# HEALTH FIRST: KEY POINTS

## Background

The Westminster Government launched a new national alcohol strategy in March last year and a consultation on some of the key measures it contains has just closed. The Scottish Government is also pressing ahead with plans to introduce a minimum unit price for alcohol. These measures have produced an unprecedented level of debate about the harm alcohol is doing in families and communities across the UK. Unfortunately, much of that debate is being driven by sections of the alcohol industry with a commercial interest in maximising sales and profits from alcohol products. As a result, both the public, the media and politicians are being misinformed by reports which are neither independent nor have been subjected to rigorous academic scrutiny.

Health First attempts to redress the balance by putting forward an independent, evidence-based plan backed by experts and organisations with the health and welfare of the public as its main aim.

Before we look at Health First and what it says it is important to recognise and acknowledge the progress already made:

- Scotland introduced legislation in May 2012 to introduce a minimum retail price per unit of alcohol of 50p. This is currently being challenged in the courts by the alcohol industry.
- A public consultation on a MUP of 45p was launched in England and Wales in November 2012
- A tax escalator introduced in 2008 to increase duty on all alcoholic drinks by 2% above base rate of inflations
- In England and Wales the licensing act of 2003 restricts irresponsible promotions in on licensed premises, including offering large quantities of alcohol for a fixed price
- Local authorities are now the licensing authorities and, as such, required to produced local licensing policies
- In the UK, the alcohol industry pledged through their 'Responsibility Deal' that by December 2013, 80% of products would have labelling that would contain unit content, sensible drinking guidelines and a warning on alcohol consumption in pregnancy.

## What is Health First?

A strategic plan setting out key recommendations, and the evidence to underpin them, to reduce the harm from alcohol in the UK.

## Who developed it?

A group of experts, from a wide range of organisations, who are independent from the alcohol industry and government. The group met a number of times over a two year period. It was chaired by Professor Sir Ian Gilmore and supported by researchers from the University of Stirling and an experienced editor.

## Who funded it?

Support for meetings of the strategy group, editorial input and production was provided by the British Liver Trust, Cancer Research UK and a number of other public health organisations who are all listed in the acknowledgements section of the report.

## Why is the strategy needed?

Alcohol poses a major burden on society in terms of health, social and economic costs. Some topline figures to illustrate the scale of the problem include:

- Each year there are more than 8,700[1] alcohol related deaths and 1.25 million hospital admissions in the UK[2]
- 49% of males charged with domestic violence have a history of alcohol abuse[3]

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1. ONS (2012) Alcohol-related Deaths in the United Kingdom, 2010. Newport: ONS.
2. North West Public Health Observatory (2012) Local Alcohol Profiles for England (National Indicators).
3. Gilchrist, E. et al. (2003) Domestic violence offenders: characteristi cs and offending related needs. London: Home Office.

- Approximately 79,000 babies under one year live with a parent who is classified as a problem drinker[4]
- Drink driving accidents lead to 9,900 casualties each year[5]
- The total cost to society of alcohol harm is estimated to be £55bn each year. This includes costs to the health and emergency services, criminal justice system and lost productivity in the workplace[6]
- Alcohol exacerbates health inequalities: People from low income groups are at a greater risk of health and social problems caused by alcohol[7,8]

## What does the strategy recommend?

The following are the 'top ten' of 30 recommendations contained within the report:

1. A minimum price of at least 50p per unit of alcohol should be introduced for all alcohol sales
2. At least one third of every alcohol product label should carry a health warning specified by an independent regulatory body.
3. The sale of alcohol in shops should be restricted to specific times of day and in designated areas.
4. The tax on every alcohol product should be proportionate to the volume of alcohol it contains and this taxation should increase with product strength in order to incentivise the development and sale of lower strength products.
5. Licensing legislation should be comprehensively reviewed and licensing authorities given the power to tackle alcohol-related harm by controlling the total availability of alcohol under their jurisdiction.
6. All alcohol advertising and sponsorship should be prohibited. In the short term, alcohol advertising should only be permitted in newspapers and other adult press and only limited to factual information about the brand
7. An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety.
8. The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml.
9. All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.
10. People who need support for alcohol problems should be routinely referred to specialist alcohol services for appropriate treatment.

## What evidence is there to support these ten recommendations?

1. **Minimum unit pricing**

A growing body of evidence suggests that minimum unit pricing (MUP) lowers alcohol consumption, and the associated harms, at the population level. For example:

A 10% increase in minimum unit prices in the province of Saskatchewan in Canada, saw a reduction in the sales of high strength beer dropping by 22%, compared to lower strength beer which also dropped by 8.2%.[9]

In some of the remoter communities of Australia, prohibition of the cheapest alcohol was followed by a 19% reduction in alcohol consumption, reductions in hospital admissions and crime. Two years in, most local people favoured retaining or even strengthening pricing restrictions.[10]

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4 Cuthbert, C., Rayns, G. and Stanley, K. (2011) All Babies Count: Prevention and protection for vulnerable babies. London: NSPCC.

5 Department for Transport (2012) Reported Road Casualties in Great Britain: 2011 provisional estimates for accidents involving illegal alcohol levels.

6 Lister, G. (2007) Evaluating social marketing for health – the need for consensus. Proceedings of the National Social Marketing Centre, 24-25 September, Oxford.

7 Siegler, V. et al. (2011) Social inequalities in alcohol related adult mortality by National Statistics Socioeconomic Classification, England and Wales, 2001-2003, ONS Health Statistics Quarterly, 50.

8 NHS National Services Scotland (2011) Alcohol Statistics Scotland.

9 Stockwell, T., Zhao, J., Giesbrecht, N., Macdonald, S., Thomas, G., Wettlaufer, A. (2012) The raising of minimum alcohol prices in Saskatchewan, Canada: Impacts on consumption and implications for public health, American Journal of Public Health, published online ahead of print, doi:10.2105/ AJPH.2012.301094

10 Gray, D., Saggers, S., Sputoré, B., Bourbon, D. (2000) What works? A review of evaluated alcohol misuse interventi ons among Aboriginal Australians. Addicti on 95(1): pp 11-22. doi: 10.1046/j.1360-0443.2000.951113.x

Modelling by the University of Sheffield provides projections of harm reduction after 10 years if a MUP of 50p were introduced in England. It estimates that every year **3,100** lives will be saved; there will be **41,000** fewer chronic illnesses, **14,000** fewer acute illnesses, **98,000** fewer hospital admissions, **43,000** fewer crimes and 442,000 fewer days of absence from work.[11]

2**. Alcohol product labelling**

Packaging on all consumer products has a number of functions – to protect the product (as in food packaging keeping products fresh for example), to serve as a marketing tool and to convey information about the product.

At the moment, alcohol product packaging achieves the first two but is extremely limited in the third respect. Current regulations require even less information on alcohol products than food in terms of ingredients and content. Food labelling is intended to allow consumers to make informed choices about what they eat and drink, but the current requirements for alcohol labelling do not facilitate that choice. Current requirements are limited to a figure describing the alcohol by volume (ABV) in the product. Research has shown that the inclusion of health warnings on alcohol products increases knowledge and awareness among consumers of the adverse health impacts of alcohol.[12] We can also look to the evidence of the impact on smoking behaviour as a result of the health warnings on cigarette packs to support this case for change.[13]

3**. Restricted sale of alcohol in shops**

There is evidence that most of the alcohol consumed in the UK today is purchased in the 'off-trade' from shops and supermarkets.[14] The removal of restrictions on the hours of sale has eroded the distinction between alcohol and other, every day, groceries and made it accessible 24 hours a day.

Pre-loading (the drinking of shop-bought alcohol before going out) has added to the night time drunkenness that is often witnessed in our cities.[15]

Scotland has recently introduced new restrictions by creating a distinction between alcohol and other food and drink products – all alcoholic products must be located in one place and all price promotions are prohibited.

4**. Taxation**

Current taxation methods for wine and beers are based on alcohol content thresholds, rather than the precise volume of alcohol a product contains. This merely encourages the alcohol industry to sell products that have the highest possible alcohol strengths just below a particular threshold – and so avoid paying higher rates of tax and also persuade the consumer that high alcohol content equals 'value'.

The most perverse pricing incentive in the UK is the high cost of alcohol-free drinks in pubs and bars, discouraging consumers from choosing them.

5**. Licensing legislation**

Attempts have been made in recent years to address the amount of alcohol-related violence and disorder by bringing together the various public services affected. This can result in targeting of problem areas, exclusion of problem individuals and tougher licensing requirements on 'problem' establishments.

Evidence of the efficacy of intelligence sharing has been demonstrated in Cardiff where the Cardiff Violence Prevention Programme brought together the local council, police and A&E to develop a strategy for tackling alcohol-related violence and drunkenness.[16]

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11 Purshouse, R.C. et al. (2009) Modelling to assess the effectiveness and cost-eff ectiveness of public health related strategies and interventi on to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group. Sheffi eld: University of Sheffi eld.

12 Agostinelli, G., Grube, J.W. (2002) Alcohol counteradvertising and the media: A review of recent research. Alcohol Research & Health 26(1): pp 15-21.

13 Cox, E.P., Wogalter, M.S., Stokes, S.L., Tipton Murff , E.J. (1997) Do product warnings increase safe behaviour? A meta-analysis. Journal of Public Policy & Marketing, 16(2): pp 195-204.

14 British Beer & Pub Association (2011) Statistical Handbook. London: BBPA.

15 Hughes, K., Anderson, Z., Morleo, M., Bellis, M.A. (2008) Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes. Addiction 103(1): pp 60-65. doi: 10.1111/j.1360-0443.2007.02030.x

16 Warburton, A.L. and Shepherd, J.P. (2004) Development, utilisation, and importance of accident and emergency department derived assault data in violence management. Emergency Medical Journal, 21 pp 473-477.

Additionally, bars and clubs need to take responsibility for reducing violence and disorder by taking measures such as providing cheap or free soft drinks, managing customers on entry, securing adequate transport and staggered closing times.[17]

Programmes currently in existence can also assist, including 'Best Bar None', a collaboration between the Home office and the alcohol industry that encourages partnerships between bar owners, the police and local authorities.

**These measures are useful in reducing late night trouble but their impact is limited while the fundamental driver of cheap, shop bought alcohol remains.**

**6. Advertising and sponsorship**

There is overwhelming evidence to suggest that exposure to alcohol advertising influences the behaviour of young people, encouraging them to start drinking earlier or increase their current levels of consumption.[18],[19] Because of the different types of media outlets now available, there is also evidence that young people are more exposed to alcohol advertising than adults.[20]

A European study found that young people in the UK aged 10-15 years viewed more alcohol advertisements on TV than adults aged 25 and above.[21]

Evidence from tobacco control demonstrates that comprehensive bans on advertising and promotion are highly effective – in Europe, advertising bans have been the second most effective way of reducing consumption of cigarettes after taxation.[22, 23]

7. Establishment of an independent body to regulate alcohol promotion

The alcohol industry's Portman Group introduced a voluntary code of practice on the Naming, Packaging and Promoting of Alcoholic drinks in 1996. This is adjudicated by an independent complaints panel.

The current UK system for regulating alcohol advertising is a mixture of self-regulation (non- broadcast) and co-regulation for broadcast advertising. This system is maintained and paid for by the alcohol industry and enforced by the Advertising Standards Authority.[24]

Despite the ASA being an independent regulator, it is funded by a levy on advertising space and so cannot be the truly independent body that this strategy calls for.[25]

8. Reduced limits for driving

The North Review of the Drink and Drug Driving Law noted that a driver with a blood/alcohol concentration of between 50-80mg/100ml is six times more likely to die in a crash than a driver who has consumed no alcohol.[26]

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17 Brookman, F., Maguire, M. (2003) Reducing Homicide, Summary of the Review of Possibilities. RDS Occasional Paper 84. London: Home Office.

18 Smith, L. A., Foxcroft , D. R. (2009) The effect of alcohol advertising, marketi ng and portrayal on drinking behaviour in young people: Systemati c review of prospecti ve cohort studies. BMC Public Health 9: p 51. doi: 10.1186/1471-2458-9-51

19 Anderson, P. et al. (2009) Impact of alcohol adverti sing and media exposure on adolescent alcohol use: A systemati c review of longitudinal studies. Alcohol and Alcoholism 44(3): pp 229-243. doi: 10.1093/alcalc/ agn115

20 House of Commons Health Committee (2010) Alcohol: First Report of Session 2009-10, Volume 1. London: The Stationery Office.

21 Winpenny, E. et al. (2012) Assessment of young people's exposure to alcohol marketing in audiovisual and online media. Cambridge: RAND Europe.

22 Saffer, H., Chaloupka F. (2000) The effect of tobacco advertising bans on tobacco consumpti on. Journal of Health Economics 19(6): pp 1117-1137. doi: 10.1016/S0167-6296(00)00054-0

23 Blecher, E. (2008) The impact of tobacco advertising bans on consumpti on in developing countries. Journal of Health Economics 27(4): pp 930-942. doi: 10.1016/j.jhealeco.2008.02.010

24 Hastings, G. et al. (2010) Failure of self regulation of UK alcohol advertising (Alcohol advertising: the last chance saloon). BMJ 340: p b5650. doi: 10.1136/bmj.b5650

25 McCreanor, T. et al. (2005) Consuming identities: Alcohol marketing and the commodification of youth experience. Addiction Research & Theory 13(6): pp 579-590. doi: 10.1080/16066350500338500

26 North, P. (2010) Report of the Review of Drink and Drug Driving Law. London: Department for Transport.

A review from NICE indicated that lowering the existing limit of 80mg/100ml would reduce fatalities by 6.4% and injuries by 1.4% in the first year after its implementation.[27] Scotland and Northern Ireland are both already considering this change.

There is further evidence from Australia to support the implementation of random breath-testing, with alcohol-related fatalities reducing by 33% and injuries by 17% when random breath-testing was introduced.[28]

Younger people have lower tolerance levels to alcohol and so there is also a case for setting a lower blood alcohol limit for young drivers.[29] Alternatively, there is good evidence from USA, Canada, New Zealand and Australia that a more effective method is the introduction of graduated driver licensing which places restrictions on young drivers and had resulted in a reduction in the number of crashes involving young people.[30]

9. Early identification and advice

There is good evidence of the effectiveness and cost effectiveness of opportunistic early identification and brief advice delivered by general practitioners and other health and social care professionals in reducing levels of harmful consumption amongst at-risk drinkers.[31, 32] However, as acknowledged by NICE, the implementation of alcohol brief interventions remains patchy and insufficient. More widespread implementation within health, social care and criminal justice services would have a significant impact on reducing the costs of alcohol to the NHS and wider society.[33, 34]

This strategy therefore calls for training for all health and social care professionals to routinely deliver alcohol brief interventions.

10. Support for those with alcohol problems

Currently only 6% of those people aged between 16 and 65 who are alcohol dependent receive treatment each year in England, and in 2008 the average spending on alcohol treatment per person was £197, compared to £1,744 for problem drug use.[35]

This Strategy calls for all people needing support with alcohol problems to be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment.

## What do the public think?

There is increasing public support for tackling the harm from alcohol in the UK. As part of the Strategy development, a national public opinion survey was conducted by YouGov in June 2012 inluding a sample of 2,075 adults recruited from a UK panel of 350,00 individuals. The results were weighted to ensure representation of the entire adult population in the UK:

- The majority of respondents thought that the nation's relationship with alcohol is unhealthy, even though most people in the UK do drink alcohol.
- Four out of five respondents thought that alcohol harms children and families 'a great or fair amount'.

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27 Rafia, R., Brennan, A. (2010) Modelling methods to estimate the potential impact of lowering the blood alcohol concentration limit from 80mg/100ml to 50mg/100ml in England and Wales. Report to the National Institute for Health and Clinical Excellence. Sheffi eld: ScHARR: University of Sheffi eld.

28 Peek-Asa, C. (1999) The eff ect of random alcohol screening in reducing motor vehicle crash injuries. In: Babor, T. et al. (2010) Alcohol: No ordinary commodity: Research and public policy. Oxford: Oxford University Press; pp171-172.

29 North, P. (2010) op cit.

30 Russell, K.F., Vandermeer, B., Hartling, L. (2011) Graduated driver licensing for reducing motor vehicle crashes among young drivers. Cochrane Database of Systemati c Reviews, Issue 10. Art. No.: CD003300. Doi: 10.1002/14651858.CD003300.pub3.

31 Kaner, E.F.S. et al. (2007) Eff ecti veness of brief alcohol interventi ons in primary care populations. Cochrane Database of Systemati c Reviews Issue 2. Art. No. CD004148. doi: 10.1002/14651858.CD004148. pub3

32 Jonas, D.E. et al. (2012) Screening, behavioral counseling, and referral in primary care to reduce alcohol misuse, Comparati ve Eff ecti veness Review Number 64. Rockville, MD: Agency for Healthcare Research and Quality (USA).

33 NICE (2010) Alcohol-use disorders: preventing the development of hazardous and harmful drinking. NICE Public Health Guidance 24. London: National Institute for Health and Clinical Excellence.

34 NICE (2011) Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE Clinical Guidelines 115. London: Nati onal Insti tute for Health and Clinical Excellence.

35 National Audit Office (2008) Department of Health Reducing Alcohol Harm: health services in England for alcohol misuse. London: The Stati onery Office.

- Other commonly cited concerns about the negative effects of alcohol on society related to health, social disorder, the cost to the police and NHS.
- Cheapness and easy availability were both identified as key factors in the problem.
- Most understood the principle of minimum unit pricing and more supported than opposed this proposal.
- Alcohol promotion was seen as a big problem – especially children's exposure to it.
- Warning labels on drinks packaging was seen to be as relevant to educating the public in a similar way as fat and salt warnings on foodstuffs and warning labels on cigarettes.

## What are the targets included in Health First?

While all of the above are commendable, more ambitious action, accompanied by targets, is needed to drive progress. 'Health First' includes the following targets:

- **To reduce alcohol sales in the UK from 10.2 to 8 litres of pure alcohol per adult per year by 2020**

- **To reduce the rate of liver deaths from 11.4 to 4 per 100,000 by 2020**

- **For the UK Government and the devolved administrations to develop appropriate alcohol policy targets for each of the nations and regions of the UK**