Opening Remarks

Good afternoon. I am Faye Abdellah, Deputy Surgeon General, U.S. Public Health Service (USPHS), and am serving as moderator for this opening session.

First – Welcome to all of you to this historic Surgeon General's Workshop. The first was initiated by Dr. Koop in 1981.

The Surgeon General's Workshop is a concept, now inveterate, of convening experts to advise the Surgeon General and to identify the public health implications of major health problems demanding resolution.

This workshop provides you, the experts, with the opportunity to come together to advise the Surgeon General, within the constraints of his office, on how best to approach the problem of drunk driving from the perspectives of needed education, services, research, and health policy.

Previous workshops have addressed equally complex problems such as the needs of ventilator/handicapped children, child abuse, elder abuse, pornography, pediatric AIDS, self-help groups, and, most recently, health promotion and aging. For example, during the last workshop, one panel dealt with the problems of alcohol abuse in the elderly – often starting when they were adolescents. The recommendations of this panel were incorporated into the research agenda of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). This is precisely the kind of result that we would like to see come out of your deliberations.

Soon after the workshop is completed, the workshop proceedings and background papers will be published and widely disseminated to appropriate groups at Federal, State, and local levels as well as private sector groups.

The purpose of this workshop is to develop a comprehensive set of recommendations that can help the Surgeon General bring drunk driving under control and eliminate drunk driving as the leading cause of death among young Americans.

Participants are encouraged to examine each expert panel charge in light of the following questions:

1. What do we know about the problem and its extent?
2. What have we done so far? Have these actions been effective or ineffective?

3. What do we need to know?
4. How do we put our knowledge into practice effectively? What will really work?

This is your mandate.

Let me now introduce this afternoon's speakers.

Introduction of Surgeon General C. Everett Koop

Dr. Koop, the 13th Surgeon General of the USPHS, has become the most effective Surgeon General since the establishment of that position. Why has he been so effective?

Dr. Koop has paid his dues to the health establishment many times over. His inimitable courage as a pioneer in pediatric surgery for more than four decades helped him climb mountains in the pediatric world never before surmounted. His appointment as the U.S. Surgeon General in November 1981 presented him with new mountains to climb; for example, planning and implementing the strategy to achieve a smoke-free society by the year 2000; introducing regulations to protect the newborn; protecting the confidentiality of those who are HIV positive, yet still seeking new ways of obtaining prospective data such as volunteer testing of college students; setting new guidelines for nutrition; and most important, strengthening the PHS Commissioned Corps to make this cadre of health professionals proud to serve throughout the United States and in many other parts of the world.

Not only does this Surgeon General climb mountains that appear to be insurmountable, but during his college days at Dartmouth, he was also known to jump off mountains. Does he fly? — NO. He does not have to. His enormous energy propels him on at least 16 cylinders!

Ladies and gentlemen, the U.S. Surgeon General C. Everett Koop.

Opening Remarks

C. Everett Koop. M.D., Sc.D.
Surgeon General of the U.S. Public Health Service
U.S. Department of Health and Human Services

Greetings to hosts, guests, and friends.

I want to thank you all for traveling to this workshop from so many parts of the country. You represent a cross-section of a nation deeply concerned

about the annual toll of death and disability caused by drunk and drugged drivers.

You were chosen by a thoughtful, hard-working interagency planning committee. Its members came from five cabinet-level departments: Transportation, Justice, Education, Defense, and Health and Human Services. I'd hardly call it a parochial group, and I'm delighted that they found the name and address of each one of you.

I also wish to recognize a member of the House of Representatives who is with us today—Congressman William F. Goodling of Pennsylvania.

Congressman Goodling has been a dedicated and tireless leader in every major effort by the U.S. Congress to fight the scourge of drunk driving. The American people are very fortunate to have had him on their side so far, and we can look ahead to his continued leadership and support in the 101st Congress when it convenes next month. Welcome, Congressman Goodling, I'm very pleased to have you with us this afternoon.

All of you, gathered here this week, are respected experts in this field, but that doesn't mean you all think alike. I'm sure as the workshop sessions continue, we will become aware of the wide range of opinions and interests represented here.

I know this is not the best time of year to ask people to leave their homes and families and spend a few days at a conference. But I believe that this workshop is different. There's an urgency about the subject: drunk and drugged driving.

The urgency is almost palpable in the many letters that come in to my office from State and local officials of every area of the country. The urgency is also clear in the cards, letters, and telegrams I've received from surviving family members grieving over the loss of a loved one—someone killed by a drunk driver.

The urgency is clear from the response we've already had to the alcoholism and alcohol abuse initiative launched by Secretary Otis R. Bowen last year and reinforced at a major national meeting in San Diego this past October.

And it's clear from the sentiment expressed by 99 United States senators and from a unanimous House of Representatives, who have asked me to take on this issue and do whatever I can to bring it under control.

Although they are not here today, I do want to recognize two other individuals who have been of immeasurable help in the United States Senate—Senator Claiborne Pell of Rhode Island and Senator John W. Warner of Virginia, the two gentlemen who cosponsored that letter signed by them and 97 of their colleagues. And, again, Congressman Goodling can take great credit for the passage of that resolution—House Concurrent Resolution 276—in the recent 100th Congress.

The Congress knows – as I certainly do, and as most of you know, also – that the powers of the Surgeon General are carefully circumscribed. I do not allocate funds, or operate programs, or carry out any specific legislation. Nor do I *pretend* that I do.

On the other hand, the power and authority of my office are heavily invested in *public education.*

My principal assignment, therefore, is to inform the American people of any threats to their health and to advise them of ways to avoid such threats, if they are known. I inherited that power and authority when I assumed the office of Surgeon General more than 7 years ago. And the credit for that goes to my 12 predecessors, going back for more than a century.

When the time comes for me to take my leave, I hope and pray that I will have done nothing to compromise the integrity and credibility of this great office. On the contrary, I hope I also might be remembered as having done something to further strengthen this office in the eyes of the Nation.

In this matter of drunk driving, the Surgeon General's role is virtually nothing more – but certainly nothing less – than public education. And by "the public," I include not only lay citizens but also my colleagues at all levels of government – Federal, State, and local – and my fellow citizens in the private sector, both in profit and nonprofit activities.

As Surgeon General, I have a responsibility to speak to them *all.* And I do, whether they are comfortable with what I have to say or not.

One of the mechanisms I have used for this purpose is the Surgeon General's Workshop. The workshop provides, as it were, an umbrella under which individuals and groups representing many diverse interests and points of view can assemble and talk out an issue of significance to the health of the American people.

That umbrella – to be effective – *has to be neutral.* Hence, let me assure all of you that I do not come to this workshop with any prearranged conclusions or recommendations or any preset ideas about what we should do next.

But let there be no mistake: I am *not* neutral about the issue of drunk driving. No sensible person can be neutral about that. Where we differ may be on the approach that the United States should take, as a civilized society, to *reduce* and maybe one day *eliminate* this terrible thief of health and life.

I ask you to please adopt this spirit as you take part in the working sessions tomorrow and Friday. In other words, I ask you to be willing to share your ideas, but also be willing to listen, and be willing to learn new things and maybe adjust some of your thinking, if need be.

If we have that kind of participation from everyone, then we may get a good deal closer to the core of this problem and the essence of its solution.

And that brings me to the announcement that the working sessions

tomorrow and Friday will *not* be open to the press. That is consistent with past practices.

I have conducted nearly a dozen Surgeon General's Workshops during my two terms in office. The issues have included AIDS, liver transplantation, the care of handicapped children, family violence, pornography, and so on.

In each workshop, the main or plenary sessions, like this one, have always been open to everyone, including the press. But the *working* sessions have *not* been open. They have always been closed to nonparticipants, again, including the press.

The reason is simple enough. I want all invited participants to go into these sessions ready to speak their minds, ready to engage in open and candid give-and-take with colleagues and counterparts, and, yes, in the course of the debate, ready to change their own minds, if need be.

This approach is not only legal, it's very successful. And I am sure it will be equally successful for us at *this* workshop, too. Let me assure you, however, that, while the actual deliberations of the working sessions will be closed, the *results* of those sessions will be made public at the final open session on Friday. The recommendations will be presented to me by the persons who lead the sessions. I will take a little time to review them and then come back to you with my response in the final session, Friday afternoon.

Now, one more word about these recommendations.

This *is* the *Surgeon General's* workshop. And *I am* the Surgeon General. But I hope *you* will look *beyond* the office of Surgeon General when you make your recommendations.

As I indicated a moment ago, there's really only one recommendation for the Surgeon General – to speak out publicly on the issue of drunk driving. Well, I'm already doing that.

That's why I urge you to set your sights beyond the Surgeon General's office and recommend future action for education – State, local, public, and private – for law enforcement, for the health professions and the public health community, for the transportation and highway interests, and for communications, including advertising and broadcasting.

So, with those few ground rules in mind, let us move forward with our agenda, because time is not on our side. Even as we deliberate here in the safety of these hotel walls during this otherwise festive season of the year, alcohol consumption is up and so is the toll of alcohol-related traffic injuries and deaths.

Hence, we can expect that 1988 – like 1987 and 1986 before it – will be a year in which 24,000 *more* Americans will have died on our highways in alcohol-related accidents.

And many thousands more will have been killed in accidents that are

drug-related, a fact we want to emphasize during this week, which is National Drunk and Drugged Driving Awareness Week.

During my brief time at this microphone – 20 minutes or so – one of our citizens will be killed by a drunk driver.

While you were grabbing a quick lunch at noontime, two more were killed.

And this evening, in the hour when you relax over dinner, *three more* will be killed in the same way.

An average of two to three of our fellow citizens are killed on our streets and highways every hour, around the clock, because they or others had their judgment and reflexes impaired by alcohol and other drugs.

By this time tomorrow, some *65* Americans will have died on the highway in alcohol-related accidents.

That's the picture in regard to alcohol-related fatalities. But over *a million* alcohol- and drug-related crashes occur every year on our highways, and most of them do *not* end in death. But they *do* result in injuries – *a half-million* injuries at a minimum.

When the vehicular wreckage is towed away, the *human* wreckage is left behind – the permanent brain damage, the spinal cord injuries, the lost or permanently deformed limbs, the blindness, and the impotence – the lifetimes crippled with disability and haunted by recurrent nightmares of how it all happened.

Tens of thousands of deaths, hundreds of thousands of injuries. Those are numbing statistics. But they are also *more than* just statistics.

They are real people, real human lives.

Unfortunately, a disproportionate number of highway victims are *young* people, young men and women between the ages of 15 and 24. No other comparable age cohort has such a record of death and injury on the highway.

And this age group, by itself, accounts for more than 8,000 alcohol-related fatalities, or about a third of all fatalities each year in which alcohol is implicated.

Fortunately, young people themselves are becoming more and more sensitive to this issue. That was one of the most encouraging aspects of the recent report of the public hearings held by the National Commission Against Drunk Driving.

Young people who testified at those hearings supported the minimum drinking-age law, seatbelt laws, more public education, and so on.

Also, according to the National Commission, young people themselves, "with near unanimity, declared that advertising encourages adolescents to drink," and the Commission went so far as to recommend that "in the absence of alcohol industry action, legislation should be enacted to regulate alcohol beverage advertising."

Young people may not be numerically represented here as they are in the death and injury statistics each year, but they should be uppermost in our minds during our deliberations today, tomorrow, and Friday.

And now, a final word. I've been spending some time lately preparing for the 25th anniversary of the publication of the first *Surgeon General's Report on Smoking and Health.* In doing so, I've been looking over that 25-year record of progress, and I find it very instructive.

Twenty-five years ago the public health community, with the support of citizens' groups and members of Congress, embarked upon a systematic program of research into the relationship between smoking and health.

At the same time, and in a responsible way, they also looked at the public policy implications of the research results, as those came to light.

From that information they were able to plan ways to help the American people end their high-risk romance with tobacco. Chief among these ways was a far-reaching program of public education and instruction.

And so it appears to me that we may now be—in terms of alcohol and drunk driving—where we were 25 years ago in terms of tobacco and the fatal diseases caused by smoking.

And that brings me to the particular charge for this workshop, the specific areas of interest I hope you address in the next 2 days:

- *First,* let's consider the *research agenda* required for this issue of drunk and drugged driving. We know quite a bit about the issue now, but much still remains to be learned. We clearly need to build a strong scientific base which either *confirms* alcohol's role in highway trauma, or *refutes* the connection between highway trauma and alcohol and other drugs.

- Next, we need to look at—or anticipate, if possible—the many *policy implications of that research.* In other words, *we* may feel we're justified by experience to have strong opinions about this and that, but the *country* needs an objective assessment of the knowledge base and its implications for public policy.

- Third—and also on the strength of an ongoing research program and its policy implications—we need to lay out *a plan with near-term and long-term public health objectives.* In other words, what kinds of actions must we take, in both the public and private sectors, in regard to drunk and drugged driving? What are our goals and objectives, and how should we go about reaching them, soon and over the long run?

- And finally, we need to devise *an overall strategy* for carrying out such a national plan. In these days of restricted and limited resources, we must make every person and every

dollar count. That means not only having a plan, but also having a coherent and cost-effective approach to the *implementation* of that plan.

Those four elements, then, constitute my charge to this workshop: *research, policy, a plan of action,* and *an implementation strategy* for that plan.

That's a big assignment for a 3-day workshop. But I've found in workshops past that people tend to work more creatively and at a higher energy level if time is of the essence.

In any case, this workshop is not an on-the-job training experience for any of you. You are all seasoned and experienced individuals. Also, I'm not searching for the ultimate statement on the issue of drugged and drunk driving. Rather, I'm hoping for a document that will give the country a strong push in the most fruitful direction.

This may be the first meeting of this kind – and it's an important one – but I doubt that it will be the last one.

I am sure all of you can think of some people who are missing from this workshop. Maybe they will be at the next one – and the ones that will follow. But first, let's make the very best start we can.

Again, thank you for joining me this week at this workshop. I appreciate it, and the country will surely benefit from your contribution.

Thank you.

Introduction of Secretary Bowen

Dr. Bowen is the first physician to serve as Secretary of the Department of Health and Human Services. Having served two highly successful terms as Governor of Indiana, we are most privileged to have this physician as Secretary of DHHS.

Secretary Bowen has been able to accomplish what no other secretary has, namely, the introduction and successful passage of legislation related to catastrophic illness. President Reagan publicly stated that this legislation is the most important of his administration.

Why is it so important that Secretary Bowen be with us at this workshop? He has accomplished the following related to drunk driving.

- *He made alcoholism and other alcohol-related problems a special priority for the Department of Health and Human Services.*
- *November 1987, the Department announced a 14-point initiative to raise public awareness about alcohol-related problems in America.*

- *The Department created a public affairs campaign to help get the message across.*
- *The Department established a National Citizens Commission on Alcoholism.*

Ladies and gentlemen, Secretary Otis R. Bowen.

Opening Remarks

Otis R. Bowen, M.D.
Secretary of Health and Human Services

I'm delighted to join such distinguished company in addressing a very real problem that should be of concern to every single American.

I think this is a very appropriate time of the year to be focusing on this matter. The holiday season, from Thanksgiving to New Year's, unfortunately, is the occasion for a general increase in alcohol intake by the average person. All too often, what ought to be a joyous celebration of the revival of the human spirit is utterly destroyed by the abuse of alcohol and the tragedies that follow in its wake.

It's well to remember that, for our purposes, drunk driving is a misnomer. What we're really talking about is drinking and driving. It isn't necessary to be intoxicated; just a drink or two can make somebody behind the wheel a threat to themselves and to others.

The fact that the holiday season is usually marked by weather that makes road and highway conditions treacherous simply compounds the matter.

Now, I don't want to be the grinch that stole Christmas. But I do think this is as good a time as any to renew our annual plea that conviviality and good times shouldn't extend to the point of endangering lives and property.

I'll let Dr. Koop terrorize those who want to enjoy a big steak and a good cigar. Let me just sound the note of caution that's in keeping both with our purpose and its timing.

I don't think there is anyone who doesn't realize that alcohol abuse and alcoholism are having a devastating effect on American society.

And it's going to get worse.

Recent studies indicate that the annual cost to the country of alcohol abuse and alcoholism will reach $136 billion by the end of next year and will rise to $150 billion by 1995.

The checklist of statistics makes a sad litany indeed.

- In all, some 18 million American adults are either alcoholics or have alcohol abuse problems.

- Alcohol is a factor in things like teenage pregnancy, poor scholastic achievement, crime and violence, the gap in health status between white Americans and Americans from minority group backgrounds, and general loss of American productivity.
- An estimated 4.6 million adolescents annually—3 out of every 10 American teenagers—have alcohol problems.
- Nearly 9 out of 10 teenage automobile accidents involve alcohol.
- Alcohol is a major disciplinary, vandalism, and crime problem on most college campuses.
- Some 40,000 babies are born each year at increased risk because of their mother's drinking during pregnancy.
- Fetal alcohol syndrome is one of the top three causes of birth defects and is the only one that's preventable.
- Women are the fastest growing component of the alcohol abuse segment of the population.
- Black, Hispanic, and Native American minorities suffer disproportionately from alcohol-related problems.

In an attempt to do something about this national catastrophe by increasing public awareness, I launched a 14-point initiative a year ago in the U.S. Department of Health and Human Services. Since putting alcohol abuse and alcoholism in the spotlight, we have been able to accomplish a number of things.

- We've established a National Citizens Commission on Alcoholism.
- We've created a special public affairs campaign to inform the American people of the serious health effects of alcohol.
- We've developed a new publication called *Alcohol Alert* to expedite the delivery of research findings into the hands of clinical practitioners.
- We've held two national conferences on alcoholism and alcohol abuse that brought together more than a thousand clinical practitioners, researchers, and prevention specialists.
- And we've joined forces with the American Medical Association to improve the training of physicians in the detection and treatment of alcohol problems.

There is, of course, much that still needs to be done. One of the major alcohol issues that demands our attention is the operation of a motor

vehicle while under the influence of alcohol. And that's the reason for this workshop.

Alcohol-related motor vehicle accidents are a very serious national public health problem. Every year, they inflict lingering spinal cord and brain injuries and other trauma on half a million people. And they kill 24,000 in this country alone. The toll in human misery is awesome and intolerable.

Dr. Koop is to be highly commended for organizing this 3-day workshop. He has enlisted in his cause the Federal Departments of Defense, Education, Justice, and Transportation.

And from our Department of Health and Human Services, the Centers for Disease Control, the Health Resources and Services Administration, the Indian Health Service, and the Alcohol, Drug Abuse, and Mental Health Administration all work together on this problem.

In the past, there have been honest disagreements on the best ways to solve this problem of alcohol-impaired driving. This workshop will attempt to bring together all the public health, academic, government, public safety, law enforcement, and advocacy points of view. And hopefully, it will produce the best background research and recommendations on the problem, from which can come a comprehensive plan to reduce alcohol-impaired driving and eliminate it as a leading cause of disability and death among Americans, many of them unacceptably young.

When these findings reach every level of our society, perhaps that process can begin.

Dr. Koop is going after alcohol-impaired driving the way he has gone after cigarette smoking. His goal is to save lives. I support his effort.

And even though my stewardship is about to end, the commitment of the Department of Health and Human Services will not. In fact, planning has already begun for the third national conference on alcoholism and alcohol abuse. The second conference, last month in San Diego, was enormously successful, with more than 1,400 people in attendance. The next conference promises to be even better.

We aren't the only ones with these concerns. Maybe from others in the international community we can learn new ways to combat the problem that brings us together today, and maybe we can teach them something of what we know.

There may be no magic bullet to end the tragedy of alcohol abuse and driving, but I think we can begin to develop at this workshop ways and means of dealing with it that will be just as effective.

I am pleased to see that several members of the Congress are participating in this workshop. They can play a vital role in anything we hope to accomplish.

Thank you for coming. I wish you every success in your deliberations.

Introduction of M. George Reagle

Mr. George Reagle is representing Secretary Burnley of the Department of Transportation. Mr. Reagle is the Associate Administrator, National Highway Traffic Safety Administration, Department of Transportation. The Department of Transportation has a long history of cooperation with the Department of Health and Human Services and has been working under an interdepartmental agreement with us for many years in a cooperative fashion on this issue. The Department of Transportation historically has been involved in drunk driving issues since the 1960s when they implemented alcohol safety action programs. This is another step in their ongoing efforts to address this issue of drunk driving.

Ladies and gentlemen—Mr. George Reagle.

Opening Remarks

George Reagle
Associate Administrator for Traffic Safety Programs
National Highway Traffic Safety Administration

Distinguished panel, ladies, and gentlemen.

I want to thank you for the opportunity to address this gathering of experts on the problem of drunk driving. I sincerely hope that your deliberations over the next few days can provide us with additional energy and information to reduce drunk driving and its tragic consequences.

Alcohol Safety Action Projects

During the 1970s, the National Highway Traffic Safety Administration (NHTSA) placed a great deal of emphasis on the problem of drunk driving via a national demonstration program involving 35 Alcohol Safety Action Projects (ASAPs). These 35 projects were designed to reduce drunk driving at the local level by combining the various elements (e.g., enforcement, licensing, adjudication, public information) into a system at each locality. Prior to this time, persons in these different areas frequently did not coordinate their efforts to deal with the drunk driving problem.

Evaluation was a major component of these ASAPs, and we were able to get a reading on how successful we were. By the end of the projects, we had demonstrated significant reductions in nighttime fatal crashes in 12 of

the 35 sites. Still, from 1970 to 1976, we were not able to detect any significant, national level changes in the problem of drunk driving.

Indepth Demonstration Projects

We then began to look in depth at the various countermeasure elements to see if we could find ways to improve them and demonstrate their effectiveness. We conducted a DWI enforcement demonstration project in Stockton, California that showed that specially trained and motivated officers were able to significantly increase DWI arrests and to make small but significant reductions in alcohol-related crashes. We conducted probation demonstrations in Mississippi and Tennessee and found that long-term followup with a diagnostic and assessment program called the "Life Activities Inventory" resulted in significant reductions in recidivism among convicted drinking drivers. In addition, we conducted a comprehensive DWI treatment demonstration in Sacramento, California which showed that intensive treatment and long-term followup could significantly reduce recidivism among convicted drinking drivers.

Again, however, we detected no changes in the national levels of drinking and driving or in the fatalities or crashes involving drinking drivers during this period (1976-80).

1980: A Pivotal Year

By 1980, we had done much groundwork in attempting to find solutions to the problem of drunk driving. We had conducted and evaluated local level, comprehensive programs; we had looked in depth at individual countermeasures, and we had reviewed the results of international efforts to reduce drunk driving during the past several decades. As a result of our experiences and those of foreign nations, we began to place significantly greater emphasis on *general deterrence* of drunk drivers. This meant that deterrence activities such as roadside sobriety checkpoints, swift and sure license actions, jail sentences for multiple offenders, and increased fines received greater emphasis and more media attention. To convey this new emphasis to State and local highway safety leaders, in 1980 we initiated a series of *alcohol-safety workshops* to review the results of the past decade and to convey the latest technology to these leaders.

About the same time, however, a much more important development emerged. Citizen activist groups, which had begun as early as 1978, became more visible across the Nation. These groups represented an element that had been missing in the efforts to reduce drunk driving in the United States – a concerned public. Recognizing the potential of such groups to bring about needed changes, we included them in our series of State workshops and gave them an opportunity to voice their concerns to State highway safety leaders.

The program we were advocating at that time was a six-point program involving (1) general deterrence, (2) prevention and intervention, (3) citizen activist support, (4) emphasis on a total systems approach, (5) financial self-sufficiency, and (6) a focus on the community level.

Suffice it to say that energy produced by the emergence of citizen activists, combined with the new emphasis on general deterrence measures, resulted in the most dramatic progress ever experienced in this Nation in terms of reducing drunk driving. The activists, and the media attention that they produced, resulted in dramatic increases in DWI legislation, arrests, convictions, sanctions, education programs, designated driver programs, responsible server programs, etc.

Most importantly, the alcohol-related proportion of fatal crashes decreased nearly every year since 1982. For example:

- The alcohol-related proportion of fatalities was reduced from 57 percent (in 1982) to 51 percent (in 1987), a reduction of 11 percent from the 1982 level.
- The proportion of fatalities involving an intoxicated driver was reduced from 46 percent (in 1982) to 40 percent (in 1987), a reduction of 13 percent from the 1982 level.
- The alcohol-related proportion of fatalities among youth (under age 21) was reduced from 63 percent (in 1982) to 51 percent (in 1987), a 19-percent reduction.
- The proportion of youth fatalities involving an intoxicated driver was reduced from 49 percent (in 1982) to 35 percent (in 1987), a 29-percent reduction.

Never before in the history of this Nation had such reductions been recorded. They were larger than ever before, and they were documented in several successive years. Unfortunately, since 1985, these reductions appear to have slowed or stopped.

Problems Remaining

Unfortunately, we have a long way to go to eliminate or even greatly reduce the tragedies that result from drunk driving. More than half of all fatal crashes continue to be alcohol-related. More than 80 percent of these alcohol-related fatal crashes involve a legally intoxicated driver (i.e., with a blood alcohol concentration greater than 0.10). Similarly, more than half of all fatal crashes involving youth continue to be alcohol-related, and approximately 70 percent of these alcohol-related fatal crashes involve an intoxicated driver.

Primary Objectives for Reducing Drunk Driving

To further reduce drunk driving, we must concentrate on specific program objectives. Some of the most important include the following.

- Deterring drinking drivers who have not been caught (but who will contribute to approximately 75 percent of alcohol-related fatal crashes in the future)
- Reducing the impaired driving recidivism of drivers who have already been arrested and processed through our criminal justice and/or administrative sanctioning and rehabilitation processes
- Preventing drinking and driving by such means as public information, education, more responsible serving and hosting practices, intervention by friends, designated driver programs, safe ride programs, and preventing the sale of alcoholic beverages to minors

We can act to reduce this problem in many areas. It is important that we look at all of them. I am encouraged to see so many topical areas being addressed at this workshop.

What NHTSA Hopes to Gain From the Workshop

From our perspective at NHTSA, this workshop provides us with an opportunity to inject new energy into the anti-drunk driving movement. Clearly, such additional energy and motivation is necessary if we are to again realize significant reductions in the tragic consequences of this serious behavior.

The recommendations made by workshop participants will broaden the activities and number of organizations involved in the efforts to stop drunk driving. We expect that this workshop will be a major factor in our current attempts to make drunk driving a public health issue and to enlist the aid of public health and medical groups in our efforts.

Thank you for taking your time to come here and address this problem. I wish you success in developing recommendations that can actually make a difference in reducing this most serious public health problem, drunk driving.

Recommendations

After meeting and debating for 2 days in closed sessions, the panels prepared and presented to the workshop participants and the Surgeon General the following recommendations and strategies for implementing them.

Note to readers:

On December 14, 1988 the National Beer Wholesalers Association filed a lawsuit in the United States District Court seeking relief under the Federal Advisory Committee Act to postpone or cancel the Surgeon General's Workshop on Drunk Driving. Pursuant to the Court's order, the Surgeon General opened the workshop to members of the public. Thereafter, the parties resolved the remainder of the lawsuit by entering into a settlement agreement in which the Surgeon General agreed to accept and consider comments from interested parties until January 31, 1989. The Surgeon General also agreed that the final recommendations would not be made before February 28, 1989 and that the final recommendations or report would consider any such written comments. Since the legal ruling was delivered after the opening plenary session of the workshop, its stipulations were not reflected in the opening remarks.

Extensive comments were submitted but are not included in these proceedings because they were not part of the offical workshop deliberations and because they were so lengthy. The comments were considered; however, they did not alter the recommendations published in this report. The comments will continue to be used in the implementation of strategies to eliminate alcohol-impaired driving.

Panel A

Pricing and Availability

Chair:	Harold Holder, Ph.D.
Background Paper:	Alexander Wagenaar, Ph.D.
Recorder:	Mary Ganikos, Ph.D.
Panel Members:	George McCarthy
	Dennis Nalty, Ph.D.
	Michael Jacobson, Ph.D.
	Charles Phelps, Ph.D.
	Sandy Heverly

The Pricing and Availability Panel was charged with discussing matters of concern and controversy, i.e., the pricing and availability of alcoholic beverages. A significant portion of American industry is involved in the production, distribution, and wholesale and retail sale of beer, wine, and distilled spirits. The panel does not challenge the rights of these industries or businesses to produce and sell alcoholic beverages. However, the panel found that by changing pricing and availability of alcoholic beverages, alcohol-impaired driving injuries and fatalities could be reduced.

The panel prefers the adjective "alcohol-impaired" rather than "drunk" in reference to driving. This acknowledges the increased risk of crash, injury, and death for drivers and others when even small amounts of alcohol are consumed. This is particularly true for young drivers.

The panel's deliberations and recommendations are based on two sources of information:

- Scientific research on relationships between alcoholic beverage price and availability and alcohol-involved driving
- Experience and expert knowledge of panel members and others in the field

Price

Research evidence shows that an increase in the excise tax could have the largest long-term effect on alcohol-impaired driving of all policy and program options available. Since Federal excise taxes differ widely by beverage type, and the effective tax rates have declined by three-quarters because of inflation since 1951, the panel makes the following recommendations to Federal and State Governments.

A-1 Recommendations to the Federal Government

A-1.1 Equalization – Equalize Federal excise tax rates by ethanol (pure alcohol) content across all beverages by raising rates for beer and wine to that of distilled spirits.

A-1.2 Adjustment for past inflation – Adjust the resulting equalized excise tax rate to reflect the change in the Consumer Price Index (CPI-U) since 1970.

A-1.3 Future indexing – Annually adjust the resulting excise tax rate to reflect changes in the Consumer Price Index (CPI-U) for the previous year.

A-2 Recommendations to State Governments

A-2.1 Equalization – Equalize excise tax rates by ethanol content across all beverages by raising rates for beer and wine to that of distilled spirits.

A-2.2 Adjustment for past inflation – Adjust the resulting equalized excise tax rate to reflect past inflation.

A-2.3 Future indexing – Annually adjust the resulting excise tax rate to reflect the change in the Consumer Price Index (CPI-U) for the previous year.

A-2.4 States with relatively low tax levels should increase their rates to at least the levels in bordering States.

Strategy

For Recommendations A-1 and A-2, the Surgeon General should take the following steps by April 1, 1989 to achieve equalization, adjust for past inflation, and provide indexing for future inflation for Federal excise taxes on beer, wine, and distilled spirits. The Federal excise tax increases should be part of the FY 1990 budget.

1. *Write letters to all members of the U.S. Congress concerning the need to raise taxes as a means of reducing alcohol-impaired driving and the Federal budget deficit.*
2. *Write similar letters to all State Commissioners of Health requesting that they urge their State's congressional delegation to support higher Federal excise taxes. The Surgeon General should also offer assistance to review State alcohol excise tax laws.*
3. *Write letters to President Bush, the Secretaries of Health and Human Services and Treasury, and the Director of Office of Management and Budget addressing the need for both increasing alcohol excise taxes and ending the tax deductibility of alcoholic beverage purchases.*
4. *Urge the National Economic Commission to include Federal alcoholic beverage excise tax increases in its recommendations.*
5. *Convene a meeting with appropriate Congressional leaders in health and financial matters on the health and budgetary benefits of raising Federal alcohol excise taxes.*
6. *Prepare a position paper on the health and fiscal benefits of raising alcohol excise taxes, addressing alcohol-impaired driving and other alcohol-related problems as well as increased revenues.*
7. *Urge organizations and citizens concerned about alcohol-impaired driving, other alcohol problems, and the Nation's economic and social well-being to urge the President and their congressional representatives to support higher alcohol taxes.*

Preventing Increased Availability

The availability of alcoholic beverages in a community can significantly affect the extent of alcohol-impaired driving. The effects of small increases in availability on alcohol-impaired driving are difficult to measure.

Nevertheless, the cumulative effect of several such changes can be substantial.

Therefore, the panel recommends:

A-3 Federal, State, and local governments should not adopt policies that result in increased availability of alcoholic beverages without careful analysis, study, and public debate about the potential effects on alcohol-impaired driving. This applies particularly to bars, restaurants, and other public facilities, since research shows that the majority of alcohol-impaired drivers obtain alcohol at such places.

Reducing Availability

To reduce alcohol-impaired driving, State and local governments, and/or the Federal Government where appropriate, should consider applying the following measures.

A-4 Adopt or strengthen server/seller liability statutes and policies to encourage responsible serving and selling practices.

A-5 Prohibit "happy hours" and other reduced-price promotions.

A-6 Require training and certification of sellers and servers of alcoholic beverages.

A-7 Restrict alcohol sales by time and place at sporting, music, and other public events.

A-8 Adopt open-container laws that prohibit drinking while driving.

A-9 Permit local governments to enact regulations that are more restrictive than State Alcohol Beverage Control (ABC) laws.

A-10 Strengthen laws concerning hours of sale, characteristics and density of outlets, and other factors relating to retail availability of alcoholic beverages.

A-11 Increase enforcement of existing State and local Alcohol Beverage Control regulations and increase resources available for enforcement.

A-12 Eliminate the tax deductibility of alcoholic beverage purchases for business purposes.

A-13 Prohibit or discourage serving and selling practices that increase the level of alcohol-impaired driving.

A-14 The Federal Government has a primary responsibility for these matters in three important settings – military bases, commercial aviation crews and travelers, and general aviation pilots – and should adopt a strong leadership role in appropriately controlling pricing, availability, and use of alcoholic beverages in these settings.

Strategy

For Recommendations A-1 thru A-14, the Surgeon General should take the following steps by November 1, 1989 to reduce alcohol-impaired driving by limiting and reducing alcohol beverage availability.

1. *Write letters to a broad range of health and other civic organizations and parents, asking that they support higher Federal and State alcohol taxes and other measures that limit and reduce alcoholic beverage availability.*
2. *Convene no later than June 1989 a conference of State budgetary and health officials to describe and discuss the health and fiscal benefits of raising alcohol excise taxes. The Surgeon General should pay special attention to States that have relatively low excise taxes.*
3. *Write letters to governors, mayors, ABC administrators, and State and local police leaders to recommend measures they could take that would reduce alcohol-impaired driving through better control of alcoholic beverage availability.*
4. *Give a national address on alcohol-impaired driving and the need to increase excise taxes and reduce alcoholic beverage availability.*
5. *Urge owners and managers of stadiums and other such public facilities to restrict alcoholic beverages as necessary to reduce alcohol-impaired driving.*
6. *Urge sellers and servers of alcoholic beverages, through their trade associations, to end reduced price promotions such as happy hours, eliminate serving practices that increase risk of*

alcohol-impaired driving, and implement server and seller training.

Future Research

Finally, in support of these above recommendations, the following research should be undertaken.

A-15 Evaluate the impact on alcohol-impaired traffic problems as policy recommendations of this panel are implemented at Federal, State, and local levels.

A-16 Determine the specific price sensitivity of changes in alcohol-impaired driving by age and gender.

A-17 Document the contribution of location, density, and hours-of-sale of alcohol outlets to alcohol-impaired driving and resulting injuries and fatalities.

Estimating Effects of Increased Federal Excise Tax on Alcoholic Beverages

Charles E. Phelps, Ph.D.*

The Pricing and Availability Panel of the Surgeon General's Workshop on Drunk Driving proposed a three-step strategy for dealing with Federal excise taxes (FET) on alcoholic beverages. This note describes the proposed changes and their consequences.

Increases in the Federal Excise Tax

Equalize all tax rates to that of distilled spirits. Currently, distilled spirits are taxed at $12.50 per gallon of 100-proof alcohol. This converts directly to $2.50 per fifth of 100-proof alcohol, or $2 per fifth of 80 proof. A standard drink of 1.41 oz of 80-proof alcohol thus has a Federal excise tax of $0.11 attached to it.

The equivalent tax on beer is derived by assuming that beer is, on average, 4.7 percent alcohol (some more, some less). This is 9.4 proof, so to equalize rates, beer should be taxed at 9.4 percent of the rate for 100-proof alcohol, or $1.175 per gallon. This equals $0.11 per 12 oz serving of 4.7-percent alcohol, the standard drink of beer.

The equivalent tax on wine is derived for wine with 12 percent alcohol content, or 24 proof. Thus, a gallon of wine should be taxed at 24 percent of $12.50, or $3 per gallon, or $0.60 per fifth (25.6 oz). Thus, a standard drink of 4.7 ounces of wine has a tax of $0.11 attached to it after equalization.

Correct for inflation since 1970. The 1970 distilled spirits tax was $10.50 per proof gallon, or $1.68 per fifth of 80 proof. Inflation correction since 1970 provides a multiplying factor of 3, so the equivalent 1989 tax would be $5.04 per fifth, an increase of $3.04 per fifth from the current tax, or $0.167 per standard drink, to a tax per standard drink of $0.277. This becomes the 1989 standard tax.

The current tax on beer is $0.027 per 12 oz serving, so the equivalent inflation-corrected tax would increase by $0.25 to $0.277 per 12 oz serving.

The current tax on wine is $0.17 per gallon and $0.034 per fifth. Raising

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it to the inflation-corrected distilled spirits tax brings the wine tax to $1.50 per fifth of 12-percent wine, (again) $0.277 per drink. This represents an increase of $1.47 per fifth of wine, or $0.271 per standard drink.

Index for future inflation. This will prevent erosion of the real Federal excise tax in the future.

Relative Price Changes

The following calculations assume, as would occur in standard competitive industries, that a tax increase will be added to retail price on a dollar-for-dollar basis. In a monopoly, the cost-passthrough would be less, using standard monopoly pricing models.

Distilled spirits. Currently, the average retail price of distilled spirits is approximately $11.50 per fifth. The added tax of $3.04 per fifth represents a 26-percent increase in the price of distilled spirits. The relative increase is smaller for premium brands (and conversely for low-price brands), since the proposed tax is based on alcohol content, not price.

Beer. Currently, the average price of beer is approximately $0.70 per can, or $4.20 per six pack. The tax would increase by $0.25 per can, representing an average increase of 36 percent. Again, the relative change would be smaller (larger) on relatively high (low) priced beers.

Wine. Currently, a bottle of wine is taxed at $0.036. The current average price has been estimated at $3.07 for table wines, higher for coolers, fortified wines, and naturally carbonated wines. On this base, an increase of $1.47 per bottle represents an increase of 48 percent.

Consumption Changes

The demand elasticity has been estimated for distilled spirits and wine at about –0.5 to –1. For beer, –0.4 is a reasonably well-established estimate.

Distilled spirits quantity. The quantity response to a 26-percent increase in price would be a decline of 11 to 21 percent, using the assumed range of elasticities.* With the current apparent consumption at 44 billion drinks, the decline would range from 4.9 to 9.2 billion drinks, giving a new

*These calculations assume a constant/elasticity demand model. The new consumption relative to current consumption is found by raising (1+t) to the power of the elasticity. For example, if the elasticity is -0.5, and if the tax adds 26 percent to the current price, then the new consumption is old consumption multiplied by (1.26 raised to the -0.5 power), which equals 0.89. Thus, current consumption would fall by 11 percent.

total of 39.2 to 34.8 billion drinks. The midrange of these estimates is a decline of 7 billion drinks to 37 billion drinks.

Beer quantity. The quantity response to a 36-percent increase in the price of beer, using an elasticity of –0.4, is a decline of 11.6 percent. The estimated current volume is 58 billion drinks annually; the projected decline of 6.7 billion would bring the new annual total to 51.3 billion drinks.

Wine quantity. The response to a 48-percent increase in the price of wine is as follows. Current consumption is estimated at 13.2 billion drinks. For a price elasticity of –0.5 to –1, consumption would decline by 18 to 32 percent. The new quantities would be 10.8 billion to 9 billion drinks. The average of these, 9.9 billion drinks, represents a decline of 3.4 billion.

Implications for Federal Tax Revenue

On the new quantity of 37 billion distilled spirits drinks, the Federal excise tax would total $10.25 billion. The current FET of $0.11 per drink imposed on 44 billion drinks produces a current revenue of $4.84 billion, thus the net increase in FET would be $5.4 billion.

On the new quantity of 51.3 billion beer drinks, the Federal excise tax would be $14.2 billion. The current tax of $0.027 per drink on 58 billion drinks produces revenues of $1.57 billion. Thus, the net increase would he $12.6 billion.

On the new quantity of 9.9 billion wine drinks, the Federal excise tax would be $2.7 billion. The current tax of $0.006 per drink on 13.2 billion drinks yields $80 million. Thus, the net increase would he $2.6 billion.

Combining these three sources, the estimated increase in FET would be $20.6 billion. These estimates rise (fall) as the assumed elasticity is smaller (larger) than the mid-range estimates used in this calculation.

Lives Saved

The estimates from Saffer and Grossman, from Cook, and from Phelps all suggest that the elasticity of fatalities with respect to alcohol price is about –0.7 to –1. The current proportions of drinks in the total market are 50 percent for beer, 38 percent for distilled spirits, 12 percent for wine. Thus, the weighted price change recommended by the Pricing and Availability Panel is 33.6 percent. The ensuing reductions in highway fatalities would be 19 to 25 percent. On an approximate base of 44,000 highway fatalities in 1988, this represents the avoidance of some 8,400 to 11,000 premature deaths annually.