver, and in women, bowel cancer. I will not go through all of the detail; it is in the submission. Essentially, we are in a situation in which we have a known carcinogen that people, for the large part, are not terribly aware of. The Cancer Council, as part of its routine work, gets routine data about people's understanding of the connection between various risk factors and cancer causality—my earlier joke about mobile phones is somewhat relevant here—and the perceptions that people have about what contributes to their cancer risk is very important. Our job is to try and bring the community's understanding of what causes cancer closer to what the scientific evidence says causes cancer.

The CHAIRMAN: In the studies that you have just referred to, is that link related to the amount of alcohol that a person drinks—I am not aware of the research—and does it compare people who drink alcohol with people who do not drink alcohol, or is it based on how much alcohol you drink as to whether you are more likely to develop one or more of those cancers?

Mr Slevin: I will answer that question in two separate ways. The first is what the scientific evidence says. The scientific evidence says that alcohol consumption contributes to cancer on a dose-response effect; that is, the more you drink, the more you increase your risk. The cancer for which we have most evidence is breast cancer, and that shows there is a small increase in risk for breast cancer for each additional standard drink—and it starts at one. The reference point, on the best evidence we have, suggests there is about a seven per cent relative risk increase. That means that, as against a woman who drinks no alcohol at all, a woman who drinks a lifetime of one standard drink per day—10 millilitres—is seven per cent more likely to be diagnosed with breast cancer than a woman who does not drink at all. Then it goes to 14 per cent for two drinks, and so on. So it increases going up.

The CHAIRMAN: In the documentation you have provided to the committee, have you referenced that research paper, or can we have a copy of that research by way of supplementary information?

Mr Slevin: We certainly can make sure that you get that specific paper, which was largely a meta analysis; and it is largely cohort studies that find this out. I will go through a little bit of basic epidemiology for those who, like me, find themselves rolling around in some of this data on a regular basis. For some time, what we understood about what causes cancer was based on things called case control studies. The way they work is you take a group of people with the disease and you compare their exposure to a particular risk factor that you are interested in to a matched group

of people who do not have the disease. You then, at the same time, ask those people about their lifetime exposure to the risk factor that you are interested in—in this case let us talk about alcohol. You do an analysis of what the people with the disease reported and compare it with those who do not have the disease. The problem with case control studies is you are reliant upon accurate recall of the two groups. That is an issue and a methodological flaw with that form of research. More recently we have been able to rely on cohort studies. The cohort studies take a particular and, often, a very large sample of the community and follow them through a significant period of their lives. They might be recruited in their forties and it might be 50 000 or 100 000 people, and there are number of these cohort studies running around the world. Then, every two years it collects data on those people about the main risk factors that we know about. So people are reporting in real time what their behaviour is at that point in time. It follows that population over 20 years and in some cases 30 years or more, and then as those people get older and succumb to a variety of chronic diseases, the researchers can then match the behaviour of those who are diagnosed with the disease earlier in their life with the behaviour of those who do not have the disease. That is a more reliable way of determining what might have been the likely causative factors of the diseases that people eventually succumb to. It is that cohort data that gives us greater confidence that over a period of time, and as that data is published, there is greater reportage of alcohol contributing to a range of cancers. For example, we have even got some data that suggests—I have to say I would not be surprised that in five years' time we have sufficient evidence—a link between prostate cancer and alcohol consumption as well. When you start adding—more recently—bowel cancer and breast cancer to the list of those cancers to which alcohol contributes, you are getting into the high volume forms of the disease. That is where we start thinking that this is part of the story in terms of cancer causality that we really must inform the public. Ultimately, it is the public who pays for this research and we really must use that research to inform them about their own risk factors when it comes to cancer. And, obviously, alcohol being a modifiable risk factor, we can choose whether we drink or not. It has very much become clear in the world that I work in—the cancer world, if you like—that this is something that we have to tell people.

The second part of my answer relates to the issue of perception. When it comes to the perception of what contributes to cancer, to a degree, people do not go into a lot of detail of the kind of thing that I have just explained to you, understandably. What they do is think, "Well, does this cause cancer?" What we have been doing is collecting data over a period of time about the things that do or do not contribute to cancer risk, in people's view. We ask in a reasonably simple way, "Do you think this increases or decreases your risk of cancer or not at all; and if it does increase or decrease, is it a little or a lot?" It is a reasonably rough measure, but it is simple and it is a means by which we can get a genuine measure of people's perceptions about the various factors that might or might not contribute to cancer risk. We throw in some factors that are dummy factors, if you like, that we know do not contribute to cancer risk and there is no viable mechanism by which they might—loud music is one of the ones we use as that kind of dummy factor. We ask a range of questions on food and beverage-related categories and also a number of non-food and beverage related categories—solariums, mobile phones, air pollution and those kinds of things. When we ask about those food and beverage categories, we include things like fruit and vegetables. Most people can see the preventive benefits of fruit and vegetable consumption. We also asked about alcohol, and we ask about it in different ways: one was just alcohol; one was beer, specifically a beverage; and the other one was red wine—again another beverage. They were specifically added because we do know that people have different perceptions about the effects of those different forms of alcohol. What we were disturbed by was the fact that there was a higher level of perception of beer contributing to cancer risk, and alcohol also contributing to cancer risk, but there was quite a significant perception that red wine prevented cancer. That is largely I am sure linked to the association that is very heavily marketed by the industry that red wine is beneficial—it is almost the elixir of life, if you believe some of the stuff that gets published—but it is essentially about the connection between red wine and cardiovascular disease prevention. I am here to say to you, and we have some evidence to

tender as well, that there is serious doubt about whether wine does play that preventive role when it comes to cardiovascular disease. That is very much a live scientific debate. But we are the Cancer Council, and cardiovascular disease is not our sphere of expertise.

[9.30 am]

The CHAIRMAN: We actually have had presentations from Professor Holman and Maurice Swanson showing us the research from the 80s from Sweden that said there was a J-shaped curve and some protection but that low level has now been thrown out because it was not clean data. They were including people who never drank alcohol with those who drank limited amounts of alcohol.

Mr Slevin: That is right. That is part of that overall perception. The other reality that we understand is when we talk about cancer we understand that is our area of expertise but when we provide public health advice, we have got to do that in the context of a broader public health benefit. We try not to isolate the advice that we provide or provide contradictory advice when it applies to cancer as opposed to other chronic diseases, for example. We try to ensure that there is a consistent set of advice about good public health practice rather than isolating "do this to reduce your cancer" or "do this to reduce your cardiovascular disease" particularly if the two pieces of advice are contradictory. There is that sense at which we take responsibility along those lines. Over the last probably two or three years, our interest in the alcohol area has been driven by two things—one is the concern we have that we have not adequately communicated what the science says; and, secondly, the strengthening of the science that is connecting alcohol with a variety of cancer risks.

The CHAIRMAN: I recently was given a copy from you of the bowel cancer screening program, that wonderful document that you put together, with comments from different people whose family members had suffered from bowel cancer. I am wondering whether you have done something like that in hospice and different areas in relation to alcohol. Are you hoping to gather some comments from the community? It is the message from individuals that often can be more effective than a message coming from a credible body like —

Mr Slevin: Sure; absolutely. The role of the consumer in providing those personal experiences is very important in the work that we do. When it comes to alcohol, however, that is probably a more complex beast. When you think about bowel cancer screening, it is an identifiable program that people can attribute a particular outcome to. They go through the experience of using a particular test. They are identified at an early and curable stage of disease; therefore they can see a specific benefit in the test. When it comes to alcohol, however, when you try to link a specific cancer diagnosis with a risk factor there may be other risk factors at play. Let us take, for example, bowel cancer as a useful test. We know alcohol is a significant contributor to bowel cancer risk. We know so too is being overweight, we know so too is lack of physical activity, and there are other factors in there—diet and so on. All of those things may play a part. Getting someone to put their hand up to say, "My bowel cancer was because I drank too much" at this stage of the game is probably pretty tough. Similarly so with breast cancer, especially because of the various complexities about causality of breast cancer and the truth is we do not know with certainty all of the major or dominant causative factors of breast cancer, despite all the research that has gone on. We are still not absolutely certain of the bulk of the causative factors, or at least which combination of factors is most powerful. There are a number of risk factors that have been established for breast cancer—alcohol is certainly one of them and is one of the fewer modifiable risk factors. But then getting to the other end of the spectrum, someone diagnosed with disease to then say, "Yes, I was diagnosed probably because I drank too much" is not something we have been able to do. You will appreciate at that stage of the journey it is a very challenging reality to face.

The CHAIRMAN: It is going to be very hard to sell the message.

Mr Slevin: It will be very hard to sell the message but it is worth you knowing that we are very, very supportive and had a hand in the campaign that is currently running, run by the Drug and Alcohol Office, which is identifying the fact that alcohol contributes to cancer risk. We worked

closely with them in the development of that campaign. We are very proud of that association. It is one of the first campaigns of its kind in the world. We are very much interested to see how the evaluation of that follows up because it is that data about risk perception that we are hoping to shift to ensure that people do have an understanding of the risks involved with alcohol consumption. I think, Janet, one of the points you raised earlier about dose response, how much people drink, is probably one of the issues we need to tackle more actively as well simply because the dose response phenomenon is not one that has been well communicated.

Mr P. ABETZ: On dose response, how finetuned is the knowledge of dose response at this point in time? If someone who, for argument's sake, has a glass of wine once a week when they go out with friends for a meal—is that a risk factor in terms of what is measured or is it more people who drink regularly, say, have a glass or two of wine every day or a couple of beers every night after work? Where does it kick in? Like pharmaceuticals, there is a dose rate before it actually has an effect—is there any knowledge on that?

Mr Slevin: The best knowledge on that, Peter, is it is generally a straight line curve. I am not aware of there being an agreement about being an acceleration. The precision of exactly where the effect kicks in is much harder to get by the nature of the cohort studies that I talked about. You will appreciate that the large majority of those studies are conducted in the Northern Hemisphere—in the US and in Europe. Those are the main places where they gather. The variety of exposure to alcohol there is wide, but getting a big population that has a uniform level of exposure is very difficult. The short answer is: it is a best estimate based on the data we have got, but that data is certainly accumulating.

Mr Pratt: I was going to add that one of the other complexities with heart disease data is patterns of drinking. The 14 drinks once a week versus the two drinks a day: are they different in terms of cardiovascular and cancer risk? The answer to that is we do not really know but we know that people who drink more certainly have a higher risk.

[9.40 am]

Mr Slevin: But I guess, Peter, with regard to the scenario that you painted, one or two glasses a week is a helluva lot less of a problem than two or three glasses. It is that kind of phenomenon. Broadly, we are going to say to people that the more they drink over a life course, the greater they will invoke the prospect of that contributing to a cancer risk.

The CHAIRMAN: Steve, the website states that you provide education sessions to primary schools, secondary schools and tertiary institutions. What proportion of these education sessions are dedicated to promoting the link between alcohol and cancer?

Mr Pratt: In those groups, not a lot. We certainly do some work in alcohol with tertiary students. We basically run a cancer control course at Curtin for the health promotion students and alcohol comes up in that. We also do other guest lecturing around cancer prevention, and certainly alcohol would come up in that. We are making an effort to let tertiary students know. Primary school and secondary school students: with primary school students our activity is largely around SunSmart, so Sunsmart schools, and Crunch&Sip, so fruit and vegetables.

The CHAIRMAN: Because of your work with schools, what do you think is the best way of promoting a message to school-aged children that alcohol consumption can be harmful?

Mr Pratt: That is a tricky one, and to an extent that is probably outside of my direct area of expertise. The secondary school students, I think, are probably more—certainly older secondary school students—exposed to the binge drinking message. That is appropriate; they are a group that is at greater risk of those behaviours. Terry is probably better placed to comment on this, but historically there was some work done with primary school students around tobacco use and getting them to become the kind of "nag factor", or the advocates for getting parents to stop. That may have potential.

Mr Slevin: It may have the potential to get us beat up!

The CHAIRMAN: Terry, there is a lot of debate now about the role that advertising plays in both children's perception of alcohol and adults' consumption of alcohol. What is the Cancer Council's position in relation to advertising at sporting events, and what is your position on whether there should be an increase in advertising on actual bottles and cans et cetera?

Mr Slevin: We have specific policies on both of those questions separately, Janet. This is under the Cancer Council Australia banner. It is probably worth ensuring in the evidence that we identify Steve as being a chair of the Alcohol Working Party in the Cancer Council Australia, so it has become a national issue for us.

The CHAIRMAN: Before we go any further then, by way of supplementary information we would be very happy to receive those two policies from you.

Mr Slevin: Sure, we have them here and we can leave them behind. I will take the labelling one first: we believe that there is a fundamental consumer right to know what the potential adverse effects are of products that people use. This is a known and established potential adverse effect of the consumption of alcohol and we think it makes sense for it to be there on the label. We are very much supportive of the establishment of mandatory regulations that require alcohol labelling to include warnings of the known risk factors. When it comes to the marketing, promotion and advertising of alcohol, there is very clearly a very powerful normalising effect of the advertising of alcohol products throughout the community. That is not just at adolescence, but through the entire community. Through the promotion and marketing of sporting products, sporting events, sporting activity, the broader presence of alcohol advertising in the community, whether it is outdoor, on the net, TV, radio, it is so omnipresent that the normalising of alcohol and what is generally referred to as responsible consumption of alcohol is so pervasive that it makes it very hard to get some of these more control-type messages in place.

I will illustrate it by, I guess, our own scenario within the Cancel Council world in tackling alcohol as an issue. It started when I was chairing the Cancer Council Australia's nutrition and physical activity committee, and that committee saw the evidence unfold and started taking more action in this area. Within the Cancer Council world there was the challenge that we faced because there are people who have come from all walks of life who work in our corner of the world. We have our fundraising people and our accounts people and so on, and our patient services people. They go home and have normal lives, like all the rest of us, and they are exposed to all of these kind of societal norms. The discomfort that goes with raising this issue was apparent from the word go, whether it was a CEO, through to someone who answered phones on the helpline, or anywhere else in the organisation. It was palpable to watch people's own personal drinking behaviour act as a powerful filter to what they thought was reasonable in terms of organisational policy. That is perfectly normal. I think it is perfectly normal. But it showed up very powerfully, to me at least, how influential a place the alcohol industry has in the community in terms of setting up what it is to be an Australian; in terms of setting up what is the normal thing to do; in terms of even what people should be expected to be able to do to celebrate pretty much anything. You cannot enjoy a meal without alcohol, so it would seem, these days. You cannot have a celebration or achieve something unless alcohol becomes a part of the story. It was a very powerful lesson for me about the influence. That phenomenon is not an accident; that phenomenon is bought and paid for through aggressive, very healthy advertising and promotional marketing budgets. This is even to the point where we could lay unequivocal evidence of the kind we use all the time when it comes to the cancer world on the table in front of the decision makers throughout our organisations, and there was still that personal reticence to take on what is ultimately a challenge in terms of societal change. To change the way we view and consume alcohol is a fundamental societal change.

The CHAIRMAN: What do you think of sporting groups that are now saying that they will not survive without sponsorship from the alcohol companies?

Mr Slevin: I guess this is where I kind of bring a personal filter along to it as well, and I have just criticised my colleagues for doing that. But, again, I have kids and I have been involved in sporting organisations and the like. I have a 16-year-old son who plays rugby, and the prospect of him being part of an organisation that normalises alcohol and alcohol abuse at an age that is only one or two years older than his current state frightens the life out of me. I understand sporting organisations; I have fundraised for sporting organisations. I was the secretary of the junior footy club and I have been the manager of his rugby team; I have stood on the side at the various sporting events that both my kids have been involved in. I know that sporting organisations struggle and scrimp and save to do the things they want to do for their participants, and that is their role. They are volunteers and it is not an easy job. But my concern is the degree to which they are becoming reliant upon, and so therefore advocates for, an industry whose product will harm their participants and members. That is what we are seeing more and more. We saw exactly the same phenomenon with tobacco sponsorship of sport 20 or more years ago. We were able to successfully tackle that through a simple process that acknowledged and recognised some of the funds that came from the taxing of that product went back into supporting those sports. The same thing can be done; it is a very straightforward mechanism. We all know the stories of sporting clubs. I mean, who has signed up to a golf club where you are expected to buy a certain amount of booze over the bar? That is absolute madness. Who has been involved in sporting organisations that had an alcohol label on people's jerseys, or it has been an absolute part of the functioning and lifeblood of the sporting club? Who has seen the drink-driving problems that have gone with it? Who has seen the poor bloke in the corner who has been around the club for a fair while: "We try to look after him but he hits the booze a bit too hard"? They are absolutely inextricably linked, and there is no accident in that. That is about setting cultural norms by the industry, which grabs their customers at a very early age—a disturbingly early age. There has been data that has been published showing a direct link between some of the football codes and alcohol-related harm in some of the rugby codes in New South Wales. Some research comes to mind by Jim Lawson.

[9.50 am]

The CHAIRMAN: Would it be possible for you to provide that research to the committee again by way of supplementary information? The sporting groups, who are working together, are very, very unhappy with Healthway trying to stop the funding to these sports from alcohol advertising. I can see that Steve is champing at the bit to join the conversation.

Mr Pratt: There is absolutely no doubt that there is a nexus between sport and alcohol and as an organisation, as a broader public health community, and as the community, we need to seriously assess whether that is something we are happy with. Another classic example, one I am sure many of you have seen, is the use of wine in fundraising for junior club sports. The more grog that mum and dad buy, the better the jumpers we get. I do not know that that is necessarily a particularly healthy message to be sending to very young children.

The CHAIRMAN: The Cancer Council has been very effective in terms of the Sun Smart and Make Smoking History campaigns. How can we raise public awareness in relation to the problems associated with alcohol? You have said that it has now become normalised. We need to shift back that normal curve. What is your advice in relation to —

Mr Pratt: To borrow something that Terry said earlier, it is about internal change. And I have seen it not only in the Cancer Council of Western Australia, but also in cancer councils across Australia. People who are employed by health agencies are obligated to toe the company line. It has been a two or three-year journey to turn some of those attitudes around. We are certainly chipping away at them, but are we going to turn the community's attitudes around overnight? Unfortunately, we are not. For example, the tobacco fight is still ongoing in various forms and at the moment, it looks like the latest battlefront is online. We are certainly very supportive of the work Healthway is doing

with these reforms. I guess we have an obligation to—and we are—publicly support those initiatives.

Mr Slevin: I guess I would add, in answer to your question, Janet, probably the best summary of the options that we have in terms of tackling our problems in relation to alcohol, is the National Preventative Health Taskforce report on alcohol. I think there was a big investment in that exercise and the findings that it came up with were clear and straightforward. It set out a timeline by which they were achievable and tackled the range of key drivers including taxing, price, and liquor licensing law at a state level, which is a very important driver. I know we have had a number of reviews about liquor licensing regulations in Western Australia. That will continue to be an open debate, and it needs to be so. The —

The CHAIRMAN: In relation to liquor licensing, we have also been made aware of the fact that some sectors of industry are very unhappy with the data about alcohol that is collected in WA. In fact, many of the other states think that WA has set a very good standard, and are now looking to gather such data, particularly data about wholesale rates. Some of the comments made suggest one reason the industry does not want this data collected is that it does not give us the full picture. Have you heard about this?

Mr Slevin: I guess I am not so familiar with the specific issue of the WA differential data collection with relation to wholesale sales data. I am however happy to put on record how disturbed I was recently—I mentioned our association with the Drug and Alcohol Office—going into the preparation for the launch of the alcohol and cancer campaign. I started hunting around because our chairman, Professor Christobel Saunders—who was involved in and represented our organisation at the launch—asked me to get some information for her about national trends in women's alcohol consumption. I hunted around and the best report that I was able to find was a detailed analysis of the quality of the data collection in terms of answering that single question, and one of the trends included in that data was about the alcohol consumption of women in Australia. The fundamental finding of that report was that it could not tell us about that trend with any confidence. I was absolutely appalled. It took my breath away. The fact that we cannot answer that question in 2010 is appalling. That is such a key, known, significant driver of social disruption and ill health and for us not to be able to answer that simple question was devastating. I will not go into the technical detail because I am probably not the most expert to do it. My interpretation of the report was that there were two different data sets that were not comparable sets and which had been collected over different periods of time. There were gaps in the data and, essentially, for anybody with professional expertise to have any confidence when answering that question, the best they could say is, "We can't say for sure."

The CHAIRMAN: Time is drawing to a close and we have another hearing. I would be interested to have you consider this issue a little further. I am always pleased when WA is ahead of the other states—as we appear to be with this data collection. If the industry is saying that the data should not be collected because it does not provide 100 per cent of the picture, maybe we need to look at how—rather than throwing the baby out with the bathwater—we make this data collection even more reliable. The committee would also be interested hear about the type of information that you believe—particularly in relation to the link between alcohol and cancer—we should be looking to gather in the future.

Mr Slevin: I can certainly give you a flavour of that, Janet. The starting point is that the wholesale sales data tells us what is actually sold. Of course, you do not know whether it is dropped on the road and smashed or poured down the sink, but obviously the vast majority is consumed. The question is who is doing the consuming and under what circumstances? I think they go to the question that Peter asked about drinking patterns. That is a very important question to answer. Having that denominator, if you like, in terms of how much is bought and then being able to be more specific about who is buying it and in what circumstances—but more specifically who is

consuming it and in what circumstances—is essential to know, particularly to get a handle on the target audience in terms of the interventions that might be developed.

I have another question for you. I do not know the answer to this one and I do not know if you do either. What contribution does the West Australian government make to that purchase? Do we know how much alcohol is consumed by government? By government departments, Parliament House —

The CHAIRMAN: Oh, Terry!

Mr Slevin: I understand that it can be taken in an accusatory way, but it is a not unreasonable question. It seems to me —

The CHAIRMAN: I think it is a very reasonable question.

Mr Slevin: Do we have any specific record of what is the alcohol —

The CHAIRMAN: Are you asking which government departments have licensed areas within their premises and how much alcohol is consumed through those premises?

Mr Slevin: No.

Mr P. ABETZ: Even just at functions.

Mr Slevin: Yes.

Mr P. ABETZ: If you have a launch and you hire a public hall, how much alcohol is consumed at that official function. Interestingly, the wine with the Parliament House label makes an excellent gift. I have not drunk one drop of it, but I have given plenty of bottles away as gifts.

Mr Slevin: Yes; sure. And I guess a reasonable question to ask is: if it is the public dollar, does it make sense for us to at least quantify how much of the public dollar goes into alcohol purchase? If we are going to make a difference here, it seems to me that government needs to take a lead. A specific example was seen in the world of tobacco when the commonwealth government banned smoking in the offices of the commonwealth public service in 1993, from memory. That was the start of smoke-free workplaces. It makes no sense for the government to say, "You should have a smoke-free workplace" if it does not create smoke-free workplaces. Similarly, if government is going to take the issue of alcohol seriously, it is a not unreasonable point to make about how much money the West Australian government spends on alcohol and that its objective is to reduce that amount by X—whatever it might be. Or it may decide that such a small amount is consumed and that that state is perfectly legitimate, and there is a clear rationale as to why that is the case. But if we are talking about that quantification of risk and we are doing it from the point of view of the public good, it is not unreasonable to ask how much the public pays for alcohol through the government of Western Australia.

[10.00 am]

The CHAIRMAN: Thank you very much for that. That is a very important question; we appreciate you putting that question to us. Do you think that the social impact of alcohol has got worse or better over the past 10 years and, following on from that, what new initiative do you think the government could consider to limit the impact of alcohol consumption?

Mr Slevin: That is an interesting broad sweep kind of question, Janet, but probably one I would prefer, ideally, to take on notice to answer.

The CHAIRMAN: I would be quite happy for you to take that notice.

Mr Slevin: All right, but I guess my instinct is to say that despite the perception of the main driver of the problem being about adolescent binge drinking—I do not downplay that as a problem—I have an abiding concern that the white collar, happy, middle-class consumers are very happy to see the focus on the kids. I am concerned that as a community there is a level of alcohol consumption

that is causing chronic disease problems and I do not think that gets enough attention. I think there is very much a focus on the immediate adverse effects. I am not saying that is bad or that there is a reason not to focus on that; what I am saying is that focus is to the exclusion of concern about chronic adverse effects. So from that point of view, as we are understanding more how alcohol contributes to those chronic adverse effects, I am reluctant to identify the easy answer. I think the easy answer to your question is binge drinking in public places—the kind of Northbridge syndrome, if you like—and then heavier law enforcement. I do not think that is right. I think there are a couple of more important drivers. I know that the tax issue is outside of state government responsibility, but I do think the key drivers have been for a long time and remain taxation, price and availability. Liquor licensing is within the realm of the state government to influence at a very fundamental level and I think that is an area where Western Australia can play an absolutely lead role. I think the liquor licensing issue is about not only seeing good strong liquor licensing regulations in place, but also enforcing them. I have seen this over a period—I have been in Western Australia since 1992—but I still remain concerned about the paucity of enforcement of liquor licensing regulations in Western Australia. I would invite you to have a look at what records there are in terms of successful enforcement in that area. I think there has been some improvement. You asked for things that are worse over the past 10 years. The perception I have is that there has been some improvement, but if you ask the simple question: how many prosecutions have been successful under the WA liquor licensing legislation? I think that might enlighten the work of the committee quite significantly.

Mr Pratt: Can I just add that I think most of the wish list is set out in that national Preventative Health Taskforce report and you have a copy of the alcohol section of that. We certainly know that consumption increases linearly with advertising, so the more advertising, the more people drink; the more licences, the more availability and the more people drink. For those two, I think the first step is to put the brakes on and give people a fighting chance to modify their own behaviour.

The CHAIRMAN: In that case before I close, when you answer that previous question that was asked, you may want to look at the data that is being collected. Also, following on from Steve's comments, you may want to look at the government's report of the Red Tape Reduction Group because alcohol comes under that report. Obviously, the Cancer Council is now a key player in this area so we would appreciate your comments in relation to that one, as well.

Because we are running late, I now have to thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thank you both very much for coming along this morning.

The Witnesses: Thank you.

Hearing concluded at 10.05 am