



LION NATHAN

Submission to Food Standards Australia and New Zealand

Application A576

Labelling of Alcoholic Beverages with a
Pregnancy Health Advisory label

Lion Nathan Limited

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Executive Summary

Lion Nathan supports evidence-based measures to reduce alcohol related harm.

Lion Nathan does not support population based interventions where there is evidence that targeted measures will have more effect and be more cost-effective.

There is medical evidence that alcohol consumption during pregnancy can damage the foetus, however the evidence on how much alcohol causes foetal development effects is inconclusive and scientific evidence does not identify a threshold of alcohol intake for pregnant women above which foetal harm is likely to occur. This lack of evidence would make a health warning either too ambivalent if presented accurately or untruthful if presented inaccurately.

There is no research in New Zealand to estimate the extent of FAS/FASD and alcohol consumption during pregnancy has only been researched intermittently in New Zealand and Australia in the last 10 years and while there is some data identifying particular at-risk groups (e.g. Western Australian Indigenous people), the size of the problem is not accurately known. Until better data and measurement are achieved, known at-risk groups may benefit from targeted programmes, however a population-based approach such as warning labels would be inefficient and costly.

Research shows that the evidence for the behaviour-change effectiveness of warning labels on alcoholic beverages is, at best, weak and suggests that warning labels may have some use when applied in conjunction with other interventions.

The New Zealand Government has decided not to develop specific health policy or programmes to prevent and/or treat FASD because there is a lack of evidence of the prevalence and incidence of FASD in New Zealand. In Australia there is no nationally co-ordinated approach to measuring the incidence of FASD, let alone a national approach to prevention and/or treatment.

In the absence of any whole-of-government approach in either country, Lion Nathan does not support the introduction of warning labels because there is clear evidence that they may only have limited benefit as one dimension of comprehensive programmes, and be ineffective without such programmes.

Should the New Zealand and Australian Governments' positions change, Lion Nathan is prepared to open discussions with Governments and public health agencies to partner on whole-of-government approaches to prevent FAS/FASD among at-risk women.

We note that FSANZ has received previous advice from the Alcohol Advisory Council of New Zealand ('ALAC') in 1996 opposing warning labels on alcohol containers for pregnancy as they are an ineffective measure.

Ten years later, their application to now introduce labelling has been unable to show any change in the problem, research on labelling, or effectiveness of other measures, to substantiate labelling as an evidence-based harm-reduction intervention.

Given the relatively high rates of awareness and action already among New Zealand and Australian women, there is no evidence that the introduction of warning labels will have any material impact on reducing rates of FASD and FAS in NZ and Australia.

Moreover, given the weakness of data collected on rates of FAS and FASD currently, there would be no means to measure the effectiveness of mandatory warning labels if implemented.

Introducing a non-evidence based social marketing exercise, instead of accurate consumer information, would undermine public faith in the reliability of FSANZ and public health warnings themselves.

The cost of introducing warning labels across the Lion Nathan portfolio is estimated at \$6.5 million in the first year and \$4.2 million a year thereafter. This cost would need to be passed on to consumers.

Lion Nathan would welcome the opportunity to provide additional information of required or meet with FSANZ to discuss any aspects of this submission further.

Existing information and programmes

Question One: What other strategies or programs are there in Australia or New Zealand (initiated by industry, public health, government, and consumer groups) to advise women of childbearing age of the risk of consuming alcohol when pregnant or if planning a pregnancy?

Question Two: What information (from industry, public health, government, and consumer groups) is available to women planning a pregnancy or pregnant women, about the risk of consuming alcohol?

- Information and activity to discourage pregnant woman from drinking alcohol is, at best, patchy. There is no organisation of the message and its methods of delivery.
- All available evidence from other social marketing and health best practice is that direct provision of information and programmes working with at-risk people have the biggest impact on actual behaviour.
- Therefore, there is a lot more scope for effort in this field.

The *intent* of many social agencies to lower alcohol consumption of pregnant women has been strong.

For example, New Zealand's Ministry of Health National Alcohol Strategy 2000 – 2003 identifies five priorities for action on drug and alcohol problems. Priority three is to "*reduce the hazardous and excessive consumption of alcohol*". One particular target of this priority is "Reduction in the prevalence of drinking amongst pregnant women and women planning pregnancy."¹

The Ministry says the mix of strategies is intentional because the "...causes of alcohol-related harm are complex and multiple, and that both broad and specific strategies are needed to ensure that those causes are effectively addressed."

This reflects increasing recognition in the public health sector of community contexts and that individual health choices are part of the human social systems and webs of mutual obligation.²

The New Zealand Ministry of Health's 'demand reduction strategy' says it will provide information to the public, develop a body of knowledge on the subject, examine effects on health and behaviour, and how much a person can responsibly drink under what circumstances.

ALAC has also been instrumental in establishing strategies and programmes to advise women of childbearing age of the risk of consuming alcohol while pregnant or when planning a pregnancy. In 1998 ALAC agreed to provide an annual grant to support the coordination of work carried out by the newly established Fetal Alcohol NZ Trust (FANZ), and funded a national FAS conference. FANZ was the only national

¹ Ministry of Health, Health and Independent Report (December 2003). Director General Annual Report on the State of Public Health. (ISBN 0-478-25877-1).

² Ministry of Health (1999) Alcohol and Public Health Research Unit. *Advice for Purchasing Strategy on Public Health Issues: Alcohol Harm Reduction*

organisation to specialise in FASD. In 2003, ALAC took over the coordination of this work with a national advisory group to guide the continuation of work on FASD issues and the drafting of a strategic plan to replace the now defunct FANZ strategic plan.

The **action** of social agencies in persuading and motivating women to lower consumption has been growing slowly, but is piecemeal.

In New Zealand General practitioners provide information to women planning or during pregnancy. There is no study of the effectiveness or prevalence of this communication, which is undertaken by them as part of their professional advice. Anecdotal reports to Lion Nathan suggest that newly pregnant women are regularly told by their GPs to avoid drinking alcohol.

Public health strategies aimed at reducing alcohol related harm are being implemented in NZ and Australia.

In Australia, one source of information is the Pregnancy Lifescripts website.³ This is sponsored by the Australian General Practice Network (AGPN) - the largest voice for general practice in Australia. It provides up-to-date information around drinking before, during, and after pregnancy.

In 2005 the Children, Youth and Womens Health Services in South Australia implemented a direct media campaign targeting TV, Radio, bus shelters, billboards, bus backs, and the press with the key message *Pregnancy and Alcohol don't mix*.

The draft public document, "Australian alcohol guidelines for low-risk drinking"⁴ recommends that no drinking is the safest option women who are pregnant or might soon become pregnant. The intention of this document is to be a resource for a wide range of groups and individuals, including health professionals, community groups, industry, professional organisations, schools and educational organisations. It is also intended to inform policy makers, planners, decision makers, and those responsible for providing alcohol, who have a broader responsibility to the community and whose decisions may influence the health of communities. Other plain-English booklets and factsheets will be produced to help individuals, families and community groups to understand and implement these guidelines.⁵

³ <http://adgp.com.au/site/index.cfm?display=22607>

⁴ National Health and Medical Research Council (2007). Australia alcohol guideline for low risk drinking

⁵ Ibid p.17

Risk Assessment

Question Three: What published and unpublished information is available that may provide answers to the risk assessment questions (1 – 3 above) regarding FASD to be addressed at Draft Assessment?

- It is clear that drinking alcohol can damage the foetus.
- The evidence on **how much** alcohol causes foetal development effects is totally inconclusive.
- Binge drinking clearly increases the risk – by how much is uncertain.

1. What is the strength of evidence that intake of alcohol at less than two standard drinks per day causes foetal developmental effects?

There is no conclusive evidence that the intake of alcohol at less than two standard drinks per day causes foetal development effects.

Research is conflicting and inconclusive on the level of intake of alcohol and its effects on the development of the foetus. While there is a general belief that FAS/FASD could result from consumption of as little as one drink per day during pregnancy, it is not exactly clear how much alcohol can or can not be drunk for FAS/FASD to occur.

In 2005 Roy Morgan conducted a survey on behalf of the Salvation Army of Australia and determined that *while there is evidence that women do drink during pregnancy, there is little evidence of the effects of this behaviour in relation to FAS/FASD*.⁶

Likewise the Department of Health in Australia states that no one can establish a “safe drinking level” during pregnancy.

Abel (1995) states that the ‘effects seen in a child and the diagnosis reached depend on the duration of exposure to substantial maternal alcohol consumption during pregnancy, the range and timing of peak blood-alcohol levels, the nutritional state of the mother, and individual susceptibility’.⁷

Confirming this, in a recent publication on obstetric practice in NZ, an obstetric specialist advised general practitioners to counsel clients planning pregnancy to cease smoking and drug taking, but to only “moderate” their alcohol intake pre-pregnancy. The author said there was debate about the amount of alcohol that was safe to drink during pregnancy.⁸

2. Does the scientific evidence identify a threshold of alcohol intake for pregnant women above which foetal harm is likely to occur? What is the quality of this evidence?

⁶ Alcohol Awareness Survey 2005 by Roy Morgan Research

⁷ Abel EL. (1995) An update of incidence of FAS. FAS is not an equal opportunity of birth defect. *Neurotoxicology and Teratology* 17: 437–43.

⁸ NZ Doctor Magazine (19 April and 3 May 2006)

Scientific evidence does not identify a threshold of alcohol intake for pregnant women above which foetal harm is likely to occur.

It is particularly important to appreciate that where alcohol is implicated in FAS/FASD, the research shows that there a number of factors that contribute. In these situations, alcohol is **not** the determining factor.

At the molecular level, it is still unclear how alcohol causes a teratogenic effect on the development of the foetus. The most critical factor for development and harm remains the direct toxic (teratogenic) effect on the baby in-utero, however, this effect seems to be dependant on the amount of alcohol, the duration of alcohol, the timing of exposure during gestation, the mothers age and state of health, whether this is the first or subsequent pregnancy, and genetic predisposition.⁹

FAS/FASD has been evident from as little as 1.5 drinks per day on the basis of self-reported consumption – but again, other factors are involved, and self-reported scores underestimate true consumption and cannot give a range of quantity consumed per day.¹⁰

This research highlights the contestability of research methodology. Scientific evidence around FAS/FASD is unreliable, as it is based on personal accounts and recollection instead of a measured environment. Self-reporting settings have the potential to reduce the validity of measures of consumption.¹¹

3. *What factors are likely to affect the impact of alcohol consumption on the foetus including:*

- a. *Binge-drinking compared with frequent smaller intakes***
- b. *Genetic differences***
- c. *Susceptible populations e.g. people with diabetes?***

The results of binge-drinking before or during pregnancy are quite clear in the higher likelihood of FAS/FASD (Abel 1998, Maier and West 2001)¹².

While excessive alcohol consumption during pregnancy, particularly in the first trimester, is known to feature in a mother's conduct linked to birth abnormalities, alcohol **cannot** be isolated as the main cause.

Murphy-Brennan and Oei (1999) support this position and report that health authorities, despite acknowledging FAS, have concluded that there is insufficient evidence to support birth defects are caused solely by alcohol consumption during pregnancy.¹³

The impact of diet, state of health, genetic disposition, high risk (as stated as being European, highly educated, twenty to thirty-four year olds)¹⁴ and susceptible

⁹ Alcohol Healthwatch (2003) Briefing paper. Alcohol Health and Safety Advisory Statements (warning labels) in New Zealand.

¹⁰ Autti-Ramo, Ilona (2002) "Foetal Alcohol Syndrome – a multifaceted condition" *Developmental Medicine and Child Neurology*(44) 141 - 144

¹¹ Stratton, K., Howe, C., and Battaglia, F. (eds) (1996). *Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment*.

¹² Abel, E. L. (1998). Prevention of alcohol abuse-related birth effects-II. Targeting and pricing. *Alcohol*, 33(4):417-420., Maier and West,

"Drinking Patterns and Alcohol-related Birth Defects" *Alcohol Research and Health* 25, 168-174, 2001

¹³ Murphy-Brennan, M & Oei, T. (1999) "Is there evidence to show that fetal alcohol syndrome can be prevented" *Drug Education*, Vol 29 (1) 5 – 24.

¹⁴ *ibid*

populations such as mothers with diabetes, all contribute to varying levels of FAS/FASD in combination with alcohol.

The National Alcohol Strategy identifies that mothers who have risk factors such as poor nutrition and smoking, as well as alcohol consumption, may affect foetal development.

Alcohol consumption

Question Four: What other data are available regarding alcohol consumption by women of childbearing age and during pregnancy in Australia and New Zealand?

- In New Zealand, 82% of woman say they stopped drinking alcohol during pregnancy
- Older studies estimate that between 25% and 41% of women may have consumed alcohol sometime in their pregnancy – including before recognition of pregnancy.

A 2007 briefing paper by the Alcohol Healthwatch found that there is no research in New Zealand to estimate the extent of FAS/FASD.

This is supported by the Initial Assessment Report by FSANZ, which also found that there is limited data collected about the consumption of alcohol by women during pregnancy.

Alcohol consumption during pregnancy has been researched intermittently in New Zealand and Australia in the last 10 years. A 2006 study of the awareness of the effect of alcohol use during pregnancy showed that more than 50% of women were of the opinion that if a pregnant woman wanted to drink, then some alcohol was safe in pregnancy.¹⁵

Other research includes¹⁶:

- A 1994 national study in New Zealand showed 41.6% of pregnant women consumed alcohol during pregnancy. Hazardous drinking was not confined to any one socioeconomic group (Counsell et al, 1994).
- A 1999 nutrition report on 500 pregnant women in New Zealand showed that 29% continued to drink alcohol after their pregnancy was confirmed. Of the 24% of women who regularly drank to intoxication before pregnancy recognition, 11% continued to do so throughout pregnancy (Watson and McDonald, 1999).
- A survey of midwives reported that 36% of pregnant adult clients and 82% of pregnant teenage clients drank during their pregnancy (Mathew et al, 2000).
- A 2002 study reported that a quarter of pregnant New Zealand women at 24 weeks report consuming alcohol in the previous 7 days (McLeod et al, 2002). The study found that women who were older, had previous pregnancies, had a tertiary education and higher income levels, were more likely to drink.
- In 2004, 82.4% of women drinkers reported having stopped alcohol intake during pregnancy. No significant differences were found between Maori and Non-Maori. (Ministry of Health, 2007a).

¹⁵ Parackal S, Parackal M, Ferguson E & Harraway J (2006). Report on Awareness of the Effects of Alcohol Use During Pregnancy Among New Zealand Women of Childbearing Age. Submitted to the Alcohol Advisory Council & Ministry of Health.

¹⁶ Alcohol Healthwatch (2007) Fetal Alcohol Spectrum Disorder in New Zealand: Activating the Awareness and Intervention Continuum

In Australia, the 2002 Fetal Alcohol Syndrome National Workshop Report¹⁷ noted that the occurrence of FAS in the general Western Australian population was 0.02/10,000 and 55 times this for Western Australian Indigenous people.

The New Zealand Government has decided not to develop specific health policy or programmes to prevent and/or treat FASD because it says there is a lack of evidence of the prevalence and incidence of FASD in New Zealand (Associate Minister of Health letter to the Fetal Alcohol Support Trust and others, 2005).

In 2004 the Ministry of Health contributed \$40,000 toward a joint alcohol and pregnancy research project with the Alcohol Advisory Council of New Zealand (ALAC). This investment followed a 2003 recommendation from the Health Select Committee to research the prevalence of FASD. However, as the current lack of clinical services for FASD precluded the gathering of accurate or meaningful incidence or prevalence data, the research grant was transferred to data collection regarding the drinking behaviour and knowledge of pregnant women. This resulted in the Parackal et al (2006) study¹⁸ which largely showed an avoidance of alcohol by pregnant woman.

<p>Question Five: Are there other data available on the incidences of FAS/FASD in Australia or New Zealand?</p>
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None known to us.

¹⁷ National Report (2002) Fetal Alcohol Syndrome National Workshop, Australian National Council on Drugs, National Expert Advisory Committee on Alcohol

¹⁸ Alcohol Healthwatch (2007) Fetal Alcohol Spectrum Disorder in New Zealand: Activating the Awareness and Intervention Continuum

Awareness of Alcohol Consumption Issues

Question Six: Are there any other data available relating to the level of awareness amongst women of childbearing age of the risk of consuming alcohol when planning to become pregnant and during pregnancy in Australia and New Zealand?

Dr Sherly Parackal of Otago University conducted a survey in 2006 revealing that New Zealand women generally have a 'good awareness' of the effects of alcohol consumption during pregnancy,¹⁹ and of the sources for information.

It found that respondents were more likely to have received their advice from television, newspapers or magazines than from health professionals.²⁰

A household survey of alcohol consumption and reduction was conducted by the Australian Institute of Health and Welfare (2001). It found that women drinking at risky or high risk levels reduced consumption based on health reasons (30.6% - 25.7%), lifestyle reasons (12.0% - 17.4%), social reasons (15.9% - 18.0%) and pregnant or breastfeeding (11.0% - 7.8%).

¹⁹ Media Release, Otago University, 13 July 2006

²⁰ Parackal S, Parackal M, Ferguson E & Harraway J (2006). "Report on Awareness of the Effects of Alcohol Use During Pregnancy Among New Zealand Women of Childbearing Age". Submitted to the Alcohol Advisory Council & Ministry of Health.

Health advisory effectiveness

Question seven: Do you think a health advisory statement about the risk of consuming alcohol when planning to become pregnant and during pregnancy on alcoholic beverage containers should be required? Why / Why not?

Question eight: What further evidence is available about the use and/or effectiveness of a health advisory statement on alcoholic beverage containers regarding the risk of consuming alcohol when planning to become pregnant and during pregnancy? – Lion Nathan response.

- No health advisory statement should be required
- The science is inconclusive
 - Alcohol causes foetal damage at high intake, but it is not known what constitutes a high level intake.
 - There is some confusion as to whether alcohol is a determining factor or not.
 - Lack of evidence would make a health warning either too ambivalent if presented accurately or untruthful if presented inaccurately.
- There is much work to be done in direct communication with mothers from trusted sources, especially with respect to specific at-risk groups (e.g. Western Australian Indigenous people) identified as having a higher risk of FAS/FASD and/or lower awareness of the potential risks of alcohol consumption during pregnancy.
- Labelling has been proven not to work. Even the submitter to FSANZ has previously admitted labelling is not a very good option.

Lion Nathan does not believe that a health advisory statement about the risk of consuming alcohol when planning to become pregnant and during pregnancy on alcoholic beverage containers should be required.

As discussed in our answers to previous questions, the science is very inconclusive.

Research shows that the evidence from the effectiveness of warning labels on alcoholic beverages is, at best, weak and suggests that warning labels may have some use when applied in conjunction with other interventions.

This position is supported by ALAC where in 2005 the Deputy Chief Executive of ALAC, Sandra Kirby announced that "... labels on their own will achieve nothing. A hard message must come from the medical profession on the dangers of drinking while pregnant",²¹ and in 1996 the then Chief Executive of ALAC, Mr MacAvoy stated that "... health warnings on bottles of alcohol would be ineffective ..." and that there were

²¹ ALAC Media release, 02 September 2005

“more effective ways of getting the message across, such as running mass media advertising campaigns and working through health professionals to inform pregnant women”.²²

A Ministry of Justice literature review also notes that “there was nothing in the way of evidence to suggest that such controls (labels) have any beneficial impact”.²³

There is a plethora of evidence²⁴ (Hankin et al 1993, Stockley 2001, Stockwell 2006) to show that the effectiveness of strategies such as health warning labels to reduce alcohol related harm is not effective in changing behaviour of ‘at risk’ groups or persuaded small changes in behaviour.

A survey ascertained sources of information for women of reproductive age and found that respondents were more likely to have received their advice from television, newspapers or magazines.²⁵

Question nine: What wording for a statement about the risk of consuming alcohol when planning to become pregnant and during pregnancy would be appropriate on an alcoholic beverage container to raise awareness in pregnant women and women planning to become pregnant?

Question ten: What further evidence is relevant to the wording of such a statement, such as its likely effectiveness or appeal to women of childbearing age and/or understanding of the statement by women of childbearing age?

Question eleven: What are the advantages and disadvantages of a written statement compared with a pictorial image for conveying the risks of consuming alcohol when planning a pregnancy and during pregnancy?

Countries that have mandatory alcohol warning labels all vary in their wording. For example, France has the option of a statement indicating consuming alcoholic beverages during pregnancy, even in small quantities can have a serious effect on the health of the child. Or it mandates the use of an image of a pregnant women with a red warning symbol over the top. South Africa and the USA both have messages warning of consumption could lead to birth defects.

Canada rejected health warning labels, concluding that their effect on change of consumption of alcohol before and during pregnancy would be minimal.

Stockley (2001) suggests that labels are an ineffective behavioural tool. While there is public support for warning labels, they are NOT effective in changing behaviours or

²² New Zealand Herald, August 5, 1996

²³ Ministry of Justice (1997) Liquor Review. Report of the Advisory Committee. Chapter 13 - Health Warnings.

²⁴ Hankin, J. R., J. J. Sloan, I. J. Firestone, J. W. Ager, R. J. Sokol and S. S. Martier. (1993) *The impact of the alcohol warning label on drinking during pregnancy*. J. Public Policy and Marketing. Stockley, Creina (2001) The effective of strategies such as health warning labels to reduces alcohol-related harms – An Australia perspective”. *The International Journal of Drug Policy*. Stockwell, T (2006) A review of research into the impacts of alcohol warning labels on attitudes and behaviour” Centre for Addictions of Research, British Columbia, Canada.

²⁵ Alcohol Healthwatch Action on Liquor (2007). Briefing Paper. *Fetal Alcohol Spectrum Disorder in New Zealand: Activating the Awareness and Intervention Continuum*.

reducing levels of consumption and they are COMPLETELY INEFFECTIVE in reaching those who drink most, the main target group.²⁶

It was revealed in a survey that the USA message failed to attract consumer attention.²⁷

Question twelve: What percentage of alcohol by volume should be used to determine which alcoholic beverages are to carry an advisory statement, if required?

If an advisory statement was required despite the lack of evidence that there was a problem or that labelling would work, then the labelling would be for social marketing purposes, not consumer information.

Therefore, it would hardly be instructive or helpful for consumer decision making to differentiate between products based on alcohol content.

²⁶ Educalcool (2005) Brief Concern Bill C-206. *Labels on bottles are totally pointless and potentially harmful. There are better things to do concerning Alcohol.* Submitted to the House of Commons Standing Committee on Health, Ottawa, Canada.

²⁷ Alcohol Healthwatch (2003) Briefing paper. Alcohol Health and Safety Advisory Statements (warning labels) in New Zealand.

Labelling impact

Question thirteen: What is the likely impact on consumers, industry, and/or government if the *status quo* was maintained?

Question fourteen: What is the likely impact on consumers, industry, and/or government if an advisory statement on the risks of consuming alcohol when planning a pregnancy and during pregnancy is required on alcoholic beverage containers?

Status Quo

The status quo would allow government and social agencies to continue building the only thing that has shown to make a difference - work in the field by people who are trusted, in direct communication with those at risk.

Evidence-based programmes are the focus of all policymakers. The status quo would allow the effectiveness of the fieldwork to be clearly measured.

Consumers who are not in the at-risk categories would not have to pay through increased product prices for labelling unlikely to work.

The industry can fulfil its commitment to participate in, and contribute to, programmes that increased not only awareness, but behaviour change.

Amending the code

- Cost to consumers: The cost of introducing warning labels across the Lion Nathan portfolio is estimated at \$6.5 million in the first year and \$4.2 million a year thereafter. This cost would be passed on to consumers.
- Cost to government: Government will not fix the pregnancy related alcohol problems that it has identified in policies and strategies. The cost to society is that the social and economic impacts of FAS will continue unabated.
- Cost to FSANZ: the adoption of a social marketing tool, and an unreliable one at that, would weaken the authority's own reputation and run counter to its roles to provide accurate information and protection for consumers.
- Cost to society: the accuracy and reliability of public health warnings is vital to society's well-being. This credibility is eroded if they are used incorrectly or at variance with public acceptability.

Lion Nathan would be prepared to work with Government and public health agencies to develop (and invest in) evidence-based education and information programmes designed to increase levels of awareness and action on reducing or ceasing alcohol consumption during pregnancy.

Question fifteen: How would labelling alcoholic beverages compare in terms of effectiveness and cost-effectiveness with other public health measures to inform pregnant women of the risks of alcohol consumption during pregnancy?

Of total awareness raised in campaigns, the evidence is that labels/posters are only a third as effective as television advertising. But that even combined, these mediums do not lead to behavioural changes in 'at risk' groups.²⁸ ALAC itself agrees that labelling alone does not work.

Moreover, the New Zealand Government has decided not to develop specific health policy or programmes to prevent and/or treat FASD because it says there is a lack of evidence of the prevalence and incidence of FASD in New Zealand (Associate Minister of Health letter to the Fetal Alcohol Support Trust and others, 2005).

In Australia there is no nationally co-ordinated approach to measuring the incidence of FASD, let alone a national approach to prevention and/or treatment.

In the absence of any whole-of-government approach in either country, there is no case to support the introduction of warning labels where there is clear evidence that they may only have limited benefit as one dimension of comprehensive programmes, and be ineffective without such programmes.

Lion Nathan believes that investment in a long term campaign such as working with Government and public health agencies to develop education and information programmes designed to increase the levels of awareness and action on reducing or ceasing alcohol consumption before and during pregnancy would be more cost effective.

Lion Nathan would welcome the opportunity to provide additional information of required or meet with FSANZ to discuss any aspects of this submission further.

²⁸ Kaskutas, Lee A., Greenfield, Thomas K. 1997 "The role of health consciousness in predicting attention to Health warning messages" *American Journal of Health Promotion* Vol. 11, No. 3

Reference and Bibliography list

Abel E.L. 1995. 'An update of incidence of FAS. FAS is not an equal opportunity of birth defect'. *Neurotoxicology and Teratology* 17: 437–43.

Abel, E. L. 1998. 'Prevention of alcohol abuse related birth effects. Targeting and pricing'. *Alcohol and Alcoholism* 33 (4): 417 – 420.

Alcohol Advisory Council of New Zealand and Ministry of Health. 2001. National Alcohol Strategy 2000 – 2003. Wellington: Ministry of Health

Alcohol Advisory Council of New Zealand. 2005. 'No Alcohol During Pregnancy'. *Media release*

Alcohol Healthwatch. 2003. 'Alcohol Health and Safety Advisory Statements (warning labels) in New Zealand'. *Briefing paper*.

Alcohol Healthwatch Action on Liquor. 2007. 'Fetal Alcohol Spectrum Disorder in New Zealand: Activating the Awareness and Intervention Continuum'. *Briefing Paper*.

Autti-Ramo, Ilona. 2002. 'Foetal Alcohol Syndrome – a multifaceted condition' *Developmental Medicine and Child Neurology* (44) 141 - 144

Centre for Addiction and Mental Health. 2001. 'Alcohol Warning Labels'

Counsel, A.M., Smale, P., and Geddes D. 1994 'Alcohol consumption by New Zealand women during pregnancy', *The New Zealand Medical Journal*, 107, 278-281.

Educalcool. 2005. *Labels on bottles are totally pointless and potentially harmful. There are better things to do concerning Alcohol*. Brief Concern Bill C-206. Submitted to the House of Commons Standing Committee on Health. Ottawa: Educalcool

Hankin, J. R., J. J. Sloan, I. J. Firestone, J. W. Ager, R. J. Sokol and S. S. Martier. 1993. 'The impact of the alcohol warning label on drinking during pregnancy'. *Journal of Public Policy and Marketing*.

Kaskutas, Lee A., Greenfield, Thomas K. 1997. 'The role of health consciousness in predicting attention to Health warning messages. *American Journal of Health Promotion* Vol. 11, No. 3

Maier, S.E. and West, J.R. 2001. 'Drinking patterns and alcohol related birth defects'. *Alcohol Research and Health* 25, 168 - 174

McLeod, D., Pullon, S., Cookson T and Cornford E. 2002. Factors influencing alcohol consumption during pregnancy and after giving birth. *The New Zealand Medical Journal*, 115, No. 1157.

Ministry of Health. 1999. Alcohol and Public Health Research Unit. *Advice for Purchasing Strategy on Public Health Issues: Alcohol Harm Reduction*. Wellington: Ministry of Health

Ministry of Health. 2003. Health and Independent Report. *Director General Annual Report on the State of Public Health*. Wellington: Ministry of Health
Ministry of Health 2007 (a) Alcohol Use in New Zealand: Analysis of the 2004 New Zealand Health Behaviour Survey – Alcohol Use.

Ministry of Health. 2006. 'Alcohol Health watch Action on Liquor 2007'

Ministry of Justice. 1997. 'Report of the Advisory Committee'. Liquor Review.

Murphy-Brennan, M & Oei, T. 1999. "Is there evidence to show that fetal alcohol syndrome can be prevented" *Journal of Drug Education*, Vol 29 (1) 5 – 24.

NZ Doctor Magazine 2006. 19 April and 3 May.

National Health and Medical Research Council. 2007. 'Australia alcohol guideline for low risk drinking'. *Draft Report for Public Consultation*. Australian Government.

New Zealand Herald, August 5, 1996

Otago University. 2006. New Zealand Women Continuing to Drink During Pregnancy. *Media Release*

Parackal S, Parackal M, Ferguson E & Harraway J. 2006. "Report on Awareness of the Effects of Alcohol Use During Pregnancy Among New Zealand Women of Childbearing Age". *Report to the Alcohol Advisory Council & Ministry of Health*.

Parackal S, Parackal M, Ferguson E & Harraway J 2006. 'Report on Awareness of the Effects of Alcohol Use During Pregnancy Among New Zealand Women of Childbearing Age'. *Submitted to the Alcohol Advisory Council & Ministry of Health*.

Roy Morgan Research. 2005. Alcohol Awareness Survey 2005 conducted for The Salvation Army of Australia. Sydney: Salvation Army

Stratton, K., Howe, C., and Battaglia, F. (eds) 1996. 'Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment'. Institute of Medicine Division of Biobehavioural Sciences and Mental Disorders, National Academy Press.

Stockley, Creina. 2001. 'The effective of strategies such as health warning labels to reduces alcohol-related harms – An Australia perspective'. *The International Journal of Drug Policy*.

Stockwell, T. 2006. 'A review of research into the impacts of alcohol warning labels on attitudes and behaviour' Centre for Addictions of Research, British Columbia, Canada.

Watson P and McDonald B. 1999. 'Nutrition During Pregnancy – report to the Ministry of Health'. Auckland: Massey University

Website references

<http://adgp.com.au/site/index.cfm?display=22607>
www.moh.govt.nz
www.nzfsa.govt.nz

About Lion Nathan Limited

Lion Nathan is a premium alcoholic beverages company with operations in Australia and New Zealand. A publicly traded company (ASX/NZX: LNN) with assets of NZ\$4.76 billion, Lion Nathan generates strong stable earnings and cash flow from its Australian and New Zealand alcoholic beverage businesses. Its portfolio of beer brands includes Lion Red, Speight's, Mac's, Waikato, Tooheys, Castlemaine XXXX, Hahn, West End, Emu, Swan, and James Squire.

Lion Nathan also has a small premium wine business formed through the combination of leading Australian and New Zealand fine wine producers Petaluma, Banksia and Wither Hills. In New Zealand, Lion Nathan distributes a portfolio of well-known and leading spirits brands on behalf of a number of international spirit producers.

Lion Nathan employs 2400 people in Australia and New Zealand and in 2007, had an operating cash flow of A\$382 million.

Lion Nathan provides significant financial support to initiatives that promote a healthy approach to alcohol consumption.

For example, in Australia the company helped fund the development and implementation of an internationally acclaimed schools' curriculum programme titled "Rethinking Drinking, You're in Control". The Programme was funded through The Australian Brewers Foundation (ABF) and developed by the Youth Research Centre at The University of Melbourne. It is now used in approximately two thirds of secondary schools in Australia and has recently been modified for delivery into indigenous communities.

Working through the ABF in conjunction with the spirits industry, Lion Nathan also actively participated in the introduction of a liquor retail industry training programme, entitled "No Worries" to promote responsible retailing techniques.

More recently, Lion Nathan Australia has introduced the BeDrinkAware icon to its packaging which directs consumers to a responsible consumption website and practical advice aligned with NH&MRC guidelines for safe consumption. In New Zealand Lion Nathan has introduced the DrinkResponsibly icon to its packaging and marketing collateral directing consumers to a responsible consumption website and practical advice aligned with ALAC guidelines for safe consumption.

Lion Nathan also supports standard drink labelling in Australia and New Zealand. Lion Nathan also supports independent medical research into alcohol consumption by providing over \$140,000 annually in grants to aspiring medical researchers from across Australia and New Zealand.

The company also remains committed to working with all the major producers and retailers in Australia and New Zealand, and other relevant organisations, to ensure there is a united industry approach to promoting responsible drinking behaviour in the community.

Over the last two years, Lion Nathan Australia has worked closely with other leading producers and the retail sector to develop and fund the *DrinkWise Australia* initiative. With an annual budget of \$10million per annum at maturity provided by industry, this

cultural change organisation has an independent Board and a mandate to encourage drinking in moderation. The Federal Government announced in the recent Budget a grant of \$5million to DrinkWise Australia to assist in the development and delivery of cultural change programmes.