SUBMISSION TEMPLATE

Policy options targeted consultation paper:

Pregnancy warning labels on packaged alcoholic beverages

Overview

This submission template should be used to provide comments on the policy options targeted consultation paper: *Pregnancy warning labels on packaged alcoholic beverages*.

Contact Details

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If we require further information in relation to this submission, can we contact you? [X] **Yes** [ ] **No**

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Submissions should be received by 5pm AEST on 14 June 2018. The Food Regulation Standing Committee reserves the right not to consider late submissions.

Please complete the attached template for your submission. Note that submissions may not be drawn upon in preparing the decision regulation impact statement (DRIS) to recommend a preferred policy option to the Australia and New Zealand Ministerial Forum on Food Regulation (the Forum) if they:

- are not supported by evidence;
- do not directly answer the questions in the Policy options targeted consultation paper; and/or
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Where possible, submissions should be lodged electronically. Please send your submission to: FoodRegulationSecretariat@health.gov.au with the title: *Submission in relation to pregnancy warning labels on packaged alcoholic beverages.*

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If you need to attach documents to support your submission, please make it clear which question/s they relate to.

Consultation questions

Please insert your comments against the consultation questions below. These questions correspond to specific sections of the Consultation Paper. If you cannot answer the question or it doesn't apply, please write "nil response" or "not applicable".

Introduction

Globally, it is estimated that Fetal Alcohol Spectrum Disorder (FASD) is the leading cause of preventable birth defects and intellectual disability. The average life expectancy for a child with FASD is tragically low, at 34 years of age. No accurate data currently exists for FASD in Australia and it is likely that the true prevalence of FASD is higher than currently reported.

The AMA supports the use of alcohol warning labels to reduce the prevalence of FASD in Australia, but acknowledges that this measure must occur alongside broader population-level responses to reduce alcohol-related harm and FASD. The voluntary pregnancy warning label scheme has been in place since 2011 and has failed to achieve an acceptable level of coverage or consumer recall. The AMA also notes that Australia has been without a National Alcohol Strategy since 2011.

1: Are these appropriate estimates of the proportion of pregnant women that drink alcoholic beverages? Do you have any additional data to show changes in drinking patterns during pregnancy over time? Please specify if your answers relate to Australia or New Zealand.
It is generally accepted that self-reported alcohol consumption data is prone to under-reporting [1]. It should therefore be considered likely that the proportion of women drinking alcohol while pregnant may be higher than the 56% of women who reported consuming alcohol before they knew they were pregnant, and the 26% who continued to drink after confirmation of pregnancy. It is similarly likely that the number of standard drinks consumed by pregnant women on any single occasion is also an under-representation of the actual quantity. There are currently significant shortfalls in the data available to determine the true prevalence of FASD in Australia.

2: Are these appropriate estimates of the prevalence and burden (including financial burden) of FASD in Australia and New Zealand? Please provide evidence to support your response.

The estimate quoted as 2% of all Australian babies being born with FASD, although significantly higher in at-risk populations, is likely to be an under-estimation, given that over half of all Australian women report consuming alcohol before they knew they were pregnant, and 26% of women continued to drink after confirmation of pregnancy.

The AMA acknowledges that progress is being made to improve the accuracy of prevalence data in Australia, including the development of diagnostic guidelines and the FASD Hub. Data must inform the basis of all evaluations of health interventions, therefore improving the data source for FASD in Australia must be a priority going forward.

Even with more appropriate prevalence data, quantifying the financial cost of FASD over a lifetime is problematic, as FASD occurs on a spectrum and the extent to which the symptoms manifest will vary significantly between individuals.

Recent research indicates that around 36% of young people in custodial settings may suffer from FASD[2], and it costs approximately $109,500 per year to keep a person incarcerated in Australia[3]. The cost to the Australian custodial system alone is likely to be substantial. This does not factor in costs to the child protection, education or health systems, all of which are known to bear significant costs related to FASD.

3: Do you have evidence that the voluntary initiative to place pregnancy warning labels on packaged alcoholic beverages has resulted in changes to the prevalence of FASD, or pregnant women drinking alcohol, in Australia or New Zealand? Please provide evidence to justify your position.

Without accurate baseline data prior to the implementation of the voluntary labelling scheme, it is not possible to suggest that the scheme has or has not reduced the overall prevalence of FASD in Australia. Given that less than 50% of alcohol products sold in Australia currently display a pregnancy warning label, it is unlikely that the voluntary labelling scheme has meaningfully reduced alcohol consumption throughout pregnancy, or the prevalence of FASD in Australia.

Further, the consultation paper highlights evidence to suggest that labelling has increased consumer awareness, but not necessarily behavioural changes. Given the relatively low rates of reported recall (>12%), it is the view of the AMA that the lack of progress to achieve behavioural change is more indicative of the ineffectiveness of the current warning labels, than the utility of warning labels more broadly.

4. Variation in labelling coverage and consistency, and some consumer misunderstanding associated with the current voluntary pregnancy warning labels in Australia and New Zealand were identified as reasons for possible regulatory or non-regulatory actions in relation to pregnancy warning labels on alcoholic beverages.

Are there any other issues with the current voluntary labelling scheme that justify regulatory or non-regulatory actions? Please provide evidence with your response.

Less than 50% of alcohol products sold in Australia currently display a pregnancy warning label and this indicates that regulatory action is required to improve coverage. The AMA is deeply concerned that the absence of the warning labels on all alcohol products may imply to consumers that products which do not display the warning can safely be consumed during pregnancy.

It should not come as a surprise that consumer recall of the warning labels is so low (>12%), given that the majority (85.7%) of products carrying a pregnancy warning do so on the back or side of the label. The industry has had seven years to arrive at an effective labelling scheme, and evidently has fallen short.

The AMA is supportive of mandatory, clear, consistent, front-of-pack warning labels of appropriate size, colour and contrast to ensure visibility.

5: Has industry undertaken any evaluation on the voluntary pregnancy warning labels? If so, please provide information on the results from these evaluations.

The AMA questions the utility of any industry-led evaluation of the voluntary pregnancy labels, given the difficulties in establishing a baseline prevalence of FASD in Australia prior to the introduction of the voluntary labels.

Further, the alcohol industry does not share its data in a transparent manner. Industry-collected data that has been shared has consistently differed from data collected to guide public health policy, such as the National Drug Household Survey.

Industry data is not an appropriate source of evidence to guide the development of strategies to reduce alcohol-related harm in Australia.

6: Considering the potential policy options to progress pregnancy labelling on alcoholic beverages and address the implementation issues:

b) Are there additional pros, cons, and risks associated with these options presented that have not been identified? Please provide evidence to support your response.

In 2010, the cost of alcohol-related harm in Australia was estimated to be $14.352b.[4] Of this, approximately 20% of these costs were borne by the criminal justice system, 11.7% was attributed to the health care system, 25.5% of costs were in relation to traffic accidents and 42.1% was due to loss of productivity. The $14.352b figure is likely to be an under-estimation as this does not include the negative impacts on others associated with someone else's drinking. Any cost to industry presented as an argument against mandatory labelling should be weighed against these figures.

b) Are there other potential policy options that could be implemented, and if so, what are the pros, cons and risks associated with these alternate approaches? Please provide evidence to support your response.

A proven method of influencing consumer behaviour is through price signalling. The AMA has repeatedly called for the introduction of volumetric taxation, particularly for wine. This policy measure has been canvassed in multiple Alcohol Strategies, as well as the *2009 Henry Taxation Review*[5]. The Government's continued failure to implement this proven intervention is unacceptable.

The Siggins Miller research undertaken to evaluate the voluntary labelling scheme[6] indicates greater recall of warnings displayed at medical practitioner offices than the alcohol warning labels. This highlights the need to both improve the current labelling scheme *and* continue to utilise broader public messaging platforms to improve societal awareness of the dangers of consuming alcohol whilst pregnant.

7: Which option offers the best opportunity to ensure that coverage of the pregnancy warning labelling is high across all types of packaged alcoholic beverages, the pregnancy warning labels are consistent with government recommendations and are seen and understood by the target audiences? Please justify your response.

Given the failure of industry to reach an appropriate level of product coverage or consumer recall since 2011, mandatory labelling, as outlined in policy option 2, is the only way to ensure adequate coverage and consistency.

The industry has had seven years to adopt the voluntary label and has failed to reach 50% coverage. Of the products carrying a pregnancy warning label, less than 2% of these warnings appear on the front of the package. Due to the industry's failure to appropriately adopt the voluntary labelling scheme, less than 12% of consumers were able to recall the presence of an alcohol warning label without prompting. Both the utility of a voluntary scheme and the sincerity of the industry's commitment to reducing FASD in Australia are becoming increasingly hard to defend.

8: Do you support the use of a pictogram? If so, do you have views on what pictogram should be used (e.g. pregnant woman holding beer glass or wine glass), and also, what colour/s should be used, and why? Do you have any views on size, contrast, and position on the package? Please provide research or evidence to support your views.

The AMA remains supportive of the use of a pictogram, providing it is implemented appropriately with adequate consideration given to size, prominence and contrast to ensure visibility. It is important to note that graphic representations such as pictograms are an accessible source of information for people with low-level literacy, English as a second language or intellectual impairments, including FASD.

Given that not all alcohol labels have the same base colour, regulating the colour of the warning label should also give consideration to contrast, not just colour. Noting the consumer evidence suggesting that the use of green confuses the message as it is commonly associated as a positive colour, it is reasonable to stipulate that colours such as green would be inappropriate in this context.

In the event that product coverage and visibility are both improved, and there is still no marked change in consumer behaviour, the AMA supports further testing to identify appropriate complementary text.

9: Do you support the use of warning text on a label? Why or why not? Do you have views on what text should be used, and if so, what is it? Do you support the use of warning messages already used in other markets? Please provide research or evidence to support your views.

It is the view of the AMA that the most immediate course of action should be to improve the utility of the current pictogram. If further evaluations highlight that a more appropriately implemented pictogram still fails to result in meaningful behavioural change, the AMA is supportive of more consumer research to identify clear and effective complementary text.

10: Do you have views on what colour should be used for text, and whether green should be permitted? Do you have any views on size, contrast, and position on the package? Please provide research or evidence to support your views.

The Siggins Miller evaluation indicates that the use of green confuses the messaging; in light of this the AMA is supportive of a colour more indicative of caution, such as red. However, given that not all alcohol labels have the same base colour, consideration should also be given to contrast to ensure visibility.

It remains the view of the AMA that all warnings relating to the harms of consuming alcohol whilst pregnant must be of appropriate size, contrast and prominence on the packaging.

11: Should both the text and the pictogram be required on the label, or just one of the two options? Please justify your response.

The AMA believes that the utility of the pictogram cannot be adequately assessed until it is implemented ensuring more prominence and consistency.

The AMA is supportive of improvements being made to the pictogram as a first priority, followed by further evaluation to establish the need and format of text if appropriate. It is important to note the role of graphic representation in communicating to people with low-level literacy, English as a second language, people with intellectual impairments, or individuals short on time.

12: Are you aware of any consumer research on understanding and interpretation of the current DrinkWise pictogram and/or text? What about other examples of pictogram and/or text?

In 2011, the Foundation for Alcohol Research and Education (FARE) undertook research to compare consumer understanding of the DrinkWise warning with other labels featuring a combination of text and graphics, and given a more prominent position on the product packaging. Consumers overwhelmingly found the alternative labels clearer in meaning than the DrinkWise labels[7]. This raises immediate concerns regarding the utility of the DrinkWise warnings. FARE's findings are consistent with the Siggins Miller evaluation which indicates both low comprehension and recall of the current warnings.

13: Describe the value of pregnancy warning labels. Please provide evidence to support your views.

It is clear that there is an under-appreciation at a societal level of the harm caused directly and indirectly by alcohol, and this is reflected by the percentage of Australian women (26%) who continue to consume alcohol after learning they are pregnant.

Cigarette packaging in Australia provides an irrefutable case study to support the potential improvements to consumer awareness and behavior, if labelling reforms are properly executed. In 2016, the Post-Implementation Review of Tobacco Plain packaging[8] found that changes to tobacco packaging had resulted in a statistically significant decline in smoking prevalence in Australia.

Pregnancy warning labels must play a significant role in improving awareness of the true harm associated with alcohol, but they are not a standalone intervention and must be implemented alongside broader public health campaigns and regulatory action, such as volumetric taxation.

14: Which is the option that is likely to achieve the highest coverage, comprehension and consistency? Please provide evidence with your response.

Mandated, front of pack warning labels of appropriate size and contrast will lead to highest coverage and consistency. It is clear from the current inconsistencies and poor levels of both coverage and consumer recall, that the current voluntary scheme is inadequate.

To improve comprehension, the AMA is supportive of broader population level education to improve awareness about the harms associated with alcohol, and influence consumer behavior. Noting the higher rates of recall for warnings displayed at medical practitioners' offices, these warnings should be replicated and more widely displayed at venues where patrons are able to purchase or consume alcohol.

15: Which option is likely to achieve the objective of the greatest level of awareness amongst the target audiences about the need for pregnant women to not drink alcohol? What evidence supports your position?

It is the AMA position that mandated, front of pack labels of appropriate size, contrast and prominence must play a role in efforts to improve awareness. Less than 10% of consumers recalled the pictogram without prompting. In this instance, the voluntary labelling scheme has proven to be inadequate.

To be effective, this must occur within the context of broader measures, noting the limited evidence supporting alcohol labelling as a standalone intervention.

16: More information is required on the benefits of each of the regulatory options. Do you have any information on the benefits associated with each option in relation to social, economic or health impacts for individuals and the community? Please provide evidence with your response.

Evidence presented within the evaluation of the labelling suggests that to improve effectiveness, mandatory alcohol warning labelling must occur alongside broader population-level measures to increase awareness about the dangers of consuming alcohol during pregnancy. It remains the view of the AMA that a suite of policy measures is needed to result in meaningful consumer changes. As previously outlined, this should include price signalling and broader public awareness campaigns about the dangers of consuming alcohol whilst pregnant.

17: To better predict cost to industry associated with each option, can you provide further information that could inform the cost to industry associated with each of these approaches, particularly costings from a New Zealand industry perspective? Please provide evidence to support your response.

N/A

18: For Australia, is the estimated cost of $340 AUD per SKU appropriate for the cost of the label changes? To what extent do these cost estimates capture the likely impacts on smaller producers? Should the cost estimates be adjusted upwards to capture disproportionate impacts on smaller producers?

N/A

19: Is the number of active SKUs used in the cost estimation appropriate? What proportion of SKUs on the market is from smaller producers?

N/A

20: Should there be exemptions or other accommodations (such as longer transition periods) made for boutique or bespoke producers, to minimise the regulatory burden? If so, what exemptions or other accommodations do you suggest?

Given the length of time already given to producers to voluntarily adopt pregnancy warning labels, any transition period given must come with stringent compliance measures. Policy option 2 allows for a transition period, this should be enforced consistently across the breadth of the industry. The AMA is concerned that leaving a certain portion of the market exempt from displaying a pregnancy warning may falsely indicate the exempt products are safe.

Noting that a number of producers indicated they were able to adopt pregnancy warning labels through the ordinary rotation and update of their labels, the AMA is reluctant to accept that any alcohol producers would require a transition period of more than 12 months to display pregnancy warning labels on all of their products.

21: To better predict the proportion of products that would need to change their label to comply with any proposed change, information on the type of pictogram and text currently used is required. Do you have evidence of the proportion of alcohol products that are currently using the red pictogram, and what proportion of products are using an alternate pictogram (e.g. green)? Do you have evidence on the proportion of alcohol products that are currently using the beer glass pictogram, or the wine glass pictogram? Please specify which country (Australia or New Zealand) your evidence is based on.

N/A

22: What would be the cost per year for the industry to self-regulate? Please justify your response with hours of time, and number of staff required. Please specify which country (Australia or New Zealand) your evidence is based on.

The AMA remains very suspicious of the industry's capacity to self-regulate given the shortcomings of the current self-regulated alcohol advertising scheme[9]. Additionally, given the very low coverage achieved through the voluntary labelling scheme, the industry has failed to demonstrate a sincere commitment to achieving meaningful change through the use of alcohol warning labels. In the absence of this commitment, self-regulation is not appropriate.

23: For each of the options proposed, would the industry pass the costs associated with labelling changes on to the consumer? Please specify which country (Australia or New Zealand) your evidence is based on.

Noting that a number of producers indicated they were able to adopt pregnancy warning labels through the ordinary rotation and update of their labels, and policy option 2 allows for a transition period, it is feasible to expect that producers could find a way to similarly absorb the cost of changing the labels.

24: If you identified an alternate policy option in question 5, please provide estimates of the cost to industry associated with this approach.

N/A

25: Based on the information presented in this paper, which regulatory/non-regulatory policy option do you consider offers the highest net benefit? Please justify your response.

Mandatory, font-of-pack warning labels of appropriate size, contrast and prominence will achieve the greatest net benefit.
This must occur in the context of broader interventions, including venue display and broader media messaging, as well as the use of price signalling and taxation reform.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4899158/
[2] http://bmjopen.bmj.com/content/8/2/e019605
[3] https://ipa.org.au/wp-content/uploads/2017/08/IPA-Report-Australian-Criminal-Justice-Costs-An-International-Comparison.pdf
[4] https://aic.gov.au/publications/tandi/tandi454
[5]http://www.taxreview.treasury.gov.au/content/FinalReport.aspx?doc=html/publications/Papers/Final_Report_Part_2/chapter_e5-3.htm
[6]http://www.health.gov.au/internet/fr/publishing.nsf/Content/C35B5AC81AED240FCA2581EE001B80B0/$File/AU%202nd%20Evaluation%202017.pdf
[7] http://fare.org.au/wp-content/uploads/research/FARE-Labelling-Market-Testing-Report.pdf
[8] http://ris.pmc.gov.au/2016/02/26/tobacco-plain-packaging
[9] https://www.alcoholadreview.com.au/key-concerns/australias-current-selfregulatory-system/