Health Select Committee

Inquiry into Alcohol

Response by
the Institute of Alcohol Studies (IAS)

March 10 2009

Executive Summary

1 Introduction

The IAS welcomes the opportunity to submit its views to the Select Committee. It welcomes progress in the field that has been made. (1.1 – 1.7)

2 Ill health from alcohol misuse

Alcohol is one of the most important factors in the global burden of disease. (2.1 – 2.7)

3 The burden to the NHS

Alcohol represents a considerable burden to the NHS. It is important facilities are maintained and developed. (3.1 – 3.7)

4 New Government initiatives

There is need for urgent action in several fields. Public health needs to be considered in the granting of licenses and initiatives in the control of marketing are required. (4.1 – 4.7)

5 Role of the NHS and other bodies, including the voluntary sector

The NHS should quantify the importance of alcohol and its various health problems that are affected; mental health and social consequences need quantifying. Numerous alliances in the voluntary sector can be harnessed to tackle all the various aspects of the cause of alcohol misuse and its consequences. (5.1 – 5.8)

6 Drinking culture

Attitudes to alcohol are a major problem. Knowledge of the probable consequences of alcohol consumption to an individual are unlikely to be enough to change habits sufficiently. (6.1 – 6.5)

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1 Introduction

1.1 The IAS welcomes this opportunity to present its views to the Health Select Committee on what is now widely recognised as a major public health issue and one that is likely to place an even greater burden on health services in the future than at present.

1.2 The IAS welcomes the considerable progress that has been made in tackling alcohol-related harm since the inception of the National Harm Reduction Strategy, published in 2004. Although universally criticised by the public health community for being largely preoccupied with issues of alcohol-related crime and disorder, there is now a general acceptance that 'Safe. Sensible. Social. Next Steps in the National Alcohol Strategy' takes a much superior approach. The impact of alcohol consumption on health issues needs to remain at the forefront of policy.

1.3 The IAS welcomes, in particular, the introduction of Public Service Agreement 25 as part of a much improved framework at local level for commissioning health and social care, including Joint Strategic Needs Assessments and the national health indicators which now include alcohol-related hospital admissions.

Public Health

1.4 Given the known public health benefits of reduction in per capita consumption of alcohol, the Government should consider setting a clear target for ensuring that overall alcohol consumption does not increase further and should preferably set a target of a decrease in consumption over the next five years.

1.5 To reduce the impact and scale of ill health related to alcohol consumption, the IAS considers that the Government should prioritise the following areas:

1.5.1 changes to primary legislation to allow for the introduction of public health considerations as a new licensing objective

Driving

1.5.2 the introduction of high visibility roadside checks with evidential roadside breath testing and a lowering of the Blood Alcohol Level to 50mg% in general and 20mg% for young and novice drivers

Promotion and finance

1.5.3 the introduction of the amendments to the duties on alcohol as proposed in the Pre-Budget Report 2008 without concession to the current financial downturn

1.5.4 the introduction of a mandatory code of practice for the promotion, advertising and sale of alcoholic beverages

1.5.5 increasing the quality and range of alcohol intervention services for those who wish to reduce their alcohol intake or stop drinking altogether

1.5.6 carry out further investigation into the hidden harm caused by alcohol to third parties, including older people and adults as well as children and young people

1.6 The IAS welcomes the shift in emphasis towards low risk guidelines and away from "sensible limits". An appreciation of risk associated with alcohol consumption at all levels is required to change cultural attitudes and norms. The introduction of a "Less is Better" message would provide greater coherence to the public health approach to reducing alcohol related harm.

1.7 The IAS welcomes the emphasis on delaying the onset of drinking contained within the draft guidelines issued by the Chief Medical Officer on the Consumption of Alcohol by Children and Young People.

2 The Scale of ill-health related to alcohol misuse

2.1 The IAS recognises the significant advances that have been achieved over this decade in improving information systems and in the collection and collation of alcohol-related data at global, European, national and local levels.

2.2 The scale of the known direct burden of ill health associated with alcohol is astounding and is responsible for 4.4% of the global burden of disease. Harmful use of alcohol is now the third leading risk factor to health in developed countries. (WHO A61/13, 20 March 2008)

2.3 The corresponding burden of ill health in Europe and in the UK is well documented and need not be repeated here. However, we would wish

to draw attention to several key indicators that point to a longer term trend in alcohol-related harm and that emphasise the need for Government to adhere to a long-term strategic public health approach to deal with the harmful consumption of alcohol.

2.4 The World Health Organisation Regional Office for Europe HBSC International Report, 'Inequalities in Young People's Health' (2008) states that the "specific characteristics of the initiation into alcohol (such as drinking at family gatherings and feeling drunk) and early drinking styles (drunkenness-orientated consumption) are particularly predictive of later problems with alcohol." (Section 4 p 127) English, Welsh and Scottish 15 year olds who report first drunkenness at age 13 or younger feature in the top eight of countries and in the top four (with Lithuania) for 13 year olds who report having been drunk at least twice.

2.5 The IAS considers that early initiation into harmful patterns of drinking and alcohol-related antisocial behaviour such as those highlighted in the Government's Youth Alcohol Action Plan can lead to later problems with alcohol and welcomes the emphasis in the Chief Medical Officer's guidelines on delaying the onset of drinking for under 15 year olds.

2.6 A key indicator of longer term damage is liver cirrhosis and the upward trend since the mid-90s to 2005/6 for both men and women highlights the need for long-term public health approaches to reduce per capita consumption. Figures for total alcohol-related hospital admissions show an increase from 147,659 in 2003/4 to 207,788 in 2006/7.* The sharp increase in levels of alcohol-related harm across all diagnoses for males and females aged 35 to 65 points to the need to take concerted and strategic action using all available means.

2.7 Although the scale of the known direct burden of ill-health associated with alcohol is high, the IAS considers that a significant additional burden of ill-health goes undetected. The impact of harmful alcohol use on third parties warrants further and systematic investigation.

3 The consequences for the NHS

3.1 The disease burden caused by the harmful use of alcohol is avoidable but the cost, in the main, is borne by health services. The ill health burden relates to volume of alcohol consumed over time, or frequent drinking episodes that lead to intoxication and to risk factors for neuropsychiatric disorders, alcohol use disorders and dependence and communicable and non-communicable diseases.

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* 'Total admissions to hospital in which the patient had a primary or secondary diagnosis which was alcohol-related at the start of his/her stay for 2003/4 to 2006/7' Statistics deposited in House of Commons Library in response to a parliamentary question from James Brokenshire on 13 October 2008

3.2 For this reason, the consequences for the NHS are both profound and far-reaching, impacting the whole spectrum of services from neonatal care to healthcare for the elderly.

3.3 Alcohol-related harm will also impact the NHS as a major employer and alcohol policies for the workforce will need to take into account the risks related to alcohol consumption on work performance and the opportunities that exist to offer helpful interventions in the workplace.

3.4 The demands placed upon the whole spectrum of health services by alcohol-related ill-health means that there is a requirement for increasing the availability and accessibility of training and awareness for staff at all grades and in all settings.

3.5 The IAS welcomed the publication of the Models of Care for Alcohol Misusers and the introduction of local planning and implementation structures. However, the Government should also ensure, through audit and inspection, that the needs of alcohol misusers and third parties are adequately met at all tiers of service.

3.6 In the current economic climate there is a real risk that local and national decisions will be made to disinvest in alcohol prevention and direct services. The IAS considers that, due to the present and likely future burden of demand on the NHS from alcohol-related ill-health, this is not the time for disinvestment but for greater investment in cost-effective interventions, particularly in partnership approaches with Local Authorities and the Police, to reduce the burden on acute services, identification and brief advice services in primary care, and integrated, multi-tiered services for those with complex needs and dependency.

3.7 Equally, the burden of evidence points to cost effectiveness of other policy options to reduce alcohol-related harm. These include a combination of measures that target the population at large, vulnerable groups, affected individuals and particular problems such as drinking-driving and alcohol-related violence. Reducing the public health impact will require the Government to regulate the availability, marketing and pricing of alcohol as well as supporting the NHS in its response to the consequences of alcohol consumption.

4 Central Government Policy

4.1 Public health objectives should be paramount in defining responses and when defining objectives and targets for national policies, strategies and action plans.

4.2 The Government should review primary Licensing legislation and introduce public health as a new licensing objective.

4.3 The adjustments to duties on alcoholic beverages announced in the 2008 Budget and the Pre-Budget Report (November 2008) should be adhered to despite the changing economic climate. Addressing the affordability of alcohol is a key issue for the immediate and longer term reduction in the burden of alcohol-related ill-health as the Government itself has recognised. Tax increases will save thousands of lives and reduce the overall burden on the NHS over time.

4.4 Recent reports have confirmed the influence of alcohol marketing and promotion on consumption and harm:

1 Independent review of the effects of Alcohol pricing and promotion

ScHARR, University of Sheffield
Project report for the Department of Health – September 2008

2 Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people? - a review of longitudinal studies

Scientific Opinion of the Science Group of the European Alcohol and Health Forum – February 2009

3 The affordability of alcoholic beverages in the European Union – Understanding the link between alcohol affordability, consumption and harms

Report prepared by RAND for the European Commission DG SANCO – February 2009

4.5 The Home Office has also recently reviewed the Social Responsibility Standards for the production and sale of Alcoholic Drinks. The IAS considers that a mandatory code of practice for producers, promoters and retailers should be introduced. Whilst such legislation may require primary enabling legislation, it may also be achieved by an amendment to the Licensing Act 2003. The Act already contains enabling sections to which a mandatory code could be added.

4.6 The IAS, in its response to the latest Department for Transport consultation on Road Safety, has supported the introduction of random breath testing at high visibility roadside checkpoints, together with the reduction to 50mg% of the legal blood alcohol level for driving and 20mg% for young and novice drivers. The combined effect of these countermeasures, together with other strategic responses referred to above, should result in the reduction of alcohol-related injury, death and ill-health.

4.7 Economic operators with a vested interest in the promotion, marketing and sale of alcoholic beverages should not decide public health policy

and their contributions should be confined to the implementation of policy.

5 The role of the NHS and other bodies including local government, the voluntary sector, police, the alcohol industry, and those responsible for the advertising and promotion of alcohol

5.1 The NHS is a main stakeholder at local and national level and can effectively reduce the harmful use of alcohol by providing direct services, engaging in partnerships and advocating with Government for the introduction and implementation of effective public health policies.

5.2 In addition, the IAS considers that the NHS is in a critical position to develop adequate mechanisms for the assessment and reporting of alcohol-related harm to third parties, and that surveillance and information systems within the NHS and across partnerships need to be developed. The aim would be to capture the impact on health (including injuries), mental health, social well-being of third parties including children's health and older people's health.

5.3 The NHS and its workforce has a role in providing leadership around values, appropriate public health strategies and interventions aimed at reducing alcohol-related harm.

5.4 One of the roles of the voluntary sector is to support advocacy, research and capacity building.

5.5 Alliances can be formed across the voluntary sector to share information and good practice. Specialist alcohol voluntary sector organisations benefit from sharing knowledge and expertise with non-specialist but related organisations. These include voluntary organisations involved with older people, young people and children, medical research organisations, liver, heart and cancer charities and social and development charities.

5.6 The IAS welcomed the establishment of the Alcohol Health Alliance and is a participating member.

5.7 The voluntary sector can provide some capacity to evaluate programmes, and assess the impact of strategies and initiatives. It can also work in partnership to implement strategies and to develop innovative approaches and actions.

5.8 The voluntary sector also has the role of alerting the Government to areas of particular concern and of representing the voice of individuals and groups who are adversely affected by alcohol consumption directly or indirectly. The IAS is currently involved with Age Concern and others in examining the impact of alcohol use on the older population.

6 Solutions, including whether the drinking culture in England should change, and if so, how

6.1 Knowledge alone will not affect the cultural shift required to significantly reduce the levels of harm currently being experienced in the UK.

6.2 Cultural expectations are currently centred around intoxication and regular frequent use and the combination of both is damaging in the short and long term.

6.3 Solutions will rely on a combination of formal and informal measures and Government will need to demonstrate leadership in introducing public health measures in order to support the efforts of the NHS and other partners in dealing with the consequences of harmful alcohol consumption. Raising prices, addressing availability and affordability, a mandatory code of practice for the industry and investment in health care will send out the right message and will create an environment for change.

6.4 The Government, together with relevant stakeholders, should also review informal measures and the content of educational/awareness messages. The IAS welcomed the introduction of the concept of 'risk' as opposed to 'sensible limits' and would support the change of emphasis to a message of 'less is better' in order to provide coherence with public health policy.

6.5 Challenging existing values and norms is required to effect change. The IAS is mindful of the five ethical principles and goals for alcohol policy set out in 1995 and adopted by the WHO at the Conference on Health, Society and Alcohol in Paris.

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.

2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.

3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.

4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.

5. All people who do not wish to consume alcohol, or who cannot do so

for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

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