House of Commons

Science and Technology Committee

Alcohol guidelines

Eleventh Report of Session 2010–12

EMBARGOED ADVANCE COPY
Not to be published
in full, or in part, in any form before
00.01am on Monday 9 January 2012

HC 1536

House of Commons

Science and Technology Committee

Alcohol guidelines

Eleventh Report of Session 2010–12

Report, together with formal minutes, oral and written evidence

Additional written evidence is contained in Volume II, available on the Committee website at www.parliament.uk/science

Ordered by the House of Commons
to be printed 7 December 2011

HC 1536
Published on 9 January 2012
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

Science and Technology Committee

The Science and Technology Committee is appointed by the House of Commons to examine the expenditure, administration and policy of the Government Office for Science and associated public bodies.

Current membership

Andrew Miller (*Labour, Ellesmere Port and Neston*) *(Chair)*
Gavin Barwell (*Conservative, Croydon Central*)
Gregg McClymont (*Labour, Cumbernauld, Kilsyth and Kirkintilloch East*)
Stephen McPartland (*Conservative, Stevenage*)
Stephen Metcalfe (*Conservative, South Basildon and East Thurrock*)
David Morris (*Conservative, Morecambe and Lunesdale*)
Stephen Mosley (*Conservative, City of Chester*)
Pamela Nash (*Labour, Airdrie and Shotts*)
Jonathan Reynolds (*Labour/Co-operative, Stalybridge and Hyde*)
Graham Stringer (*Labour, Blackley and Broughton*)
Roger Williams (*Liberal Democrat, Brecon and Radnorshire*)

Powers

The Committee is one of the departmental Select Committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No.152. These are available on the Internet via www.parliament.uk

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at http://www.parliament.uk/science. A list of reports from the Committee in this Parliament is included at the back of this volume.

The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

Committee staff

The current staff of the Committee are: Mrs Elizabeth Flood (Clerk); Dr Stephen McGinness (Second Clerk); Dr Farrah Bhatti (Committee Specialist); Xameerah Malik (Committee Specialist); Andy Boyd (Senior Committee Assistant); Julie Storey (Committee Assistant); Henry Ayi-Hyde (Committee Support Assistant); and Becky Jones (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Science and Technology Committee, Committee Office, 7 Millbank, London SW1P 3JA. The telephone number for general inquiries is: 020 7219 2793; the Committee's e-mail address is: scitechcom@parliament.uk.

Contents

Report

Summary

The UK Health Departments first introduced the concept of sensible drinking to the public in 1981, and in 1987, the "sensible limits" for drinking were defined as 21 units of alcohol a week for men and 14 for women—guidelines that were endorsed by the medical Royal Colleges.

By the early 1990s, scientific evidence had emerged suggesting that alcohol consumption might reduce the risk of coronary heart disease (CHD), prompting a review of the guidelines. The resulting 1995 report *Sensible Drinking*, which has formed the basis of individual drinking guidelines since, concluded the evidence showed that low daily intake of alcohol conferred protection from CHD mortality. It therefore recommended that drinking guidelines should be couched in daily terms: men should not regularly drink more than three to four units a day and women no more than two to three units a day. We found a lack of expert consensus over the health benefits of alcohol. We are sceptical about using the purported health benefits of alcohol as a basis for daily guidelines for the adult population, particularly as it is clear that any protective effects would only apply to men over 40 years and post-menopausal women.

While public awareness of the existence of guidelines was high, a deeper understanding of what the guidelines were and of what a unit of alcohol looked like was lacking. Because there is very little evidence that the guidelines have been effective at changing behaviour, the Government should treat the guidelines as a tool for informing the public. Efforts should be focused on helping people to understand the guidelines and how to use them.

The Government is working with the drinks industry to ensure that over 80% of alcoholic products will have labels with alcoholic unit content and the drinking guidelines by 2013. The Government should remain mindful that sensible drinking messages may conflict with the business objectives of drinks companies and exercise proper scrutiny and oversight. The Government should conduct an interim assessment of the pledge in December 2012 rather than waiting for the target date of December 2013.

There are sufficient concerns about the current drinking guidelines to suggest that a thorough review of the evidence concerning alcohol and health risks is due. The Department of Health and devolved health departments should establish a working group to review the evidence and advise whether the guidelines should be changed. In the meantime, the evidence suggests that (i) in the context of the current daily guidelines, the public should be advised to take at least two alcohol-free days a week; and (ii) the sensible drinking limits should not be increased.

1 Introduction

The inquiry

1. Alcohol has been produced and consumed by humans for thousands of years and is an accepted part of our society today. Although it has applications in medicine and industrial processes, its most popular use is as an intoxicant. Drunk in moderation, alcohol can provide enjoyment and encourage social cohesion. Excessive drinking, on the other hand, is viewed as a serious problem with a range of health, social and economic consequences.

2. Despite the long history of alcohol consumption and misuse in the UK, Government guidance on individual drinking was not developed until the 1980s. Since then, successive governments have produced various alcohol strategies and policies aimed at reducing alcohol misuse and its consequences. After the Coalition Government was formed in May 2010, it outlined its plans for alcohol policy in the document *The Coalition: Our Plan for Government*, focusing on pricing, taxation and availability of alcohol.[1] In March 2011, the Government produced the *Public Health Responsibility Deal*, in which its core commitment on alcohol was described: to "foster a culture of responsible drinking, which will help people to drink within guidelines".[2] We were interested in the robustness of the guidelines, particularly as they are a foundation for alcohol policies yet have not been the subject of recent Parliamentary scrutiny. We were also interested in the differences in approaches among the devolved administrations. We decided to explore how evidence-based the Government's guidelines on alcohol consumption are and how well they are communicated to and understood by the public. In July 2011, we issued a call for evidence, seeking written submissions on the following questions:

a) What evidence are Government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed?

b) Could the evidence base and sources of scientific advice to Government on alcohol be improved?

c) How well does the Government communicate its guidelines and the risks of alcohol intake to the public?

d) How do the UK Government's guidelines compare to those provided in other countries?[3]

3. We received 29 written submissions. On 12 October 2011 we took oral evidence from Professor Sir Ian Gilmore, Royal College of Physicians; Dr Richard Harding, Member of the 1995 Interdepartmental Working Group on *Sensible Drinking*; Professor Nick Heather, Alcohol Research UK; Dr Marsha Morgan, Institute of Alcohol Studies; Jeremy Beadles, Chief Executive, Wine and Spirit Trade Association; Professor Averil Mansfield, British

[1] Cabinet Office, *The Coalition: Our Plan for Government*, May 2010, p 13

[2] Department of Health, *The Public Health Responsibility Deal*, March 2011, p 10

[3] "Committee announces new inquiry into the evidence base for alcohol guidelines", Science and Technology Committee press notice, 19 July 2011

Medical Association; and Chris Sorek, Chief Executive, Drinkaware. On 26 October 2011 we took oral evidence from Anne Milton MP, Parliamentary Under-Secretary of State for Public Health; Dr Mark Prunty, Senior Medical Officer for Substance Misuse Policy, Department of Health; and Chris Heffer, Deputy Director, Alcohol and Drugs, Department of Health. We would like to thank everyone who provided oral and written evidence to our inquiry.

Structure of the report

4. The risks posed by alcohol consumption range from health to social harms. While we recognise the importance of strategies to deal with social harms, in this inquiry we have focused primarily on health harms as these are the basis of the Department of Health's alcohol guidelines. Chapter 2 of this report provides background information and chapter 3 looks at the evidence base underpinning the current guidelines and at scientific evidence that has emerged since the guidelines were last reviewed. Chapter 4 examines public understanding and communication of the guidelines and of the health risks posed by drinking.[4]

[4] Throughout this report, "drinking" refers specifically to drinking alcohol.

2 Background

History of alcohol guidelines

5. Concerns about the rising number of alcohol-related deaths and illnesses in the 1970s prompted the Government to produce a consultative document *Prevention and Health: Everybody's Business*.[5] The focus of that document, however, was on overall levels of alcohol consumption and on corresponding legal, fiscal and social controls. At the individual level, alcohol consumption remained a matter of personal choice.[6] In 1981, the UK Health Departments published the booklet *Drinking Sensibly*, which provided a definition of alcohol misuse and introduced the concept of sensible drinking. The booklet called for a programme of public education about sensible drinking.[7] It was not until 1984 that guidance on individual drinking was produced, in a pamphlet *That's the Limit*, published by the then Health Education Council. The pamphlet gave "safe limits" for drinking, defined as 18 "standard drinks" a week for men and 9 for women. One standard drink was equivalent to one alcohol unit—a concept that would be introduced in the next edition. The pamphlet also defined "too much" alcohol as 56 standard drinks a week for men and 35 for women.[8] The 1987 edition of the leaflet described units for the first time and revised the 1984 guidelines down to "sensible limits"—described as the amount to which people should limit their drinking if they wanted to avoid damaging their health—as 21 units a week for men and 14 for women, with "too much" defined as 36 units for men and 22 for women. A 1989 edition of the pamphlet contained the same guidelines.[9] In 1986 and 1987, the three medical Royal Colleges—the Royal College of General Practitioners, the Royal College of Physicians and the Royal College of Psychiatrists—produced reports on alcohol that endorsed the Health Education Council's 1987 guidelines on sensible drinking.[10]

6. The advice of the Royal Colleges and Health Education Council was officially adopted by government in 1987, in a report that stated "the Government does not wish to discourage the sensible consumption of alcohol, but is committed to reducing alcohol related harm".[11] In 1992 the sensible drinking message was used to set targets for the reduction of alcohol misuse in *The Health of the Nation* and other national health strategies.[12]

7. By the early 1990s, however, scientific evidence had emerged suggesting that alcohol might reduce the risks of coronary heart disease (CHD), prompting the Government to set up an inter-departmental working group to review the guidelines in 1994. The working

[5] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, Annex E

[6] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, Annex E

[7] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, Annex E

[8] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, Annex E

[9] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, Annex E

[10] Ev 27 [Department of Health] para 1; The Royal College of General Practitioners, *Alcohol: a balanced view* , 1987; The Royal College of Psychiatrists, *Alcohol: our favourite drug,* 1986; and The Royal College of Physicians, *A Great and Growing Evil: the medical consequences of alcohol abuse*, 1987

[11] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, Annex E

[12] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, Annex E

group produced the 1995 report *Sensible Drinking*, that has formed the basis of individual drinking guidelines since. The most significant change to the Government guidelines was the move from weekly limits to daily limits. The Royal Colleges also revisited the issue in 1995, including a review of the evidence linking alcohol and CHD, and concluded that the guidelines adopted in 1987 were still sufficient.[13] This marked a divergence in opinion between the Government and Royal Colleges that is explored further in the next chapter.

8. The Government's sensible drinking message, based on the analysis in the 1995 report and agreed by the devolved health departments, is that:

a. men should not regularly drink more than three to four units a day;

b. women should not regularly drink more than two to three units a day; and

c. after an episode of heavy drinking, it is advisable to refrain from drinking for 48 hours to allow tissues to recover.[14]

9. The 1995 Sensible Drinking report contained guidance for pregnant women, which was that "to minimise risk to the developing fetus, women who are trying to become pregnant or are at any stage of pregnancy, should not drink more than 1 or 2 units of alcohol once or twice a week, and should avoid episodes of intoxication".[15] Following revised guidelines published by the Chief Medical Officers in 2006 and advice from the National Institute of Health and Clinical Excellence (NICE), current guidance for pregnant women in England is that:

> pregnant women or women trying to conceive should avoid drinking alcohol; if they do choose to drink, to minimise the risk to the baby, they should not drink more than one to two units of alcohol once or twice a week and should not get drunk.
>
> NICE additionally advised that the risks of miscarriage in the first three months of pregnancy mean that it is particularly important for a woman not to drink alcohol at all during that period.[16]

10. Until 2009, alcohol consumption guidelines had been produced only for adults. The 1995 report considered alcohol consumption by children and young people "very briefly".[17] The Chief Medical Officer for England published specific guidance on the consumption of alcohol by children and young people in 2009. The advice was that:

- An alcohol-free childhood is the healthiest and best option;
- If children do drink alcohol, they should not do so until at least 15 years old;
- If 15 to 17 year olds drink alcohol, it should be rarely, and never more than once a week. They should always be supervised by a parent or carer; and

---

[13] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, Annex E

[14] Ev 27 [Department of Health] para 3

[15] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, p 27

[16] Ev 27 [Department of Health] para 6

[17] Ev 27 [Department of Health] para 8

- If 15 to 17 year olds drink alcohol, they should never exceed the recommended adult daily limits (3-4 units of alcohol for men and 2-3 units for women).[18]

Alcohol units

11. Units are a fundamental concept used in alcohol guidelines. In the UK, one unit is 8 grams (g) of alcohol.[19] One unit, or 8 g, is equivalent to 10 millilitres (ml) of pure ethanol (alcohol), which is the amount of alcohol the average adult can process within an hour.[20] This means that if the average adult consumes a drink containing one unit of alcohol, within an hour there should in theory be no alcohol left in their bloodstream, although it will of course differ according to the individual.[21] Approximately, one unit equates to a 25 ml measure of spirit or half a pint of beer, whereas a 175 ml glass of wine contains two units,[22] although the situation is complicated by the differing strengths of alcoholic beverages. The strength of an alcoholic beverage is commonly expressed as alcohol by volume (ABV) or sometimes just "vol.".[23] For example, if a 750 ml bottle of wine contains 12 per cent ABV, this means that 12 per cent of the total volume of wine (750 ml) is pure alcohol, which works out to 90 ml alcohol, or 9 units. Within a 175 ml glass of 12 per cent ABV wine, there will be 2.1 units. A 750 ml bottle of wine with 13 per cent ABV, on the other hand will contain 9.8 units of alcohol and a 175 ml glass of that wine will contain 2.3 units.

International comparisons

12. Table 1 summarises recommended drinking guidelines from a range of developed countries.

[18] Ev 28 [Department of Health] para 9

[19] Ev 30 [Department of Health] para 28

[20] Alcohol Units: your guide to alcohol units and measures", *Drinkaware*, 25 Oct 2011, Drinkaware.co.uk

[21] Alcohol Units: your guide to alcohol units and measures", *Drinkaware*, 25 Oct 2011, Drinkaware.co.uk

[22] Ev 55 [Drinkaware] para 2.6

[23] Alcohol Units: your guide to alcohol units and measures", *Drinkaware*, 25 Oct 2011, Drinkaware.co.uk

Table 1: International comparisons of recommended alcohol consumption guidelines (countries ranked according to male daily guidelines)[24]

Country (ranked low to high)	Unit/ standard drink	Men	Women
Japan	19.75 g	1-2 units/day (19.75-39.5 g/day)	
United States	14 g	1-2 units/day (14-28 g/day), not to exceed 14 units/week (196 g/week)	1 unit/day (14 g/day), not to exceed 7units/week (98 g/week)
Australia	10 g	no more than 2 standard drinks (20 g) on any day reduces lifetime risk	no more than 2 standard drinks on any day
Poland	10 g	2 units/day (20 g/day) up to 5 times/week (not to exceed 100 g/week)	1 unit/day (10 g/day) up to 5 times/week (not to exceed 50 g/week)
Slovenia	N/A	not to exceed 20 g/day and 50 g on a drinking occasion	not to exceed 10 g/day and not to exceed 30 g/drinking occasion
Sweden	N/A	not to exceed 20 g/day	not to exceed 20 g/day
Czech Republic	N/A	less than 24 g per day	less than 16 g per day
Austria	10 g	24 g pure ethanol per day	16 g pure ethanol per day
Finland	11 g	not to exceed 15 units/week (165 g/week) *[equivalent to 24 g/day]*	not to exceed 10 units/week (110 g/week)
Germany		not to exceed 24 g/day	not to exceed 12 g/day
United Kingdom	**8 g**	**should not regularly drink more than 3-4 units/day (24-32 g/day)**	**should not regularly drink more than 2-3 units/day (16-24 g/day)**
Canada	13.6 g	not to exceed 2 units per day (27.2 g/day); 14 units per week (190 g/week)	not to exceed 2 units/day (27.2 g/day); 9 units per week (121.5 g/week)
Portugal	14 g (unofficial)	2-3 units/day (28-42 g/day)	1-2 units/day (14-28 g/day)
Spain	10 g	not to exceed 3 units/day (30 g/day)	not to exceed 3 units/day (30 g/day)
New Zealand	10 g	not to exceed 3 units/day (30 g/day), 21units/ week (210 g/week)	not to exceed 2 units/day (20 g/day), 14 units/week (140 g/week)
France	10 g	not to exceed 30 g/day	not to exceed 30 g/day
Ireland	10 g	21 units/week (210 g/week) *[equivalent to 30 g/day]*	14 units/week (140 g/week)
Romania	N/A	not to exceed 32.5 g beer/day or 20.7 g wine/day	not to exceed 32.5 g beer/day or 20.7 g wine/day
Denmark	12 g	not to exceed 21 alcohol units (252 g) a week *[equivalent to 36 g a day]*	not to exceed 14 (168 g) units a week
South Africa	N/A	not to exceed 21 units/week (252 g/week) *[equivalent to 36 g/day]*	not to exceed 14 units/week (168 g/week)
Nether-lands	9.9 g	not to exceed 4 units/day (39.6 g/day)	not to exceed 2 units/day (19.8 g/day)
Italy	12 g	less than 40 g per day	less than 40 g per day

It is worth noting that units vary by country, for example one unit of alcohol in the United States is 14 g and in Japan a unit is significantly larger at almost 20 g.[25] International

[24] Ev 45 [The British Beer & Pub Association, The National Association of Cider Makers, The Scotch Whisky Association and The Wine and Spirit Trade Association]

comparisons, therefore, should be adjusted to represent a like-for-like basis. The Sheffield Addiction Research Group considered that "the UK drinking guidelines can be considered as in line with other developed nations and there appears no case to be made for altering them on the basis of international consensus" and stated:

> As different nations define a unit of alcohol differently or base guidelines upon the notion of a 'standard drink', it is easier to compare guidelines after converting recommended levels into pure alcohol consumption in grams. [...]
>
> The UK guidelines recommend not regularly drinking more than 24–32 g of pure alcohol a day if you are a man and not more than 16-24 g if you are a woman. These levels are similar to those used in many other nations such as Italy (24–36 g and 12–24 g), the USA (24 g and 14 g), France (30 g and 20 g), Germany (36 g and 24 g) and New Zealand (30 g and 20 g). Some nations do have slightly higher recommendations, particularly for men, such as The Netherlands and Spain (both 40 g and 24 g). Few nations have significantly lower guidelines and those that do include Denmark (21 g and 14 g), Poland (20 g and 10 g) and Slovenia (20 g and 10 g).[26]

Dr Richard Harding, member of the 1995 *Sensible Drinking* working group, told us:

> World-wide recommendations on alcohol consumption show wide disparity among countries. This is in some ways surprising, given that the science is the same everywhere. But the objective of those who frame such guidance is to influence their target populations. It follows therefore that several factors then become relevant, e.g. the behaviour that is thought to be in need of change, the culture and mindset of the target population, and the kind of message that is likely to be effective.
>
> Therefore the best approach is to formulate advice firmly based on and argued from the science, but that which is also appropriate to the problems that the UK face and is likely to be effective, and not to take much notice of what other governments or health bodies recommend.[27]

13. **The UK's alcohol guidelines are about average, compared with those of other developed nations. However, national guidelines can reflect social objectives and cultural differences as well as scientific evidence, and therefore we do not consider that international comparisons should be relied on as an indicator of how appropriate the UK's alcohol guidelines are.**

14. Aside from additions to the advice for pregnant women and children, the guidelines have not been the subject of a formal review since 1995.[28] The next chapter explores the evidence base for the current guidelines.

---

[25] Ev 45 [The British Beer & Pub Association, The National Association of Cider Makers, The Scotch Whisky Association and The Wine and Spirit Trade Association] para 27

[26] Ev w25, paras 4.1–4.3

[27] Ev 50, paras 34-35

[28] Ev 28 [Department of Health] para 10

3 The evidence base

The 1995 Sensible Drinking report

15. As explained in the previous chapter, today's alcohol guidelines arose from a review of the Government's sensible drinking message in the light of evidence which indicated that drinking alcohol might give protection from coronary heart disease.[29] The findings of the review were published in the 1995 report *Sensible Drinking*.[30] The Department of Health explained the process that the working group had followed:

> The authors of the 1995 report drew upon a wide range of research, including epidemiological evidence, and written and oral advice of experts, as set out in the report. The report considers the harmful effects of alcohol consumption to both health and mortality and considers the evidence for its potential benefits. [...]
>
> The 1995 report carefully described the scientific basis for its recommendations, which included review by the authors of the major published research evidence, review of written evidence submitted by a wide range of contributors, independent assessment and critique of the medical and scientific evidence by an external academic statistician, and receipt of oral evidence by invited key experts.[31]

16. Sources of evidence to the 1995 review included relevant reports of the various Royal Colleges.[32] As mentioned in paragraph 5, these reports had re-endorsed the 1987 consumption guidelines of no more than 21 units of alcohol for men and 14 for women per week.[33]

Weekly vs. daily guidelines

17. Possibly the most significant change in the guidelines following the 1995 *Sensible Drinking* report was the move from providing weekly guidelines to daily guidelines. Dr Richard Harding, member of the 1995 *Sensible Drinking* working group, explained that the working group had thought it sensible to move away from advice based on weekly consumption in favour of daily consumption because "weekly drinking could mask episodes of heavy drinking (21 units/week could be consumed in two binges of 10 units each)". The working group also considered that it was difficult for individuals to keep account of their own consumption over a week. Furthermore, there was evidence that showed there could be benefit in regular drinking, so long as it was moderate. As a result, the working group decided to couch advice in terms of daily drinking.[34]

---

[29] Department of Health, Sensible Drinking: Report of an inter-departmental working group, 1 December 1995

[30] Department of Health, Sensible Drinking: Report of an inter-departmental working group, 1 December 1995

[31] Ev 27, paras 1–2

[32] Ev 27 [Department of Health] para 1; The Royal College of General Practitioners, *Alcohol: a balanced view* , 1987; The Royal College of Psychiatrists, *Alcohol: our favourite drug,* 1986; and The Royal College of Physicians, *A Great and Growing Evil: the medical consequences of alcohol abuse*, 1987

[33] Department of Health, *Sensible Drinking: Report of an inter-departmental working grou*p, 1 December 1995, Annex E

[34] Ev 48 [Dr Richard Harding] para 26

The *Sensible Drinking* report therefore stated that for men:

> Regular consumption of between 3 and 4 units a day by men of all ages will not accrue significant health risk.
>
> Consistently drinking 4 or more units a day is not advised as a sensible drinking level because of the progressive health risk it carries.[35]

And for women:

> Regular consumption of between 2 and 3 units a day by women of all ages will not accrue any significant health risk.
>
> Consistently drinking 3 or more units a day is not advised as a sensible drinking level because of the progressive health risk it carries.[36]

18. Two concerns were raised about the shift to daily guidance. First, the change appeared to increase the weekly "allowance" of alcohol from 21 for men and 14 for women to 28 for men and 21 for women. The Institute of Alcohol Studies (IAS) argued that the move:

> effectively increased the weekly limit for men by 33 per cent and women 50 per cent, exceeding the recommended threshold for low risk drinking as presented by the medical profession. These changes were met with concern by the health community, as they contradicted the evidence base.[37]

Secondly, some felt that the move "appeared to endorse daily drinking".[38] This issue is examined in paragraph 49 where we look at drinking patterns.

Health benefits of drinking alcohol

19. The primary rationale for the shift to daily guidelines was evidence that regularly drinking alcohol at low quantities may confer health benefits, particularly in relation to coronary heart disease (CHD), which, according to Dr Marsha Morgan, Institute of Alcohol Studies, is where "the biggest body of evidence on the potential beneficial effects of alcohol" lies.[39] According to the 1995 *Sensible Drinking* report, "the evidence shows alcohol consumption confers protection from CHD mortality, starting at levels as low as 1 unit a day".[40] However, the report also cautioned that there was only a slight dose response relationship, meaning that drinking more than one to two units a day "confers only a little extra benefit" and that at very high levels of consumption, the risk of mortality increases.[41]

20. The report summarised possible biological mechanisms that would explain the beneficial effect, although it acknowledged that a causative mechanism had not been firmly

---

[35] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995

[36] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995

[37] Ev 74 [Institute of Alcohol Studies] para 1

[38] Ev w32 [Grampian Alcohol and Drugs Partnerships] para 3.1.2

[39] Q 10

[40] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, para 5.5

[41] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, para 5.5

established. It explained that a major cause of CHD is deposition of fatty tissues in coronary arteries, largely consisting of cholesterol, which cause narrowing or blockages of arteries. In blood, two types of protein work to either increase or decrease cholesterol levels. Simply put, low density lipoproteins (LDL) carry most of the cholesterol in blood and high density lipoproteins (HDL) remove cholesterol. It is the ratio of LDL and HDL that determines how much cholesterol is deposited in fatty tissues in arteries. The report stated that:

> Physical activity appears to raise HDL cholesterol but does not change LDL cholesterol levels. Alcohol, more than any other dietary factor, raises HDL levels in the blood. In addition, however, alcohol lowers LDL blood levels, and it has been speculated that it is through these lipoprotein cholesterol pathways that alcohol inhibits the formation of coronary [fatty tissues].[42]

Another significant biological mechanism was thought to be that alcohol reduced blood clotting. Additional and less widely acknowledged mechanisms were also offered, including that alcohol:

a) might lower blood pressure;

b) caused increased blood flow;

c) could reduce coronary artery spasm induced by stress.[43]

However the report noted that "the full significance of these additional mechanisms awaits further research".[44] The submission from the International Scientific Forum and Alcohol in Moderation stated that "the message is little and often as the blood thinning effect of alcohol lasts for approximately 24 hours and one drink confers the benefit".[45] Interestingly, the report also explored the theory that the low rates of CHD in predominantly wine drinking countries could be caused by the presence of antioxidants and other constituents in wine. The report concluded that "overall, current research indicates that the major factor conferring benefit is probably alcohol rather than the other constituents of wine".[46]

21. The report highlighted other potential benefits from drinking alcohol, including mixed evidence for the effects of alcohol on stroke risks and a possible protective effect from gallstones. It had also been reported that there could be a reduced risk of non insulin-dependent diabetes, stress, rheumatoid arthritis, gastro-intestinal diseases and colds, although the report stated that "in our view, this evidence is not sufficiently strong or consistent to inform public policy".[47]

---

[42] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, para 5.7

[43] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995

[44] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, paras 5.8–5.9

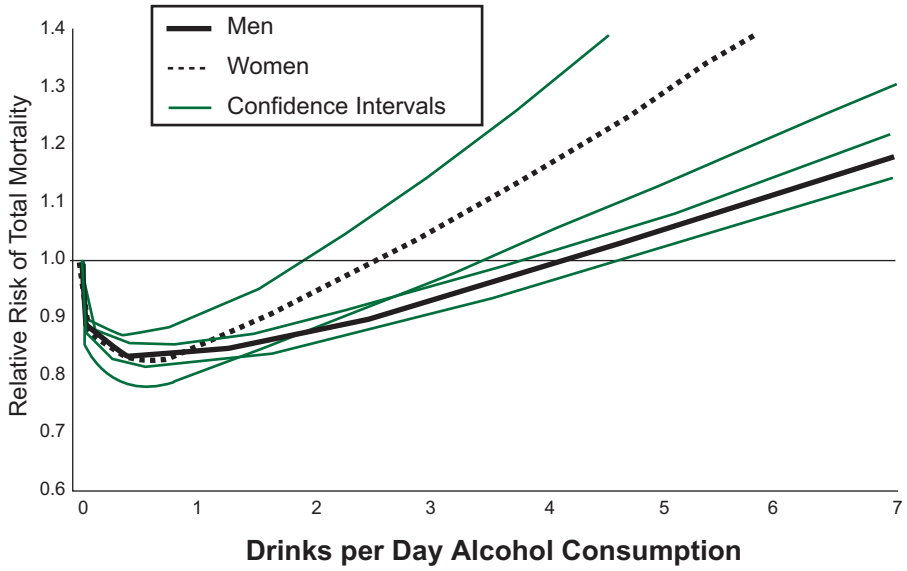
[45] Ev w10, para 1.7

[46] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, para 5.11

[47] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, para 5.20

22. The theory that drinking alcohol at low quantities might confer health benefits greater than abstainers would enjoy, but that drinking alcohol at high quantities increases mortality risk is represented by the J-shaped curve.

Figure 1: The J-shaped curve for all cause mortality and alcohol consumption[48]



Explanatory note: A confidence interval helps assess the likelihood of a result occurring by chance. A confidence interval represents a range of values that is believed to encompass the "true" value with high probability (usually 95%). In figure 1, this means that the wider the gaps between confidence intervals surrounding the trends for men and women, the more uncertainty there is.

The International Scientific Forum on Alcohol Research and Alcohol in Moderation explained that:

> The J shaped curve shows that light and moderate drinkers of any form of alcohol live longer than those who abstain or drink heavily. The relative risk of mortality is lowest among moderate consumers (at the lowest point of the J), greater among abstainers (on the left-hand side of the J), and much greater still among heavy drinkers (on the right-hand side of the J). In addition to longevity in general, the J-shaped relationship also exists for cardiovascular deaths, specifically for coronary heart disease and ischemic stroke.[49]

The greater uncertainty for women, represented by the wider confidence intervals, may be due to a lack of evidence: the Sensible Drinking report noted that "sufficient studies on all cause mortality do not exist to indicate clearly the advantages or disadvantages of alcohol to women as compared to men".[50] This issue is explored further in paragraph 29.

[48] Ev w9 [International Scientific Forum on Alcohol Research and Alcohol in Moderation]

[49] Ev w10, para 1.3

[50] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995

23. The evidence we took during this inquiry suggested that a number of experts were less convinced that alcohol caused beneficial effects in the body. For example, Sir Ian Gilmore, Royal College of Physicians, stated:

> There probably is an effect, but it does not affect the main age group that is damaged by alcohol. The peak deaths from alcohol are among 45 to 65-year-olds, who are in the most productive phase of their lives. Certainly young people damaged by alcohol get no cardio-vascular benefit whatsoever. There are serious scientists who still believe that the apparent cardio-vascular benefits are spurious. [...] I believe it is overplayed as a benefit.[51]

Professor Nick Heather, Alcohol Research UK, agreed, and stated:

> when the "Sensible Drinking" report was written [...] there was much more confidence in the cardio-protective effect, which is reflected in the report [...] That consensus has now largely disappeared, which is the result of more careful research.[52]

Dr Marsha Morgan noted that "there is enormous contention [...] in general" and pointed out that "if there were to be a cardio-protective effect, it would selectively be found in middle-aged men and post-menopausal women, and you do not gain that protective effect in middle life by drinking at a younger age".[53] She also disputed the evidence for other beneficial effects of alcohol and highlighted evidence that had emerged since 1995 on alcohol-related cancer risks:

> The two other areas where there have been alleged protective effects are in the development of diabetes and possibly [...] on the development of cancers. However, the evidence is very thin. There is no body of evidence like that for the cardio-protective effect. Much more important, since the guidelines were last considered in 1995, is that the major body of evidence has been on the detrimental effect of alcohol and the cancer risk, particularly for breast cancer in women, and that the risk levels are not far off the top end of the current guidelines. Although there have been some reports in the press for a protective effect about diabetes and some types of cancer, there is not a strong evidence base.
>
> Equally, there is much more important evidence that we did not have in 1995 which suggests a quite significant risk of cancer of the oropharynx, larynx and oesophagus and cancers among people who already have liver damage, and there is evidence on breast cancer and to a degree some early evidence on bowel cancer. As far as I am concerned, those detrimental effects overwhelm any potential benefit that there might be on diabetes.[54]

24. One reason why the beneficial effects of alcohol are disputed lies in the methods used to gather data and produce studies. To determine whether alcohol has a beneficial effect, the mortality risks of drinkers must be compared to lifelong non-drinkers, or abstainers. We

[51] Q 8

[52] Q 9

[53] Q 10

[54] Q 10

heard that some studies had in fact included "sick quitters"—that is, individuals who abstained from alcohol because "they have an alcohol problem or are unwell"—in the abstainer category.[55] This would make abstainers appears less healthy and thus indicate that there could be health benefits gained from drinking alcohol. Professor Heather stated that more careful research on the cardio-protective effects of alcohol had shown that "people who were classified as lifetime abstainers were not really lifetime abstainers".[56] In response, Dr Richard Harding, member of the working group, stated that:

> The "sick quitter" hypothesis is that the abstainers are unwell and therefore have a higher rate of disease. However, some studies have been large enough to take them out, yet when you omit the sick quitters and lifetime abstainers you still see the effect. In many studies, the confounding factor has been taken care of.[57]

In addition, there are methodological difficulties that arise from proving causation; that is, whether alcohol itself confers health benefits rather than confounding factors such as eating healthily and exercising, which may be common behaviours amongst moderate drinkers. Studies may also be skewed by inaccurate reporting of alcohol consumption by individuals.[58] The Department of Health's view on the matter was that:

> A number of studies have been published since 1995 on the protective effects of low level alcohol consumption. Some have suggested that the effect for coronary heart disease may have been over-estimated [...] We think it likely that the conclusion of the 1995 report that a risk reduction is likely from levels of regular consumption as low as one unit per day, with limited additional benefit at levels above that, is still correct. However, we have acknowledged in advice to the public that a similar reduction of risk may be achieved through other means such as improved diet and exercise.[59]

We asked Anne Milton MP, Parliamentary Under-Secretary of State for Public Health, whether the Government believed that alcohol had beneficial effects. She responded:

> There is, possibly, evidence to suggest that it remains true for older adults. However, a number of experts and research books recently have raised some questions about the robustness of that body of evidence.[60]

Dr Mark Prunty, Senior Medical Officer for Substance Misuse Policy, Department of Health, added:

> It is true that the number of studies has increased and multiplied. There have been major reviews which have looked at the methodology underpinning those studies and questioned their robustness. [...] There is still evidence of the health benefits, particularly for coronary heart disease, but it is certainly true that the concerns about

---

[55] Q 8

[56] Q 8

[57] Q 9

[58] Ev 37 [Alcohol Research UK] paras 2.8.1–2.8.4

[59] Ev 28, para 15

[60] Q 94

> how robust the methodology is and whether there are other confounding factors has strengthened considerably, particularly in the last five to 10 years.
>
> There has also been increasing consensus that many of those benefits are likely to be achieved by other methods as well, such as diet and exercise. Certainly, the British Heart Foundation has come to the conclusion that equal or greater benefit may be accrued by diet and exercise, to which the 1995 report did refer.[61]

25. **There is a lack of consensus amongst experts over the health benefits of alcohol, but it is not clear from the current evidence base how the benefits of drinking alcohol at low quantities compare to those of lifelong abstention. In addition, it seems likely that the same purported health benefits could be gained through a healthy lifestyle. Therefore we are sceptical about using the alleged health benefits of alcohol as a basis for daily alcohol guidelines for the general adult population, particularly as these benefits would apply only to men over 40 years and post-menopausal women and the guidelines are aimed at all adults.**

Older people

26. As mentioned above, the CHD benefits of alcohol would be predominantly applicable to men over 40 years and post-menopausal women. In June 2011, the Royal College of Psychiatrists published a report on alcohol related harm in the elderly. The report concluded that "because of physiological and metabolic changes associated with ageing, these [Department of Health] 'safe limits' are too high for older people; recent evidence suggests that the upper 'safe limit' for older people is 1.5 units per day or 11 units per week".[62] The Institute of Alcohol Studies was critical of the report[63] and the Royal College of Physicians stated:

> there is no arbitrary age when drinking patterns should be advised to change. Individual factors also contribute to the risks of alcohol consumption, including factors such as medication use, co-morbidity and frailty, as well as the physiological changes associated with ageing.
>
> Recommended limits for safe drinking by older people in the UK require further consideration, especially considering the ageing UK population alongside changing drinking patterns, which are expected to increase alcohol-related morbidity and mortality.[64]

27. The International Scientific Forum on Alcohol Research and Alcohol in Moderation considered that despite suggestions that older people should drink below daily guidelines, "moderate, regular consumption within the guidelines helps protect against cardiovascular disease, cognitive decline and all cause mortality, especially among post menopausal women and men over 40".[65] Sir Ian Gilmore, Royal College of Physicians, considered there

[61] Q 95

[62] Ev w43, para 6

[63] Ev 79, Attachment 4

[64] Ev 73, paras 41-42

[65] Ev w12, para 1.20

was a rationale for setting lower limits for older people, based on their "propensity to fall" as well as the prevalence of other diseases.[66] However, he brought the question back to the issue of complexity:

> If you start saying that it should be different for men and women, different for people under 65 and over, different for pregnant and not pregnant women, and different for under age and over 18, you run the risk of getting to a level of complexity that will not be understood by the public.[67]

28. **As the Government provides guidelines for specific population groups such as children and pregnant women already, we consider that there could be merit in producing guidelines for older people, balancing evidence of beneficial effects of alcohol with evidence of increased risks.** We deal with the issues of guideline complexity further in the next chapter.

Women and alcohol

Lower guidelines

29. The 1995 report *Sensible Drinking* recognised the difficulties of providing guidelines for women and alcohol, stating that "the problems of giving accurate advice and information about sensible drinking are nowhere more evident than in this area", explaining that while the broad spectrum of alcohol-related disease and social problems was similar for both sexes, there was a "less secure scientific literature from which to make conclusions about women as compared with men".[68] The report considered physiological differences between men and women and health risks to women such as coronary heart disease, breast cancer and liver disease. The tendency for women to drink less than men at that time was also considered. The report stated that there was, in particular, "very little data linking high levels of consumption in women with a variety of alcohol related diseases".[69] The conclusion was that it was not possible to produce an authoritative statement about women and alcohol as the scientific evidence did not allow that clarity. However, the report stated there was "sufficient indication from the physiology and the patterns of illness for women overall to be advised to drink at lower levels than men".[70]

30. We were interested in exploring whether the basis for the guidelines for women were still considered to be scientifically sound, 16 years after the *Sensible Drinking* report was published. Dr Marsha Morgan explained that:

> women have less body water [than men]. [...] the difference in how the body is made up between fat and water means that, if a woman of 70 kg drinks a double gin, a man of 70 kg would have to drink a triple gin to match her blood alcohol level. Her blood alcohol tends to be about a third higher on a weight-for-weight basis. The tissue dose

---

[66] Q 23

[67] Q 23

[68] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995

[69] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995

[70] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995, para 8.7

> of alcohol that she receives is clearly higher. Overall, the propensity for her to develop harm therefore kicks in earlier, after seemingly less alcohol. That is beautifully demonstrated in studies of the 1970s from Germany, where they looked at the risk of developing cirrhosis of the liver, which kicked in at as low as 20 grams of alcohol per day for women and at about 40 or 50 grams for men. There is a physiological basis to it, and there is epidemiological evidence showing that the risk of harm is higher. That was very much behind the 21:14 differential [...] decided on in 1987. [...] There is a physiological basis for assuming that women are at a different risk, and there is epidemiological evidence that clearly shows that that is the case.[71]

Aside from a minority, such as the Association of Small Direct Wine Merchants, who stated that "suggesting 2–3 units of alcohol a day for women or 3–4 alcohol units a day for men without reference to body size [...] is akin to having driving speed limits of 20–30 MPH for women or 30–40 MPH for men",[72] most of the written submissions we received did not challenge the advice that women should be advised to drink less than men, based on health risks. In fact, it appeared that even more evidence had emerged to support this since 1995. For example, Dr Morgan explained that "since the guidelines were last considered in 1995, [...] the major body of evidence has been on the detrimental effect of alcohol and the cancer risk, particularly for breast cancer in women".[73] However, Dr Harding suggested that as women "are exposed to the risk of cardio-vascular diseases" after the menopause, "the benefit that they gain from moderate consumption after the menopause would outweigh any increased risk of cancer".[74]

31. The issue of whether alcohol confers health benefits has already been discussed in paragraph 19. **We are content that there is sufficient physiological and epidemiological evidence on health risks to support the retention of lower drinking guidelines for women in general.**

Drinking during pregnancy

32. The *Sensible Drinking* report's advice on alcohol and pregnancy was that "to minimise risk to the developing foetus, women who are trying to become pregnant or are at any stage of pregnancy, should not drink more than 1 or 2 units of alcohol once or twice a week, and should avoid episodes of intoxication".[75] In 2006, the UK Chief Medical Officers published revised guidelines taking into account a report commissioned by the Department of Health on the fetal effects of prenatal exposure.[76] The UK Chief Medical Officers advised that "pregnant women or women trying to conceive should avoid drinking alcohol; if they do choose to drink, to minimise the risk to the baby, they should not drink more than one to two units of alcohol once or twice a week and should not get drunk".[77] In England, this was

---

[71] Q 22

[72] Ev w4, para 3.3

[73] Q 10

[74] Q 10

[75] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995

[76] Gray, R. and Henderson J., "Report to the Department of Health: Review of the fetal effects of prenatal alcohol exposure", May, 2006

[77] Ev 27, para 6

followed by guidance from the National Institute for Health and Clinical Excellence (NICE) in 2007, who advised that the risks of miscarriage in the first three months of pregnancy mean that it is particularly important for a woman not to drink alcohol at all during that period.[78] A slight divergence of advice occurs in Scotland, where the Scottish Chief Medical Officer's current advice on alcohol and pregnancy is that "there is no 'safe' time for drinking alcohol during pregnancy and there is no 'safe' amount".[79]

33. It is generally accepted that high alcohol consumption levels can be harmful during pregnancy.[80] However, the expert views we received suggested that no "safe limit" of alcohol consumption had been identified and that a great deal of uncertainty remains.[81] This scientific uncertainty can be used to produce contrasting but equally probable statements: (i) there is no evidence for a level of risk-free drinking during pregnancy;[82] and (ii) drinking one to two units once or twice a week has not been shown to be harmful.[83] Faced with this uncertainty, the development of policy and provision of definitive advice is difficult[84] and a precautionary approach is clearly attractive to health advice providers. For example, the Royal College of Obstetricians and Gynaecologists highlighted that the positions of its counterparts in the USA, Canada, Australia and New Zealand were, based on factors such as insufficient evidence and a lack of consensus, to encourage abstinence during pregnancy.[85] **The UK's Chief Medical Officers (CMOs) reviewed the guidelines for drinking during pregnancy in 2006 and produced updated guidelines that encouraged abstinence but also provided advice for women who chose to drink. We are satisfied that the CMOs have recently reviewed the evidence base and consider that the current guidance adequately balances the scientific uncertainty with a precautionary approach. However, we note that the Scottish CMO has adopted different advice. Consistency of advice across the UK would be desirable.**

Sources of scientific advice

34. Sources of scientific advice to Government on alcohol guidelines include the Chief Medical Officers and NICE. We asked Sir Ian Gilmore whether the Government used advice from a wide enough range of sources, and he responded:

> They do not use a sufficient evidence base when it comes to developing alcohol policy. That evidence base can come from a wide range of sources, whether it is social sciences, clinical sciences or basic sciences. The problem that I have is that the evidence is out there on what will reduce alcohol-related harm, but it is true that we need to persuade the Government to use that evidence.[86]

---

[78] Ev 27, para 6

[79] Ev 27, para 7

[80] Royal College of Obstetricians and Gynaecologists, *Alcohol consumption and the outcomes of pregnancy*, March 2006

[81] Royal College of Obstetricians and Gynaecologists, *Alcohol consumption and the outcomes of pregnancy*, March 2006

[82] Ev 77 [Institute of Alcohol Studies] para 4

[83] Ev w38 [Royal College of Obstetricians and Gynaecologists] paras 1.2-1.3

[84] Ev 36 [Alcohol Research UK] para 2.6.1

[85] Ev w39 [Royal College of Obstetricians and Gynaecologists] para 1.5

[86] Q 27

The Minister told us that the Department of Health monitors the evidence base "in a variety of ways", both by using its own internal experts and commissioning external advice and support from various bodies.[87] Chris Heffer, Deputy Director, Alcohol and Drugs, Department of Health, described some of the "bespoke" research that had been commissioned by the Department in recent years, including on pricing, licensing and other alcohol policies. However, he noted that "we have not, to my knowledge, done specific research on the guidelines of particular health risks".[88]

35. The Institute of Alcohol Studies suggested that the Government establish a working group, "with representation of health experts, to regularly review the evidence base and provide scientific advice for public health messaging on alcohol".[89] Dr Harding said that although all of the relevant information is published in the literature, "what is needed is a mechanism that brings it all together in a fair and balanced way, so that sensible public health messages can be crafted".[90] He suggested that a review of the relationship between alcohol consumption and disease was "overdue" and recommended the establishment of "a multidisciplinary team, involving experts in the appropriate fields [for example] alcohol misuse, epidemiology, public health, heart disease, dementia, and social science, who are knowledgeable about the current scientific data and who are capable of taking a broad overview".[91] The Department of Health stated that it was "not currently planning a formal review of the guidelines, but would be willing to consider this if it were felt to be useful".[92]

36. When we announced our inquiry into alcohol guidelines in July 2011, there was some media speculation about the possibility of increasing the guideline limits. This appeared to be based on international comparisons with countries that set higher drinking limits in public guidelines as well as the claim that the Royal College of Physicians' 1987 guidelines were "plucked out of the air".[93] However, none of our expert witnesses recommended an increase, and several were in fact adamant that the guidelines should not be increased.[94] Dr Richard Harding also cautioned against relying on international comparisons.[95] When we asked the Minister whether the guidelines should be lowered, she responded: "I do not believe that there is currently any evidence available that would suggest that we ought to alter those guidelines".[96]

37. **We have heard sufficient concerns from experts to suggest that a thorough review of the evidence on alcohol and health risks is due. The Department of Health and the devolved health departments should establish a nationwide working group to review the evidence base and use the findings of the review to provide advice on whether the**

---

[87] Q 65

[88] Q 66

[89] Ev 74, para 2

[90] Ev 49, para 31

[91] Ev 49, para 32

[92] Ev 29, para 19

[93] "Healthy alcohol limits likely to be increased", *The Independent*, 25 July 2011; "Cheers... An extra glass of wine is fine as the daily allowance could be raised", *The Daily Mail*, 26 July 2011.

[94] Q 11 [Professor Nick Heather; Sir Ian Gilmore]

[95] Q 11

[96] Q 100

guidelines should be changed. In the meantime, we consider that there does not appear to be sufficient evidence to justify increasing the current drinking guidelines.

4 Public understanding and communication

38. An inherent difficulty of developing generic guidelines for the public on sensible drinking is the loss of recognition of individual risk factors. Individuals vary not just by age and gender but also by factors, such as body weight or socio-economic background, that will influence the health risks they face when drinking alcohol. Yet the Government also has to tread a fine line between informing and *over*-informing the public because the more complex guidelines become, the more difficult they may be to communicate. We delved into this issue with witnesses. Sir Ian Gilmore, Royal College of Physicians, warned about reaching a level of complexity that would not be understood by the public[97] and Professor Heather, Alcohol Research UK, told us:

> There are lots of risk factors—individual personality, and genetic and social factors. For example, socio-economic status is a big risk factor for alcohol-related harm. Recent research shows that middle-aged men in the lowest quintile had a four times higher rate of alcoholic liver cirrhosis than those in the highest socio-economic status quintile. That cannot be explained by differences in consumption. There are lots of risk factors, but they cannot all be incorporated into guidelines, as it would make them immensely complex.[98]

With this warning in mind, we will explore the public understanding and communication of the Government's alcohol guidelines.

Effectiveness of guidelines

39. Alcohol consumption guidelines could have two purposes: to inform people and their drinking choices or to seek to influence and change behaviour. In both cases, decisions on how much to drink would remain at the discretion of the individual because the guidelines impose no legal obligation. We wanted to know whether the Government saw the guidelines as a tool for information or for influencing behaviour and Anne Milton MP, Parliamentary Under-Secretary of State for Public Health, told us that they were seen as useful for both.[99] As the Government considers the guidelines to have a dual purpose of raising awareness and influencing public behaviour we have therefore also considered the evidence relating to the impact of guidelines on public awareness and behaviour.

Informing the public

40. In our view, there are four levels of public understanding of the alcohol guidelines:

a) knowing that drinking guidelines and alcohol units exist;

b) knowing what the drinking guidelines are;

[97] Q 23

[98] Q 26

[99] Q 71

c) being able to identify the unit content of alcoholic beverages; and

d) understanding the health risks of drinking.

41. A 2009 survey by the Office for National Statistics (ONS) showed that overall, 90 per cent of respondents "said they had heard of measuring alcohol consumption in units", up from 79 per cent in 1997.[100] This statistic was echoed by the Minister.[101] The ONS noted that "on the whole, the more people drank, the more likely they were to have heard of units".[102] Awareness of alcohol units was consistently over 80 per cent across gender, age and socio-economic groups (with the exception of women over 65, amongst whom awareness was at 78 per cent).[103] These figures were broadly in line with those supplied by the charity Drinkaware.[104] Moreover, public awareness of what the guidelines were had increased since 1997. However, the ONS acknowledged that having heard of daily recommended levels did not necessarily mean that people knew what they were:

> Forty four percent of people thought correctly that, for men, drinking three or four units a day was within the guidelines, and 52 per cent said correctly that for women, drinking two or three units a day was a recommended maximum. These percentages have increased significantly from 35 per cent and 39 per cent respectively in 1997. [...] The percentage of people who said they had heard of but did not know the limits decreased from around 44 per cent in 1997 to around 30 per cent in 2009.[105]

42. Awareness of the existence of alcohol units did not necessarily translate into an understanding of the unit content of alcoholic drinks. While 69 per cent of respondents correctly identified one unit as being equivalent to a 25 ml measure of spirits, and 63 per cent correctly equated a unit with half a pint of beer, only 27 per cent accurately identified how much one unit of wine was ("less than a small glass").[106] Around half of respondents incorrectly thought that one unit of wine was equivalent to one glass of wine. The ONS offered a partial explanation, which was that public information on the alcohol content of wine had changed over time.[107] Drinkaware's findings were less positive: the charity reported that only 38 per cent of adults were able to select a drink from a list which correctly contained one unit of alcohol, and that this figure did not improve much if the person was aware of the term "units".[108] Drinkaware stated that "for consumers who are unable to make a direct correlation between "units" and "drinks" the practical impact of

---

[100] Office for National Statistics, *Opinions Survey report No. 42, Drinking: Adults' behaviour and knowledge in 2009*, 2010, p 61

[101] Q 73

[102] Office for National Statistics, *Opinions Survey report No. 42, Drinking: Adults' behaviour and knowledge in 2009*, 2010, p 56

[103] Office for National Statistics, *Opinions Survey report No. 42, Drinking: Adults' behaviour and knowledge in 2009*, 2010, p 61

[104] Ev 56, paras 6.1–6.2

[105] Office for National Statistics, *Opinions Survey report No. 42, Drinking: Adults' behaviour and knowledge in 2009*, 2010, p 14

[106] Office for National Statistics, *Opinions Survey report No. 42, Drinking: Adults' behaviour and knowledge in 2009*, 2010, p 64

[107] Office for National Statistics, *Opinions Survey report No. 42, Drinking: Adults' behaviour and knowledge in 2009*, 2010, p 56

[108] Ev 56, para 6.2

guidelines will be limited".[109] The Department of Health (DH) has acknowledged that "public understanding of both unit measures (especially for wine) [...] needs to improve".[110]

43. The Association of Small Direct Wine Merchants pointed out that "a UK unit just happens to be the same as [one centilitre] of alcohol", (which is equivalent to 10 ml) and suggested that units should be replaced by centilitres (cl).[111] In contrast, Professor Averil Mansfield, British Medical Association, said:

> It is pretty clear that the units that we have at present are as good a way as any of describing the amount of alcohol that we consume. A lot of effort has been put into making them understood by the general public. For better or worse, the message should be retained because it is now fairly widely understood. [...] The other ways, in milligrams or millilitres, are rather complicated, and we need something simple and straightforward.[112]

Jeremy Beadles, Chief Executive of the Wine and Spirit Trade Association added that "the important thing is that we stick with what we have. Changing now would set us back a long way".[113] Drinkaware was optimistic, and stated:

> Between 2007 and 2010, the UK Government carried out a series of unit guideline campaigns, spending about £4 million in 2008–2009. The impact of these campaigns alongside those run by Drinkaware has led directly to an increased awareness and understanding of unit guidelines and how they translate to individual drinks. It is our belief that although there are still significant numbers of consumers to inform, we are certainly approaching a 'tipping point' with consumers and that many more are beginning to understand units on a practical level.[114]

44. **Public awareness of alcohol units appears to be high, but there are problems with public understanding of how many units are in alcoholic beverages. We see no reason why the established concept of alcohol units should be changed. We consider that efforts should be focused on helping people to translate the concept of alcohol units and sensible drinking guidelines into practice.**

Changing behaviour

45. Despite high levels of awareness of units, the ONS survey showed that of the 90 per cent of drinkers in the survey group who had heard of units, only 13 per cent kept a check on the units they drank on a daily, weekly and/or other basis.[115] This had not improved noticeably since 1997: the average between 1997 and 2009 was around 13 per cent, with women slightly more likely to keep a check than men (despite the fact that men were more

[109] Ev 56, para 6.2

[110] Ev 30, para 26

[111] Ev w4, para 3.3

[112] Q 35

[113] Q 35

[114] Ev 56, paras 6.1–6.2

[115] Office for National Statistics, *Opinions Survey report No. 42, Drinking: Adults' behaviour and knowledge in 2009*, 2010

likely to drink heavily). Furthermore, women who did keep a check on units were slightly more likely to do so on a weekly basis (6 per cent) than on the daily basis (2 per cent) suggested by the government's current advice on sensible drinking, but there was no difference among men. [116] The ONS added that "it should be noted, however, that since by no means everyone who drank each type of drink knew what a unit of that drink was, it is likely that in some cases the check they were keeping was inaccurate".[117]

46. The Institute of Alcohol Studies (IAS) stated that "there is much debate both in the UK and internationally about the efficacy of drinking guidelines as a policy to reduce alcohol harm".[118] The IAS considered that:

> whilst guidelines have a role to play in educating the public and increasing knowledge about the risks of alcohol, they have not been proven to be effective at changing behaviour. The pharmacological properties of alcohol, which include loss of inhibitions in the short term and dependence in the long term, make it impractical to rely on a 'nudge' framework[119] of 'rational man making informed decisions' about drinking alcohol to effect behaviour change.[120]

Dr Marsha Morgan, IAS, stated:

> The Government have an obligation to provide, on the basis of the best evidence, information about the risks of alcohol intake so that the general public can make informed decisions. [...] the purpose of the guidelines [...] is to inform.[121]

We queried whether it would be possible to conduct research that would identify whether the guidelines had an effect on changing drinking behaviour. Dr Morgan replied:

> One of the difficulties is that it would have to be a two-tiered approach. If our basic premise is to provide guidelines in order to inform the public, we would first have to see whether they are actually informed. In other words, you would have to look at a scenario whereby you questioned a group of people, provided information on the guidelines and then revisited the matter. Running in parallel, or even sequentially, you would then look at individuals' drinking behaviour and see whether the acquisition of knowledge had changed it. It would be a two-step procedure; whether it was done in parallel or sequentially would be up to the individuals designing the studies. It could be done, but it would be a difficult piece of research.[122]

47. The joint written submission from the British Beer & Pub Association, The National Association of Cider Makers, The Scotch Whisky Association and The Wine and Spirit

---

[116] Office for National Statistics, *Opinions Survey report No. 42, Drinking: Adults' behaviour and knowledge in 2009*, 2010, p 58

[117] Office for National Statistics, *Opinions Survey report No. 42, Drinking: Adults' behaviour and knowledge in 2009*, 2010, p 58

[118] Ev 75, para 2

[119] The nudge framework refers to the use of non-regulatory interventions that seek to influence behaviour by altering the context or environment in which people make choices.

[120] Ev 75, para 2

[121] Q 2

[122] Q 6

Trade Association stated that "there does not appear to be a correlation between recommended drinking guidelines and consumption patterns".[123] They stated that "countries such as Germany and Ireland have higher overall alcohol consumption but similar recommended daily guidelines to the UK" and Italy and Netherlands have lower overall alcohol consumption but higher recommended guidelines".[124]

48. There is little evidence that the Government's alcohol guidelines are effective in changing behaviour. We recognise that it would be difficult to establish whether guidelines had had a direct effect on behaviour and also that it is a challenging area of research, particularly given the problems caused by inaccurate reporting. Behaviour could be changed by other interventions such as alcohol pricing and availability and it would be difficult to disentangle the effects of these from those of the guidelines to establish a causative effect. **We are concerned that the Government views the guidelines as a tool to influence drinking behaviour when there is very little evidence that the guidelines have been effective at this. The Government should treat the guidelines as a source of information for the public.**

Drinking patterns

49. In paragraph 18 we noted concerns that the move from weekly to daily guidelines had appeared to endorse daily drinking. The current guidelines advise that men and women should "not regularly drink" more than a certain number of units a day.[125] According to the DH, "regularly" means drinking every day or most days of the week".[126] The IAS stated that:

> the recommendation that 'regular drinking', defined as 'drinking every day or most days of the week' does not pose a significant health risk is a direct contradiction to the evidence base on the health harms associated with alcohol. Daily and frequent drinking is associated with a greater risk of developing dependency problems with alcohol and alcoholic liver disease and cannot therefore be considered a 'safe' or 'low risk' practice. Furthermore, the guideline for men to drink up to 4 alcoholic drinks per day on a regular basis would be classified as "hazardous" drinking under the [World Health Organisation] standards for assessing risky alcohol consumption.[127]

The *Sensible Drinking* guidelines were supplemented with advice that "after an episode of heavy drinking, it is advisable to refrain from drinking for 48 hours to allow tissues to recover".[128] However, the report stated that "this is a short term measure and people whose pattern of drinking places them at significant risk should seek professional advice. Such breaks are not required on health grounds for people drinking within the recommended benchmarks".[129] In other words, a 48 hour break from drinking was not deemed necessary

[123] Ev 44, para 27

[124] Ev 44, para 27

[125] Ev 27 [Department of Health] para 3

[126] "Alcohol advice", *Department of Health*, 22 March 2011, dh.gov.uk

[127] Ev 74, para 2

[128] Ev 27 [Department of Health] para 3

[129] Department of Health, *Sensible Drinking: Report of an inter-departmental working group*, 1 December 1995

for those drinking within guidelines. The DH website clarified that "'regularly' means drinking every day or most days of the week".[130] We were interested in whether the DH definition of "regular" was well communicated and understood by the public given that "most days of the week" was not quantified. However, it appears that many people may not be aware that advice is framed in terms of regular drinking, let alone what the definition of "regular" is. Professor Nick Heather, Alcohol Research UK, said that: "unfortunately [...] the word "regularly" in information given out by health authorities is sometimes dropped, so that it appears as an absolute maximum upper limit, which it was not intended to be".[131] He explained that "it is intended as guidance on the average amount of consumption".[132] Professor Averil Mansfield, British Medical Association, told us that she would be in favour of daily rather than weekly limits but added:

> what matters most is that the message should not be that you should drink two to three units a day. Somehow, we have to get the message over that you do not have to drink at all, and that you certainly should not drink at all on a couple of days a week. It almost gives the green light to go ahead and drink two, three or four units a day; the Government guidelines seem to indicate that that is okay. We need to tone that down so that people know it is the maximum and not something that is desirable every day, and it will not give you added health, but if they do consume that amount there will inevitably be a health risk.[133]

50. The differing risks of regular drinking and binge drinking were raised during our inquiry. Binge drinkers were defined by 2020Health as men who drink 8 or more units in a single session and women who drink 6 or more units in a single session.[134] Grampian Drugs and Alcohol Partnerships considered that "the implication that daily drinking is less risky contradicts the evidence which shows that the frequency of consumption is a key risk factor".[135] Similarly, 2020Health stated that those who drank regularly but did not binge drink or get drunk:

> may be drinking several drinks every day, and are increasing the risk of developing long-term health conditions. Given the time lag between alcohol consumption and the development of conditions such as liver disease or cancer, the harm caused by drinking is often not seen for up to 10 or 20 years.[136]

The Royal College of Physicians suggested that a simple remedy to the problem would be to recommend that people should have three alcohol-free days a week to stay within safe drinking limits.[137] In Scotland, the advice is to "aim to have at least two alcohol-free days a week".[138]

---

[130] "Alcohol advice", *Department of Health*, 22 March 2011, dh.gov.uk

[131] Q 16

[132] Q 16

[133] Q 38

[134] Ev w7, para 4.6

[135] Ev w32, para 3.1.2

[136] Ev w7, para 4.4

[137] Ev 72, para 32

[138] "Keeping within the limits", *DrinkSmarter*, December 2011, drinksmarter.org

51. Professor Heather explained the different types of harm that could be expected from different drinking patterns:

> Long-term average drinking is related to chronic illnesses. Binge drinking [...] leads to intoxication-related harms such as accidents and violence. [...] There are two types of harm. In my view, therefore, there should be two types of guideline.[139]
>
> [...] my advice is that the guidelines should take this form. For example, men should not drink more than X units a week, probably 21, and never more than Y units in a day, whatever that might be—perhaps eight units, as at present, or a bit lower.[140] As well as that, there should be at least two days' abstinence. We should revert to the old weekly limits of 21 and 14 for the average guideline, and have another daily limit that should never be exceeded on any day. That would help communication.[141]

The Sheffield Addiction Research group and 2020Health both broadly agreed with this suggestion.[142] The International Scientific Forum on Alcohol Research and Alcohol in Moderation drew attention to guidelines in the USA and Australia that had upper limits for individual drinking episodes.[143] The DH stated:

> We are aware that some governments do offer advice on levels of consumption for individual drinking episodes, in addition to advice for regular drinking. For example, the 2009 Australian Government's guidelines, do include such advice. [...] The recommendations are based on statistical evidence of the lifetime risk of death from injury related to individual drinking episodes. While we do see some possible value in such a guideline, we have no plans at present to introduce this within the UK. We believe that this would require particular consideration of its likely impact and its real value in influencing the behaviour of individuals who currently choose to engage in 'binge' drinking.[144]

52. **It is unclear to us how the term "regular", as applied to all adults who drink, relates to the advice to take a 48 hour break after heavy drinking episodes. We suggest that, if daily guidelines are retained, the Government consider simplifying the guidelines so that, as is the case in Scotland, all individuals are advised to take at least two alcohol-free days a week. This would enforce the message that drinking every day should be avoided, and would helpfully quantify what "regular" drinking means to the public.**

53. **On balance, we consider that introducing guidance for individual drinking episodes could be helpful to inform the public and we invite the Department of Health to consider the suggestion as part of a review of the evidence base, taking into account social science evidence, including evidence from other countries on the impact that similar guidelines have had on drinking patterns. Guidance for individual drinking**

---

[139] Q 17

[140] Note by witness: Within the context of the weekly limit.

[141] Q 13

[142] Ev w23, para 2.2.3; Ev w6-7, para 3.3

[143] Ev w13, para 4.6

[144] Ev 29, para 20

episodes should only be introduced if guidance is provided in a weekly context again, as having two daily drinking limits would be confusing to the public.

The role of the drinks industry

54. In March 2011, the Government published *The Public Health Responsibility Deal*. It said:

> Businesses have both the technical expertise to make healthier products and the marketing expertise to influence purchasing habits. If the full strength of these skills can be directed towards activities to encourage and enable people to make healthier choices—as many responsible businesses do already—the benefits could be great.
>
> The Public Health Responsibility Deal has been established to maximise these benefits. By working in partnership, public health, commercial, and voluntary organisations can agree practical actions to secure more progress, more quickly, with less cost than legislation.[145]

The Government's core commitment on alcohol is to "foster a culture of responsible drinking, which will help people to drink within guidelines".[146] Specific pledges include ensuring that over 80% of products on shelf (by December 2013) will have labels with clear unit content, NHS guidelines and a warning about drinking when pregnant.[147]

55. There have been strong criticisms about the increased involvement of industry in communicating messages about sensible drinking. For example, the Royal College of Obstetricians and Gynaecologists (RCOG) argued "there is a conflict of interest in engaging with business to promote products" although it acknowledged that "there are examples of responsible drinking programmes developed by the drinks industry, such as [Drinkaware]".[148] The British Medical Association (BMA) stated that "industry self-regulation has at its heart a conflict of interest that does not adequately address individual or public health".[149] Sir Ian Gilmore considered that "it is a great disappointment to me that the present Government's policy seems to be against funding public health information; they are devolving it to other organisations, including those funded by the drinks industry".[150] A 2009 report by the House of Commons Health Committee on *Alcohol* stated:

> It is time the Government listened more to the [Chief Medical Officer] and the President of the [Royal College of Physicians] and less to the drinks and retail industry. If everyone drank responsibly the alcohol industry might lose about 40% of its sales and some estimates are higher. In formulating its alcohol strategy, the

[145] Department of Health, *The Public Health Responsibility Deal*, 22 March 2011

[146] Department of Health, *The Public Health Responsibility Deal*, 22 March 2011

[147] Department of Health, *The Public Health Responsibility Deal*, 22 March 2011

[148] Ev w41, para 4.4

[149] Ev 80, paras 3 and 5

[150] Q 13

> Government must be more sceptical about the industry's claims that it is in favour of responsible drinking.[151]

56. When we put these concerns to Jeremy Beadles, Chief Executive of the Wine and Spirit Trades Association and co-chair of the Alcohol Responsibility Deal, he replied:

> [*The Public Health Responsibility Deal*] is not about setting or dictating Government policy; it is about the alcohol industry and other organisations finding ways of delivering things that the Government wish to have delivered, such as unit labelling and point of sale information. To be frank, it would be extremely time-consuming and costly putting it through Europe and getting the legislation out on the other side, and frankly impossible in terms of providing unit information in a pub environment. The evidence base would be extremely difficult to put together, and the cost of administering a scheme of that nature would be disproportionate. If the industry is prepared, willing and happy to do this stuff and can roll it out through its mechanisms, I am not sure that I see a problem. [...] the Responsibility Deal now has more than 220 businesses signed up to it. It is one of the largest voluntary agreements ever put together.[152]

The Minister acknowledged the importance of being aware that all interest groups had their own agenda and added "we have to judge it on the results that we see. In 2013 [...] we will be having an independent analysis as to how much progress has been made".[153] She stated:

> the drinks industry are interested in their brands, so, if a brand is associated with crime, anti-social behaviour and people being paralytically drunk, it is not necessarily a positive brand. However, they are there to sell alcohol. We have to work in those areas that we can, make sure it is properly scrutinised and analysed so that we have confidence, and be aware of the fact that there are legislative and regulatory tools which we can take into account.[154]

Drinks labelling

57. The labelling of alcoholic beverages with guideline advice is an important way of communicating alcohol content and guidelines, and was a key focus of our inquiry. Figure 2 shows what information will be included on labels under the alcohol pledge.

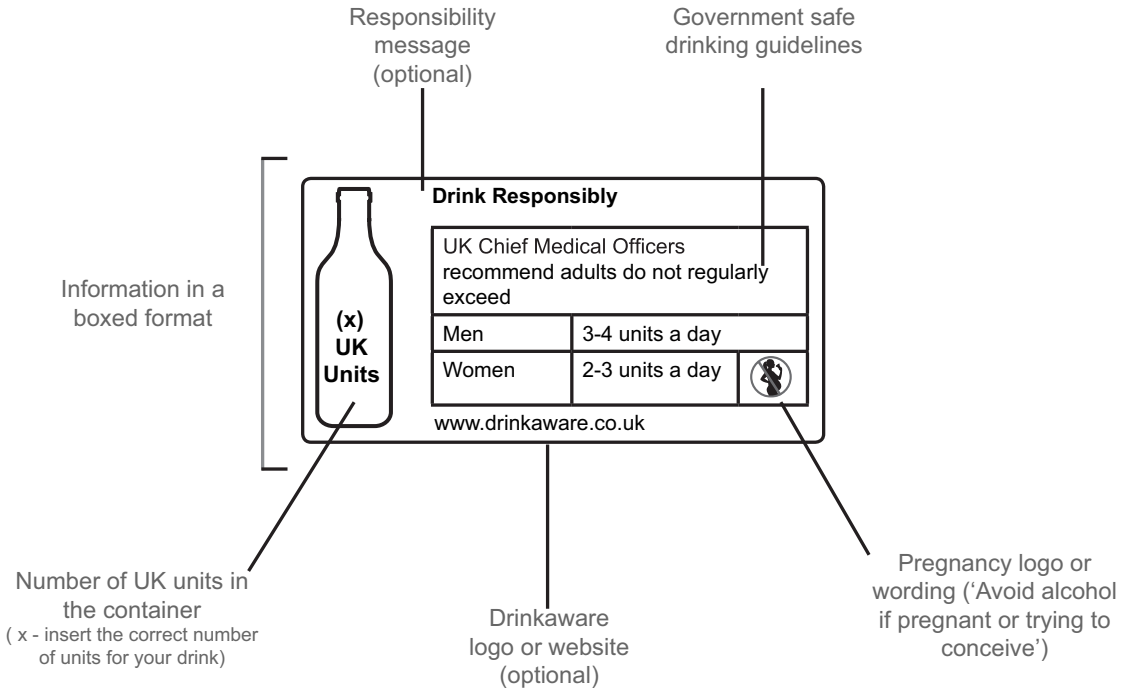
[151] Health Committee, First Report of Session 2009-10, *Alcohol*, HC 151-I

[152] Q 43

[153] Q 81

[154] Q 81

Figure 2: Format of alcoholic beverage label[155]



58. The pledge to have over 80 per cent of products on the shelf with "labels with clear unit content, NHS guidelines and a warning about drinking when pregnant" by 2013 is voluntary, although some, such as the BMA, considered that mandation was necessary.[156]

59. We asked the Minister how close the Government was to achieving the 80 per cent target. She responded that the process had just started recently, noting "how difficult it is for the industry to get it in place" and that there had been a lot of concerns about the *Public Health Responsibility Deal*.[157] We were also informed that around 100 companies covered approximately 80 per cent of the industry and that most of them were signing up to the pledge.[158] Mr Heffer, Deputy Director, Alcohol and Drugs, DH, added that:

> the advantage to them is that they are doing this voluntarily—some of their brands do not have to comply. If you are bringing in a special product from America for the whole of Europe, they can exclude that brand while offering a choice of products to consumers across the rest of Europe. A mandatory approach would mean that that brand was probably not stocked. Most of the brands have signed up for most of their products. That should add up to 80 per cent. There will be an independent verifier by December 2013.[159]

[155] Ev 46 [The British Beer & Pub Association, The National Association of Cider Makers, The Scotch Whisky Association and The Wine and Spirit Trade Association]

[156] Ev 80, paras 3 and 5

[157] Q 86

[158] Q 85

[159] Q 85

60. In addition to labelling of alcoholic drinks, the drinks industry is involved with campaigns to increase consumer awareness of units in "the on and off trades", working with Drinkaware.[160]

61. We are mindful of the concerns expressed by medical experts and relevant organisations about the involvement of the drinks industry in communicating public health messages concerning alcohol. **There is clearly a risk that drinks companies could face a conflict of interest as promoting a sensible drinking message could affect profits. However we have heard no evidence to suggest that the alcohol labelling pledges within the Public Health Responsibility Deal could be achieved without the cooperation of drinks companies. Nor have we heard sufficient evidence to suggest that, given the Government exercises proper scrutiny and oversight, a conflict of interest would jeopardise the progress of the alcohol pledges.**

62. **We are concerned that there will not be an independent assessment of the programme until the target date of December 2013. We recommend that the Government immediately set an interim labelling target for December 2012. It should then conduct a preliminary assessment of the progress of the alcohol pledges in the Public Health Responsibility Deal in December 2012. If through the voluntary involvement of the drinks industry, the intermediate target has not been met by December 2012, the Government should review the initiative, including the possible need to mandate compliance with labelling requirements.**

[160] Ev 44 [The British Beer & Pub Association, The National Association of Cider Makers, The Scotch Whisky Association and The Wine and Spirit Trade Association] paras 23-24

5 Conclusions

Evidence base

63. We were disappointed to find that alcohol consumption guidelines for the general adult population had not been formally reviewed since 1995. Since then, a greater body of scientific evidence has emerged that challenges the guidelines. In particular, more studies have emphasised the causal relationships between alcohol and cancers, and the theory that drinking alcohol at low quantities may confer health benefits has been vigorously disputed. Having taken into account recent updates to the guidelines on drinking during pregnancy and for people under 18 years, we have nevertheless concluded that a review of the evidence base would be worthwhile and timely. **At a time when the Government is putting efforts into encouraging people to drink within guidelines, we consider that a review of the evidence would increase public confidence in the guidelines.**

64. **The review of the evidence base should be conducted by an expert group, including amongst its members civil servants and external scientific and medical experts from a wide range of disciplines, including representatives from the devolved administrations. The group should review:**

a) **The evidence base for health effects of alcohol including risks and benefits;**

b) **Behavioural and social science evidence on the effectiveness of alcohol guidelines on (i) informing the public and (ii) changing behaviour;**

c) **How useful it would be to introduce guidance on individual drinking episodes;**

d) **What terminology works well in public communication of risks and guidelines; and**

e) **Whether further research is needed, particularly for the alcohol-related risks to specific demographic groups (for example, older people).**

The group should provide a recommendation to Government on whether the current alcohol guidelines are evidence-based, and if they are not, what the guidelines should be changed to.

Public understanding and communication

65. We were pleased to find that the Government is promoting sensible drinking messages through initiatives such as the Public Health Responsibility Deal. Public awareness of the guidelines has been improving, although there is a long way to go. While many members of the public have heard of alcohol units and the guidelines, far fewer people understand how to translate them into practice.

66. **We consider that the Government, industry and charities should emphasise in public communications:**

a) **The specific risks associated with drinking patterns, that is, (i) the acute risks associated with individual episodes of heavy drinking and (ii) the chronic risks associated with regular drinking;**

b) **That there are situations where it is not appropriate to drink at all, for example while operating machinery; and**

c) **That people should have some drink free days every week.**

67. **Having explored the complexity around the risks faced by different groups of people, for example women, pregnant women, older people and young people, we consider that while simplicity of advice is preferable for public communication, complexity should not be avoided if it improves public understanding and confidence in the guidelines. For example, the guidelines for children and young people are more complex than for adults but are also clear, concise and leave no room for misinterpretation, and we consider that guidelines for adults could be similarly expressed.**

68. **We recommend that there should be an online resource where individuals could obtain more individualised advice where factors such as weight, age, ethnicity and family history of alcohol problems could be taken into consideration. This resource should include links to sources of further information and support, and recommendations on whether to seek further expert medical advice. We consider that this resource could help dispel people's notions that generic alcohol guidance does not apply to them. Charities such as Drinkaware and other organisations should develop methods of increasing access to this type of individualised advice for those who have limited or no access to online resources.**

69. **The cooperation of the drinks industry is essential if the Government wants to achieve the Public Health Responsibility Deal's alcohol pledges. However, the Government should remain mindful that sensible drinking messages may conflict with the business objectives of drinks companies, and should therefore exercise scrutiny and oversight to ensure that any conflicts of interest are mitigated and managed.**

Conclusions and recommendations

International comparisons

1. The UK's alcohol guidelines are about average, compared with those of other developed nations. However, national guidelines can reflect social objectives and cultural differences as well as scientific evidence, and therefore we do not consider that international comparisons should be relied on as an indicator of how appropriate the UK's alcohol guidelines are. (Paragraph 13)

The evidence base

2. There is a lack of consensus amongst experts over the health benefits of alcohol, but it is not clear from the current evidence base how the benefits of drinking alcohol at low quantities compare to those of lifelong abstention. In addition, it seems likely that the same purported health benefits could be gained through a healthy lifestyle. Therefore we are sceptical about using the alleged health benefits of alcohol as a basis for daily alcohol guidelines for the general adult population, particularly as these benefits would apply only to men over 40 years and post-menopausal women and the guidelines are aimed at all adults. (Paragraph 25)

3. As the Government provides guidelines for specific population groups such as children and pregnant women already, we consider that there could be merit in producing guidelines for older people, balancing evidence of beneficial effects of alcohol with evidence of increased risks. (Paragraph 28)

4. We are content that there is sufficient physiological and epidemiological evidence on health risks to support the retention of lower drinking guidelines for women in general. (Paragraph 31)

5. The UK's Chief Medical Officers (CMOs) reviewed the guidelines for drinking during pregnancy in 2006 and produced updated guidelines that encouraged abstinence but also provided advice for women who chose to drink. We are satisfied that the CMOs have recently reviewed the evidence base and consider that the current guidance adequately balances the scientific uncertainty with a precautionary approach. However, we note that the Scottish CMO has adopted different advice. Consistency of advice across the UK would be desirable. (Paragraph 33)

6. We have heard sufficient concerns from experts to suggest that a thorough review of the evidence on alcohol and health risks is due. The Department of Health and the devolved health departments should establish a nationwide working group to review the evidence base and use the findings of the review to provide advice on whether the guidelines should be changed. In the meantime, we consider that there does not appear to be sufficient evidence to justify increasing the current drinking guidelines. (Paragraph 37)

Public understanding and communication

7. Public awareness of alcohol units appears to be high, but there are problems with public understanding of how many units are in alcoholic beverages. We see no reason why the established concept of alcohol units should be changed. We consider that efforts should be focused on helping people to translate the concept of alcohol units and sensible drinking guidelines into practice. (Paragraph 44)

8. We are concerned that the Government views the guidelines as a tool to influence drinking behaviour when there is very little evidence that the guidelines have been effective at this. The Government should treat the guidelines as a source of information for the public. (Paragraph 48)

9. It is unclear to us how the term "regular", as applied to all adults who drink, relates to the advice to take a 48 hour break after heavy drinking episodes. We suggest that, if daily guidelines are retained, the Government consider simplifying the guidelines so that, as is the case in Scotland, all individuals are advised to take at least two alcohol-free days a week. This would enforce the message that drinking every day should be avoided, and would helpfully quantify what "regular" drinking means to the public. (Paragraph 52)

10. On balance, we consider that introducing guidance for individual drinking episodes could be helpful to inform the public and we invite the Department of Health to consider the suggestion as part of a review of the evidence base, taking into account social science evidence, including evidence from other countries on the impact that similar guidelines have had on drinking patterns. Guidance for individual drinking episodes should only be introduced if guidance is provided in a weekly context again, as having two daily drinking limits would be confusing to the public. (Paragraph 53)

11. There is clearly a risk that drinks companies could face a conflict of interest as promoting a sensible drinking message could affect profits. However we have heard no evidence to suggest that the alcohol labelling pledges within the Public Health Responsibility Deal could be achieved without the cooperation of drinks companies. Nor have we heard sufficient evidence to suggest that, given the Government exercises proper scrutiny and oversight, a conflict of interest would jeopardise the progress of the alcohol pledges. (Paragraph 61)

12. We are concerned that there will not be an independent assessment of the programme until the target date of December 2013. We recommend that the Government immediately set an interim labelling target for December 2012. It should then conduct a preliminary assessment of the progress of the alcohol pledges in the Public Health Responsibility Deal in December 2012. If through the voluntary involvement of the drinks industry, the intermediate target has not been met by December 2012, the Government should review the initiative, including the possible need to mandate compliance with labelling requirements. (Paragraph 62)

Conclusions

13. At a time when the Government is putting efforts into encouraging people to drink within guidelines, we consider that a review of the evidence would increase public confidence in the guidelines. (Paragraph 63)

14. The review of the evidence base should be conducted by an expert group, including amongst its members civil servants and external scientific and medical experts from a wide range of disciplines, including representatives from the devolved administrations. The group should review:

a) The evidence base for health effects of alcohol including risks and benefits;

b) Behavioural and social science evidence on the effectiveness of alcohol guidelines on (i) informing the public and (ii) changing behaviour;

c) How useful it would be to introduce guidance on individual drinking episodes;

d) What terminology works well in public communication of risks and guidelines; and

e) Whether further research is needed, particularly for the alcohol-related risks to specific demographic groups (for example, older people).

The group should provide a recommendation to Government on whether the current alcohol guidelines are evidence-based, and if they are not, what the guidelines should be changed to. (Paragraph 64)

15. We consider that the Government, industry and charities should emphasise in public communications:

a) The specific risks associated with drinking patterns, that is, (i) the acute risks associated with individual episodes of heavy drinking and (ii) the chronic risks associated with regular drinking;

b) That there are situations where it is not appropriate to drink at all, for example while operating machinery; and

c) That people should have some drink free days every week. (Paragraph 66)

16. Having explored the complexity around the risks faced by different groups of people, for example women, pregnant women, older people and young people, we consider that while simplicity of advice is preferable for public communication, complexity should not be avoided if it improves public understanding and confidence in the guidelines. For example, the guidelines for children and young people are more complex than for adults but are also clear, concise and leave no room for misinterpretation, and we consider that guidelines for adults could be similarly expressed. (Paragraph 67)

17. We recommend that there should be an online resource where individuals could obtain more individualised advice where factors such as weight, age, ethnicity and family history of alcohol problems could be taken into consideration. This resource

should include links to sources of further information and support, and recommendations on whether to seek further expert medical advice. We consider that this resource could help dispel people's notions that generic alcohol guidance does not apply to them. Charities such as Drinkaware and other organisations should develop methods of increasing access to this type of individualised advice for those who have limited or no access to online resources. (Paragraph 68)

18. The cooperation of the drinks industry is essential if the Government wants to achieve the Public Health Responsibility Deal's alcohol pledges. However, the Government should remain mindful that sensible drinking messages may conflict with the business objectives of drinks companies, and should therefore exercise scrutiny and oversight to ensure that any conflicts of interest are mitigated and managed. (Paragraph 69)

Formal Minutes

Wednesday 7 December 2011

Members present:

Andrew Miller, in the Chair

Stephen Metcalfe
David Morris
Stephen Mosley
Pamela Nash
Roger Williams

Draft Report (*Alcohol guidelines*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 69 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Eleventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for placing in the Library and Parliamentary Archives.

[Adjourned till Wednesday 14 December at 9.00 am

Witnesses

Wednesday 12 October 2011

Page

Wednesday 26 October 2011

List of printed written evidence

List of additional written evidence

(published in Volume II on the Committee's website www.parliament.uk/science)

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2010–12

First Special Report	The Legacy Report: Government Response to the Committee's Ninth Report of Session 2009–10	HC 370
First Report	The Reviews into the University of East Anglia's Climatic Research Unit's E-mails	HC 444 (HC 496)
Second Report	Technology and Innovation Centres	HC 618 (HC 1041)
Third Report	Scientific advice and evidence in emergencies	HC 498 (HC 1042 and HC 1139)
Second Special Report	The Reviews into the University of East Anglia's Climatic Research Unit's E-mails: Government Response to the Committee's First Report of Session 2010–12	HC 496
Fourth Report	Astronomy and Particle Physics	HC 806 (HC 1425)
Fifth Report	Strategically important metals	HC 726 (HC 1479)
Third Special Report	Technology and Innovation Centres: Government Response to the Committee's Second Report of Session 2010–12	HC 1041
Fourth Special Report	Scientific advice and evidence in emergencies: Government Response to the Committee's Third Report of Session 2010–12	HC 1042
Sixth Report	UK Centre for Medical Research and Innovation (UKCMRI)	HC 727 (HC 1475)
Fifth Special Report	Bioengineering: Government Response to the Committee's Seventh Report of 2009–10	HC 1138
Sixth Special Report	Scientific advice and evidence in emergencies: Supplementary Government Response to the Committee's Third Report of Session 2010–12	HC 1139
Seventh Report	The Forensic Science Service	HC 855 (Cm 8215)
Seventh Special Report	Astronomy and Particle Physics: Government and Science and Technology Facilities Council Response to the Committee's Fourth Report of Session 2010–12	HC 1425
Eighth Report	Peer review in scientific publications	HC 856 (HC 1535)
Eighth Special Report	UK Centre for Medical Research and Innovation (UKCMRI): Government Response to the Committee's Sixth Report of session 2010–12	HC 1475
Ninth Report	Practical experiments in school science lessons and science field trips	HC 1060–I (HC 1655)
Ninth Special Report	Strategically important metals: Government Response to the Committee's Fifth Report of Session 2010–12	HC 1479
Tenth Special Report	Peer review in scientific publications: Government and Research Councils UK Responses to the	HC 1535

	Committee's Eighth Report of Session 2010–12	
Tenth Report	Pre-appointment hearing with the Government's preferred candidate for Chair of the Technology Strategy Board	HC 1539–I
Eleventh Special Report	Practical experiments in school science lessons and science field trips: Government and Ofqual Responses to the Committee's Ninth Report of Session 2010–12	HC 1655