National Alcohol Strategy

- A response by the Institute of Alcohol Studies

1.0 We fully support the comprehensive national alcohol strategy consultation being carried out by Alcohol Concern, which we believe to be potentially of great value, but we wish briefly to emphasise some particular points. Our views on specific aspects of alcohol policy such as liquor licensing will be provided in due course.

2.0 The Nature and Scale of the Problem and Future Prospects

2.1 It is known that deaths from alcohol-related disease increased by over a third in the 10 years from 1984 to 1994. Deaths from chronic liver disease and cirrhosis increased by two thirds during this period. The increase was especially steep in young adults aged 15-44, in whom the death rate doubled.[1]

Since 1994, the death rate from chronic liver disease and cirrhosis, conventionally taken as an indicator of the general extent of alcohol-related health damage, has increased in men by over a further 30 per cent, and in women by a further 24 per cent.[2] Alcohol-related health problems affect not just the individual drinkers concerned but also impose a heavy burden on the health service.

2.2 However, important though health problems are to individuals and to society, we believe strongly that it is a mistake for national alcohol strategy, and messages about 'sensible drinking', to be dominated by health issues to the exclusion of other considerations and, especially, for these health issues themselves to be limited to chronic problems such as cirrhosis. In relation to the numbers of people affected and the total burden on society, the problems of acute intoxication are undoubtedly more important than the chronic health conditions, important though these are to those who experience them.

2.3 In societies such as ours alcohol is more accurately described as a social problem that can have medical complications than the other way around. For example, the strong associations of alcohol with crime and anti-social behaviour are also well known.

2.4 A major disadvantage of an undue focus on the health aspects is that it tends to divert attention away from the ways in which problematic drinking can impair and destroy relationships, and can have highly adverse effects on people other than the drinkers themselves. In the recent EUROCARE report to the European Union, we estimated that there are probably around a million children in the UK experiencing often severe problems from parental alcohol consumption.[3]

2.5 Crime and family problems associated with alcohol consumption are particularly important examples of social problems which impose huge burdens on individuals and society but which are ignored totally by burden of disease studies designed to ascertain whether the supposed cardioprotective effects of alcohol result in less, as many or more deaths being prevented as caused by alcohol consumption. Such studies are concerned with only a small part of the total picture. For most people, most of the time, alcohol problems mean problems in their lives, not the causes of their deaths. Moreover, in many cases the person with the problem is someone other than the person doing the drinking. These aspects of the problem were almost entirely ignored in the Report of the Interdepartmental Working Group on Sensible Drinking, which, when it was published, was described by a senior Department of Health official as governing national alcohol policy for the foreseeable future.[4]

3.0 The Need for a National Alcohol Policy

3.1 In our view, the need and justification for a national alcohol policy arises not from the fact that drinkers may damage themselves but from the excessive and inappropriate consumption of alcohol causing harm to people other than the drinkers and placing an enormous burden on society at large.

3.2 We believe that this should be made explicit in a statement of national policy. The statement should refer in particular to alcohol problems as they affect families. On this subject, we have recently made a series of specific recommendations in our Report to the European Union: these are reproduced as Appendix 1.

4.0 Trends in Alcohol Consumption

4.1 After a period of relative stability during the early 1990's, per capita alcohol consumption is now rising again to historically high levels. Taking into account the consumption of unrecorded imports of alcohol, legal and illegal, from across the Channel, per capita consumption in 1998 was probably higher than at any time since the turn of the century.

4.2 Despite the 'Health of the Nation' targets set by the previous Government, there is no sign at all of any reduction in the numbers of those exceeding the recommended limits of regular consumption. On the contrary, the proportion of women exceeding the limits has increased by 55 per cent since 1984 and is still rising. The latest available information suggests that the proportion of men exceeding the limits is now also increasing.[5]

4.3 Barring an unwanted turn-down in the economy, there is no reason to believe that this growth in average consumption, heavy drinking and in alcohol problems will come to a halt spontaneously, still less go into reverse.

5.0 A Strategy on Alcohol or on Alcohol Problems?

The alcohol industry expends much time and effort in trying to discredit the scientific consensus* that there is a close relationship between per capita alcohol consumption and the level of alcohol-related harm (the 'whole population theory'), or more usually simply asserts that this view has already been discredited, which it has not. An equally erroneous argument employed by the industry is that because of the supposedly cardioprotective effects of alcohol, the health of the population could be put at risk by a reduction in the overall level of national alcohol consumption.[6]

6.0 The Health Benefits of Alcohol

6.1 The argument of the alcohol industry concerning health benefits is invalid. The scientific consensus is that light drinking may have health benefits for some (mainly middle aged and elderly) individuals, although the evidence is more ambiguous than is often suggested. For example, the one major, reliable study of these issues in the UK, found that while lifetime non-drinkers did have an increased risk of heart attack, they also had the lowest overall mortality rate from cardiovascular disease.[7]

6.2 Moreover, at a population level the cardioprotective effects of alcohol 'are essentially cancelled out by increases in other causes of death'.[8] This is exemplified by France, where a particularly low death rate from coronary heart disease coexists with a high overall excess mortality rate in men, largely attributable to alcohol and tobacco.[9] It is of particular interest that far from the decline in French national alcohol consumption causing any increase in mortality from cardiovascular disease, deaths from this cause have in fact declined as consumption has declined.

6.3 The absence of adverse consequences from reduced consumption arises from the fact that, in relation to the cardioprotective effects of alcohol, the optimum level of per capita consumption is estimated to be around 3 litres per annum.[10] There is no valid reason, therefore, to suggest that a reduction from the present UK consumption of more than three times this amount would have any adverse health consequences: on the contrary, any health benefits would remain while the adverse health effects would be reduced.

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* The Report of the Interdepartmental Working Group on Sensible Drinking concluded that '...most experts still posit a dynamic correlative relationship between average consumption and the level of problem drinking..'

7.0 The Whole Population Model

7.1 The original statistical formulation of the whole population theory has indeed be shown to be wanting. This does not invalidate the essential finding that average per capita consumption of alcohol is causally related to levels of alcohol-related harm.

7.2 The relationships between per capita consumption and alcohol-related mortality that the alcohol industry wishes to deny exist, except, presumably, by coincidence, are shown in the tables below for the UK and France.

Table A: France alcohol consumption per head of population and alcohol-related mortality for quinquennial periods 1960-1988*

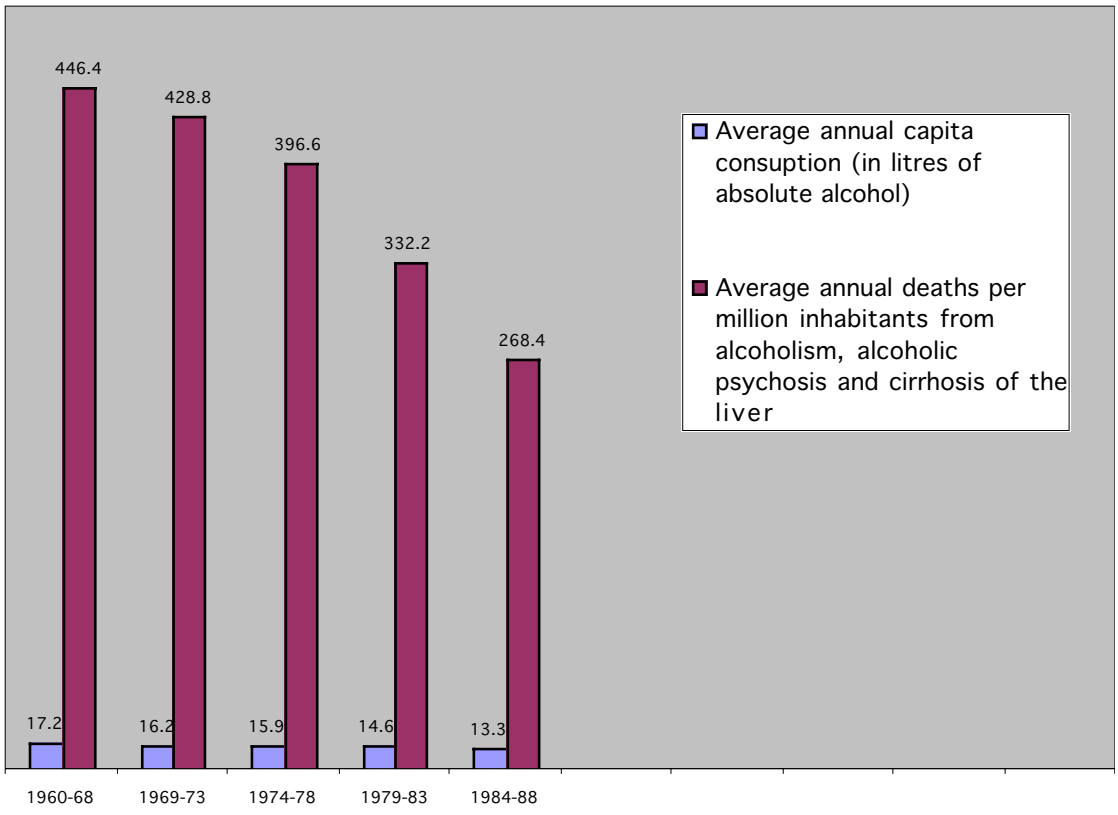
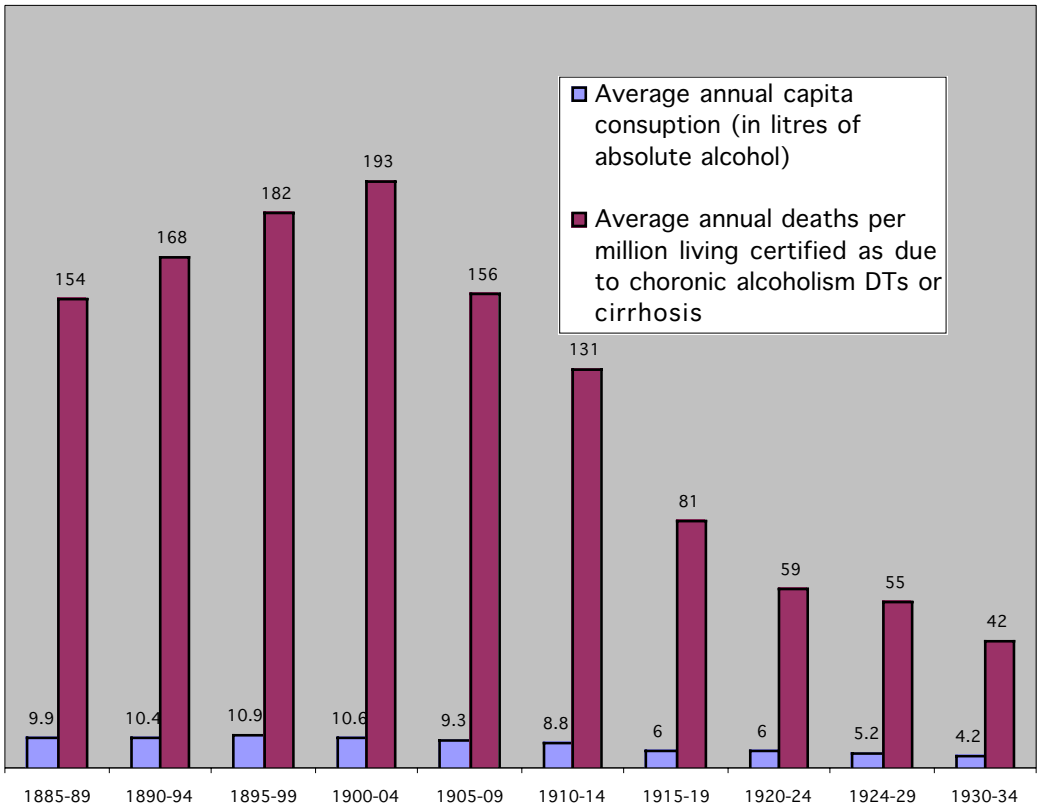


Table A: United Kingdom alcohol consumption per head of population and alcohol-related mortality for quinquennial periods 1885-1930



7.3 Despite the statement quoted above, the Interdepartmental Review on Sensible Drinking discounted the whole population theory as 'scientifically uncertain and difficult to apply, especially in the UK'. The Review speculated that while the theory might apply to comparisons of one country with another (countries with higher average consumption would probably be found to have

more heavy drinkers), it did not necessarily follow that the theory applied within a single country, such as the UK.

7.4 Prompted by this challenge, researchers analysed information on drinking habits in fourteen regions of England.[11] They found that, exactly as the whole population theory predicted, the regions with the lowest average consumption had the fewest heavy drinkers and vice versa - the regions with the highest average per capita consumption also had the highest proportions of heavy drinkers (defined as those drinking above both the old and the new 'sensible limits') and the highest prevalence of people reporting symptoms of alcohol dependence. This was found for both men and women.

7.5 These observations confirm that heavy drinking or 'alcohol abuse' are not purely the result of individual attributes scattered randomly through the population, but are also, and mainly, a reflection of the prevailing drinking culture and the average level of consumption. They also imply that factors encouraging increased average consumption in light to moderate drinkers, - such as longer drinking hours, alcohol becoming cheaper, or, perhaps, governments raising the 'sensible drinking limits' and sending messages about the heath benefits of 'moderate' consumption - are also likely to result in an increase in heavy drinking and alcohol-related problems.

7.6 Given these findings, the statement of the Minister of Health that what is required is action against the harm caused by alcohol, not action against alcohol itself needs to be qualified in certain key respects.* We share the Minister's distaste for 'nannying lectures' but the problem is that any would-be national alcohol strategy is confronted by certain realities. The demand of the alcohol industry and, it seems, of the Minister for Public Health, that the national strategy should focus wholly on alcohol 'abuse', leaving alcohol 'use' alone ignores the rather obvious point that use and abuse are so intimately connected that when the one increases so, generally, does the other.

It will do no service to the public to base a national alcohol strategy on the absurd delusion that average alcohol consumption and the level of harm are

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* *The Rt Hon Tessa Jowell M.P. (House of Commons 29.4.98): "Alcohol misuse is a significant public health issue. We treat it as such now, and shall continue to do so. However, we are not interested in depriving of their drink millions of people whose moderate consumption causes no harm to themselves, their families or society. If policies to combat abuse are to be effective, we need widespread public support. There is no place for crusading zealotry against alcohol as such.*

In dealing with such a complex subject, we need a balanced, realistic, sensible and practical approach to policies on alcohol. We need to address the harm that it causes, not the substance; that means no nannying lectures.

entirely unconnected, that it is possible to tackle the harm caused by alcohol while ignoring alcohol.

7.7 Other than in overblown rhetorical declamations, the prospect of depriving millions of moderate drinkers of their alcohol does not, of course, arise. In the real world, the main issue that the national alcohol strategy needs to address is that alcohol consumption and harm are at high levels, are rising and will, presumably, continue to rise unless preventative action is taken. We hope that the Government does not intend systematically to divert attention from this real and pressing issue by conjuring up the entirely bogus threat of prohibition.

7.8 We know of no country in which the goal of reduced alcohol-related harm is regarded as compatible with a policy of encouraging increased alcohol consumption. On the contrary, in countries which have formulated national alcohol strategies, the objective, implicit or explicit, is always to reduce or at least stabilise alcohol consumption, this being seen as either the means or the consequence of reduced alcohol-related harm (see Appendix 2).

7.9 In our view, therefore, it would be not just foolish as well as dishonest for the Government to base its strategy on the mythology cultivated by the alcohol industry that the level of national consumption is a matter of complete indifference. Measures - the level of excise duties is an obvious example - which affect the drinking population as a whole must necessarily play an important role in an overall strategy.

7.10 None of this is to deny the importance of the targeted approach, or that the main need is, to focus on harmful and dangerous patterns of consumption. In our view, the whole population and the targeted approach are complementary: far from its being necessary to make a choice between them, to be fully effective the one requires the other. In the words of a recent, comprehensive international review of the research evidence: '… if the level of alcohol consumption is allowed to run free and go high, more targeted interventions will be rendered null and void.'[12]

8.0 A Popular Strategy Based on Evidence

8.1 Alcohol Concern lists some of the main components of a national strategy. To these we would add public acceptability and an approach based on evidence. In our view, these two components are linked.

8.2 We agree fully with the Minister's statement that widespread public support is needed successfully to tackle alcohol problems. We would however question the implication of the Minister's statement that public opinion is normally or necessarily hostile to preventative measures. In relation to drinking and driving, for example, it is clear that for several years public opinion has been in favour of rather tougher measures than Governments have been prepared to

introduce. It is also clear that a succession of measures has been introduced - and more are being proposed - to weaken licensing controls in defiance of public opinion. The Government's advice on the need for public support is so obviously sensible and desirable that we can only hope that the Government takes it itself.

8.3 We also make the assumption that public opinion is more likely to support measures which they are convinced are designed to protect or promote the public good and which are based on evidence rather than prejudice and the demands of vested interests.

Fortunately, there is now a good deal of evidence available on which to base policy decisions. The international review summarises what the research evidence shows to be effective policies for reducing alcohol problems:[12]

* *Taxation of alcohol*

* *Measures influencing physical access to alcohol*

* *Drink driving countermeasures if vigorously enforced and given a high public profile*

* *Other situationally directed measures such as control of alcohol at sporting events*

* *Treatment of alcohol problems, including simple forms of help given in primary care settings*

The review adds that *school-based education, public education, warning labels and advertising restrictions* can be added to the policy mix, but on the basis of the reasonable hope of long-term pay-off, rather than on evidence of the kind that supports the above group of measures.

9.0 The Sensible Drinking Message

9.1 As suggested above, the evidence is that public education of this kind has very limited direct effect on actual drinking behaviour. However, it is possible that over a prolonged period such campaigns may effect the general social climate.

9.2 We have explained previously our reservations about the 'sensible limits' approach to educational programmes aimed at the public at large.[13] We hope that the Government will reconsider this approach, and be alert to the obvious danger of appearing to endorse levels of consumption which are higher than those of the majority of the population.

9.3 We do accept that the 'sensible limits' approach may be appropriate in programmes aimed at heavy drinkers and in view of the extensive media publicity that these limits receive there is an urgent need to correct the confused and contradictory advice on limits inherited from the previous Government. We hope the Government will emphasise that medical advice is that the new daily limits should not result in the old weekly limits of 21 and 14 units being exceeded.[14] In other words, the Government should make it clear that there never was any valid scientific case for raising the drinking limits.

10.0 Administrative Responsibilities

10.1 A feature of the situation that has become very clear over recent years is that statements of good intention and exhortations to do better are not enough. There is a real danger that a national alcohol strategy will founder through a failure to make anyone in particular responsible for its implementation.

10.2 We fully support calls for the Interdepartmental Group on Alcohol Misuse to be re-established. We believe that, as before, the Ministerial Group should have the tasks of coordinating departmental policies towards the agreed strategic objectives and providing the national leadership required: this includes providing a framework for action for those involved in implementing the strategy at local level.

10.3 In regard to local initiatives, we believe that the Government has made a good start with the Crime and Disorder Act by requiring local partnerships to formulate plans to tackle alcohol-related crime. This approach could be further developed.

AMcN
February 1999

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Appendix 1

Recommendations from Alcohol Problems in the Family - A report to the European Union. EUROCARE 1998.

National Governments should:

- Establish improved systems of research and monitoring to obtain more complete and reliable information about the contribution of alcohol to divorce, family break-up, child neglect and abuse and other family problems and to assess the economic costs of these problems.

- Ensure that national alcohol education programmes provide information not just about alcohol and health but also about alcohol as a potential social problem and the ways in which alcohol can disrupt social and, especially, family relationships.

- Require local health and social service authorities to draw up plans for tackling alcohol problems and, in particular, for meeting the needs of family members including children. This will involve specifying the ways in which they will make best use of specialist alcohol services, including those provided by NGOs.

- Ensure that schools and other institutions and professionals having contact with children are provided with the education and training necessary for identifying and supporting children from problem drinking families.

- Ensure that a free telephone help line is available for children. It is probably unrealistic to propose a special, dedicated helpline for the children of problem drinking parents: however, alcohol helplines (such as those available in Denmark and the UK) should be geared up to dealing with enquiries from children as well as adults and, similarly, general helplines for children should be geared up to deal with calls concerning alcohol problems.

- Ensure that the bodies responsible for the education and training of social workers and other professionals having contact with families and children, and their accreditation, receive appropriate education and training about alcohol problems, methods of intervention and the needs of family members.

Appendix 2

Aims of alcohol policy in some other countries

France:

By the year 2000, to reduce by 20% the average consumption of alcohol by people over 15; to reduce the impact of alcohol on society and health; to reduce regional disparities by bringing all regions to the level of those with the lowest consumption.

(Health in France 1994. High Committee on Public Health 1996).

Ireland:

The National Alcohol Policy is directed at reducing the prevalence of alcohol-related problems and thereby promoting the health of the community. The policy is based on current research from the World Health Organisation and is in keeping with the European Charter on Alcohol which Ireland endorsed in December 1995.

The aim is to influence people's attitudes and habits so that, for those who choose to drink, moderate drinking becomes personally and socially acceptable and favoured in the Irish culture.

Measures targeting the whole population as well as specific at risk groups are required No single measure will be effective if taken in isolation. High prices and restriction on the availability of alcohol are the most effective measures but cannot be sustained long term without public support through information and advocacy. Measures targeting specific groups, especially young people, and specific settings such as workplace along with accessible and effective treatment services ensure a comprehensive policy.

A multi-sectoral commitment to the National Alcohol Policy at national level and a strong local ownership through health boards and local communities, where real influence and attitude shaping occurs, are key factors. The success of preventive measures hinges on the interaction between reducing availability, through access, pricing and promotion measures, and limiting demand by awareness, advocacy, education and training.

(National Alcohol Policy. Department of Health. Dublin 1996)

Finland:

Finnish Alcohol Policy is motivated by social and health considerations and forms the heart of Finland's welfare policy. The objective of this alcohol policy is

to reduce the detrimental effects of alcohol use by steering the consumption of alcoholic beverages and drinking habits in a more healthy direction. As the level of detrimental effects depends directly on the level of consumption, the primary method of the alcohol policy is to produce a downturn in the consumption of alcohol beverages. At the very last, the growth of alcohol consumption should be kept a lower level than the growth of other private consumption.

Finland has committed itself to the objective of the World Health Organisation, whereby the consumption of alcohol beverages should be reduced by the year 2000. Furthermore, together with 50 other countries, Finland undertook in 1992 to carry out the objective of the European Alcohol Policy Programme (European Alcohol Action Plan), which aims to minimise hazards by lowering total consumption. Finland's contribution to the European Alcohol Policy Programme, "A Proposal for a National Alcohol Policy Programme in Finland for 1996-99", was published in 1995 and was followed in 1997 by "A Proposal for Implementing the National Alcohol Policy Programme". These programmes continue to base the country's alcohol policy on the control of supply and demand. Other means include influencing local alcohol policies, promoting a responsible attitude among citizens, developing health promoting environments and improving the welfare of intoxicant abusers.

(Ministry of Social Affairs and Health, 1997)

Sweden:

The ultimate aim of Swedish alcohol policy is to reduce the harmful effects of alcohol, which means that the number of people with a hazardous consumption of alcohol must be kept as low as possible. This can be achieved by reducing recruitment for the heavy consumer category and also by inducing the heavy consumers to reduce their consumption.

The Government and Riksdag (Parliament) have laid down, as the aim of Swedish alcohol policy, at least 25 per cent reduction of total consumption between 1980 and 2000, which harmonises with the health policy objective for the European region adopted by the World Health Organisation.

The strategy which Sweden has adopted for reducing total consumption is a combination of measures for reducing the availability of alcohol and measurer limiting demand. The most important way of limiting total alcohol consumption is by reducing the availability of alcohol while at the same time trying to influence drinking habits through information, education, opinion formation and caring measures. Fundamental to Swedish alcohol policy, then, is a close interaction between preventive measures, control policy and treatment of alcohol abusers.

Swedish alcohol policy is based on measures addressed to the entire population. In addition, important supplementary measures are addressed to groups specially at risk, above all juveniles, children of alcohol abusers and various groups with high levels of alcohol consumption.
Swedish alcohol policy continues to be guided by the following sub-objectives, formulated in 1977.

- Limiting the availability of alcohol, partly by means of an active pricing policy.
- Counteracting the home-distilling of spirits, smuggling and other illegal handling of alcohol.
- Achieving moderate drinking habits among the population.
- Promoting abstinence in situations making heavy demands on reactions and judgment.
- Focusing alcohol consumption on the drinks containing less alcohol.
- The avoidance of any significant consumption of alcohol during childhood and adolescence.
- Ensuring that both young persons and adults are well aware of the harmful effects of alcohol.
- Promoting consumption of non-alcoholic drinks as an alternative to alcoholic ones.
- Encouraging environments and social habits free from alcohol.
- De-glorifying alcohol.
- Enlarging the total abstinence sector.
- Achieving a pattern of drinking where consumption mostly accompanies meals.
- Ensuring that the significance of the alcohol issue is "taken into account in the shaping of the environment we live in".

(Swedish Alcohol Policy & National Plan of Action for Prevention of Alcohol-Related Harm and Drug Abuse in Sweden, National Institute of Public Health, 1995)

Spain:

There is a direct relationship between the per capita consumption and the percentage of heavy drinkers which has been called the unique or unimodal distribution model.

The international comparative studies correlating the production and consumption of alcohol with the death and morbidity rates Which can be attributed to it suggest that there is a direct proportion between the incidence of these pathologies and the proportion of heavy drinkers and that this latter proportion is directly related to the consumption of alcohol per inhabitant and per annum in that community.

The unique distribution model has achieved great acceptance among the expert groups set up in order to recommend methods for avoiding alcohol-related problems and social difficulties.

Three basic proposals have been derived from the Population's consumption model:

- Firstly, that a change in the total alcohol consumption is probably accompanied by a change in the same direction with the proportion of heavy drinkers

- Secondly, as alcohol abuse increases the probability of physical and social harm, the mean consumption has to be closely related to the prevalence of this harm to society

- Finally, the measures intended to influence general consumption are probably also affecting the prevalence of alcohol-related problems and therefore must be of primordial importance in any prevention programme.

(Alcohol and Public Health. Ministry of Health and Consumer Affairs. 1994)

Netherlands:

The central aim of Dutch alcohol policy is to prevent health risks and social problems resulting from the use of alcoholic beverages. To achieve this aim a population-based approach reducing overall consumption in combination with specific measures targeted at risk groups and risk situations is formulated.

Five kinds of policy instruments have been proposed:

- more education and prevention (especially mass media campaigns)
- better treatment
- stricter Alcohol Licensing and Catering Act
- more sensible advertising of alcoholic beverages
- (if possible) higher taxes

In April 1998 a proposal for a new Alcohol Licensing and Catering Act was presented to Parliament. It will be debated in the spring of 1999. The most important proposals are:

- a ban on serving alcohol in work canteens
- a ban on selling alcohol in non-food stores and petrol stations
- an age limit of 16 years for entering a disco bar
- a statutory obligation for sport canteens and other non-profit bars to introduce house-rules
- a statutory obligation for alcohol suppliers to control the age of all customers

- an authorisation to the Minister of Health to regulate alcohol advertising
- an authorisation to the Minister of Health to ban alcohol sales in soccer stadia, schools, hospitals etc

Other new regulations are:

- stricter rules on 'good behaviour' of licensees
- maximum permitted blood alcohol level of 20mg% for air plane crews

Currently, there is also debate on lowering the maximum permitted blood alcohol level for young drivers to 20mg%.

(Personal communication S. van Ginneken. Ministry of Health, Welfare and Sport. Directorate of Public Health. Netherlands. January 1999).

Australia:

The Mission, goals and policy objectives of the National Alcohol Action Plan include the following:

1. Minimise the level of illness, disease, injury and premature death associated with the use of alcohol.
2. Minimise the level and impact of alcohol-related crime, violence and anti-social behaviour within the community.
3. Minimise the level of personal and social disruption, loss of quality of life, loss of productivity, and other economic costs associated with the inappropriate use of alcohol.

1. Reduce the proportion of the population who drink regularly at levels above that identified by the NHMRC as low risk.
2. Reduce the incidence and consequences of heavy binge drinking, particularly unlawful supply and consumption among young people.
3. Reduce the rate of road crashes involving drivers who have consumed alcohol at prescribed blood alcohol content levels; and
4. Reduce the rate of alcohol related crime including criminal assaults,domestic violence, public order and summary offences.

The National Alcohol Strategy Committee is responsible for providing expert advice to the Minister for Health and Aged Care on matters of national health policy on alcohol. Its principal objectives are to identify the nature and extent of harm caused by alcohol misuse in Australia and to identify the most appropriate mechanisms to reduce the national health, social and economic costs of alcohol.

The National Alcohol Strategy Committee (NASC) is intended to become one of the five expert advisory groups providing policy advice to the newly formed

Australian National Council on Drugs (ANCD) and the Ministerial Council on Drug Strategy (MCDS).

The activities which this group are undertaking include:

(1) Contributing to the development of a National Alcohol Strategic Plan;

This Plan will provide national direction on: priority issues and strategies; needs of high risk communities and populations; evaluation and monitoring strategies; improving collaboration between government and non-government organisations in resource and program development to achieve greater impact and cost efficiency and to preclude unnecessary duplication; the need for interventions to reduce alcohol related harm, with particular reference to at risk population groups; and other matters associated with alcohol related problems.

(2) The development of a nationally targeted education campaign which addresses health and social issues surrounding the misuse of alcohol.

(3) Examining and making recommendations in relation to a system for the monitoring and regulation of alcohol advertising.

The NASC will review current arrangements for the regulation of alcohol advertising in light of the abolition of the Media Council of Australia, and recommend to the Minister any changes required to the system to monitor and regulate alcohol advertising. The Committee will provide advice on: the appropriateness of the existing Alcoholic Beverages Advertising Code; and non-legislative options for the regulation of alcohol advertising.

(Commonwealth of Australia, 1998)