

Institute of Alcohol Studies response to House of Commons Health Committee inquiry on alcohol

Summary

The main points the Institute of Alcohol Studies (IAS) would like to highlight are:

- **IAS welcomes the Government's Alcohol Strategy, in particular the proposal to introduce a minimum unit price for alcohol.** We applaud the recognition that affordability of alcohol is a major driver of alcohol related harm and **support a minimum price of at least 50p per unit** in the first instance.
- The commitments made in the strategy are a significant step forward in the battle to reduce problems caused by alcohol. However, in order to be meaningful, these commitments must be supported with **measurable targets and indicators** over established time periods. They must also be subject to **robust monitoring and evaluation**.
- Alcohol harm is ubiquitous and covers many policy areas. IAS recommends that a **cross-departmental alcohol coordination committee** is established to ensure the Strategy is successful in reducing health and social harms caused by excessive drinking.
- IAS is concerned that the Strategy reinforces and indeed enhances existing roles and structures for alcohol industry involvement in alcohol policy and calls for robust monitoring and independent evaluation of industry initiatives.
- **IAS is concerned about the lack of reference to drink driving policies within the Strategy**, and calls for the introduction of **unrestricted police powers to breathalyse drivers** and a **lowering of the legal BAC limit to 50mg** in line with the majority of European countries.
- IAS is concerned that although there is significant emphasis on the use of screening and brief intervention to moderate drinking behaviour within the Strategy there is **no provision for the early detection of the health problems associated with alcohol misuse**.

Introduction

The Institute of Alcohol Studies (IAS) welcomes the opportunity to respond to the Health Select Committee inquiry into the Government's Alcohol Strategy. **It is clear that the UK is faced with a rising tide of alcohol harm:** Each year, alcohol causes the admission of over a million people to hospital, death rates from alcohol-related liver disease are amongst the highest in Europe and alcohol is linked to 13,000 new cases of cancer and is associated with one in four deaths among young people aged 15 to 24.

IAS sees the Government's Alcohol Strategy as a step in the right direction. However, the major focus of the strategy is on binge drinking and alcohol-related crime with little direct emphasis on the far greater problems of the health issues associated with long-term misuse of alcohol reflecting, perhaps, its Home Office remit. Many of the commitments made to reduce consumption are to be applauded, especially the introduction of a minimum unit price for alcohol. However, in order to be meaningful, the commitments made in the Strategy must be supported with **measurable targets and indicators** over established time periods. They must also be subject to **robust monitoring and evaluation**.

IAS responses to terms of reference:

- 1. Establishing who is responsible within Government for alcohol policy writ large, policy coordination across Whitehall and whether the Department of Health should take a leading role.**

Alcohol harm is ubiquitous and spans across a wide range of policy areas, including health, justice, transport, culture, education, economics and many more. In order to be effective this Strategy requires **a cross-departmental alcohol coordination committee**, which will in turn need to connect effectively with research and public health bodies.

It is however vital that one Department takes overarching responsibility. Given that there is a need for an alcohol strategy to address public health concerns at its core, it would be sensible for the Department of Health to take the leading role.

- 2. Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol.**

While health and law are devolved within the UK, taxation and several other fiscal powers are not. England and the devolved administrations have differing approaches to alcohol policy, illustrated by the Scottish ban on multi-buy discounts and the Northern Ireland commitment to changes in the drink drive levels.

In pursuing different policy approaches, the UK administrations are able to cater for individual health needs and cultural sensitivities. However, some policies may be at risk of being undermined if they differ from neighbouring territories. This is particularly true with pricing policies. For example, the introduction of a ban on bulk discount purchases for alcohol in Scotland led a leading supermarket to contact customers north of the border to reassure them that they could still access bulk discount offers online because the location of the distribution warehouse was in England.

In order to avoid problems associated with cross-border trading, administrations must work together to coordinate, where appropriate, policy responses and share evidence and best practice examples. **An alcohol policy working group**, with representatives from England and each of the devolved administrations, could be established to perform this function, which could report to the cross-departmental alcohol coordinating committee.

Alongside the devolution of UK administrations, there is an important need to remember the European context within which UK policy sits. Much of our domestic alcohol policy is governed by European Directives for example taxation and marketing regulations. The UK Government must be strong in Europe and represent our domestic public health interests.

- 3. Impact of alcohol industry lobbying on changing or influencing alcohol policy of successive governments, and the potential impact on minimising regulation in the future.**

IAS has repeatedly expressed concerns about the involvement of the alcohol industry in public health policy through partnerships developed by the previous Labour administrations and the Coalition Government. Indeed IAS joined other leading health bodies in boycotting the Public Health Responsibility Deal for Alcohol in March 2011,

which was seen as a culmination of inappropriate relations between government policymakers and industry officials that represented a direct conflict of interest between public health goals and economic objectives. Thus, despite acknowledgement in the strategy that **'industry needs and commercial advantages have too frequently been prioritised over community concerns'** many of the Strategy's proposals rely strongly on industry patronage and support.

IAS is concerned that the Strategy reinforces and indeed enhances existing roles and structures for alcohol industry involvement in alcohol policy through initiatives such as the Public Health Responsibility Deal and Drinkaware, in the absence of independent evaluation of their effectiveness. Furthermore, there is evidence that industry-led 'social responsibility' initiatives are ineffective: findings of a report commissioned by the Home Office in 2008 on the efficacy of industry self-regulation in the pursuit of effective alcohol policies identified the persistence of 'many irresponsible and harmful practices' despite the establishment of the drink's industry Social Responsibility Standards in 2005ⁱ.

IAS believes it is not the role of the alcohol industry to define public health policy or to be responsible for the creation of public health information, as in many cases this is in direct conflict with their interests and responsibilities to shareholders and employees. To ensure policies relating to alcohol are developed and implemented with the maximum public health benefit, they must be subject to rigorous evaluation and monitoring, by agencies free from alcohol industry interests.

4. The evidence base for and economic impact of introducing a fixed price per unit of alcohol, including the impacts on moderate and harmful drinkers. The legal complexities of introducing fixed pricing should also be explored.

The IAS strongly supports the Strategy's commitment to introduce a minimum price per unit of alcohol. We applaud the recognition that affordability of alcohol is a major driver of alcohol related harm and congratulate the Government for taking a significant step forward in the fight against alcohol harm.

Numerous studies across the world have shown public health benefits as a result of alcohol price increases and taxation policies: increasing the cost of alcohol is associated with sustained reductions in all-cause mortality, liver related deaths; suicide rates; hospital admissions; road traffic accident rates and youth fatality ratesⁱⁱ. Alcohol price increases have also been directly linked to reduced rates of homicides, rape, robbery, assaults, motor vehicle theft, domestic violence and child abuseⁱⁱⁱ. Young people and harmful drinkers are the two groups that are the most responsive to pricing policies and would be the most affected by the introduction of a minimum price policy, as they consumer cheap alcohol. 'Moderate' drinkers however will be less affected by the price changes^{iv}.

A study by the University of Sheffield conducted as part of the NICE review estimated that on average, hazardous drinkers drink 15 times more alcohol than moderate drinkers, yet pay 40% less per unit. The modelling used as part of the report showed that as the minimum unit price increased, public health gains also increased, as outlined in Table 1:

Table 1: Estimated effects of minimum unit pricing policy in England^v

Outcome	40p	45p	50p
Alcohol-related deaths prevented after 1 year	157	268	406
Alcohol-related deaths prevented after 10 years	1,381	2,288	3,393
Hospital admissions prevented after 1 year	6,300	10,800	16,400
Hospital admissions prevented after 10 years	40,800	66,600	97,000
Crimes prevented after 10 years	16,000	28,900	45,800
Violent crimes prevented after 10 years	3,200	6,200	10,300

IAS therefore supports the introduction of a minimum unit price of **at least 50p**, which the modelling suggests would save 3,393 lives, prevent 97,000 hospital admissions and 45,800 crimes each year when the policy has reached its full affect.

Concerns have been raised that minimum price may be illegal under EU competition law. The Scottish Government, which has examined this issue thoroughly, strongly disagrees and argues EU Competition Law does provide for a public health exemption. This exemption has been successfully used by the French Government to ban alcohol advertising and sponsorship in certain circumstances (the ‘Loi Evin’), winning a number of cases in the European Court of Justice (ECJ) after challenges on its legality.

5. The effects of marketing on alcohol consumption, in particular in relation to children and young people.

There is extensive evidence that exposure to alcohol marketing encourages children to drink at an earlier age and in greater quantities than they otherwise would. The Health Select Committee reported in 2010 that the current regulatory framework for alcohol marketing in the UK was inadequate:

“The current system of controls on alcohol advertising and promotion is failing the young people it is intended to protect. The problem is more the quantity of advertising and promotion than its content. This has led public health experts to call for a ban. It is clear that both the procedures and the scope need to be strengthened.”^{vi}

Whilst the Strategy recognises the link between marketing and consumption, the proposed actions outlined focus on working within the current structures and do not go far enough to curb children’s exposure to alcohol advertising.

A framework exists in France to protect children and young people from exposure to alcohol marketing and promotion. The ‘Loi Evin’ allows alcohol marketing and promotion in media that is used by adults, but not where a large proportion of children and young people make up the audience. Given the complexities of marketing regulation in the UK and the ease at which alcohol promoters are able to advertise their products to children within the current codes of conduct, for example in cinemas for under-18 films, music festivals and football sponsorships, the Loi Evin model provides a simple framework that can offer clarity on what marketing practices can and cannot be implemented whilst ensuring that children and young people are protected from an exposure that poses a risk to their health and wellbeing.

IAS would support a UK adapted version of the “Loi Evin”. The “Loi Evin” has been challenged in the French courts upheld in the ECJ, which found in 2004 that the measure is proportionate, effective, and consistent with the Treaty of Rome.^{vii}

6. The impact that current levels of alcohol consumption will have on the public's health in the longer term.

Making future projections on the health impacts of alcohol is a difficult task, especially for a population that is subject to increasing demographic change. However, it is clear that alcohol-related harm increases when population consumption levels increase (Figure 1).

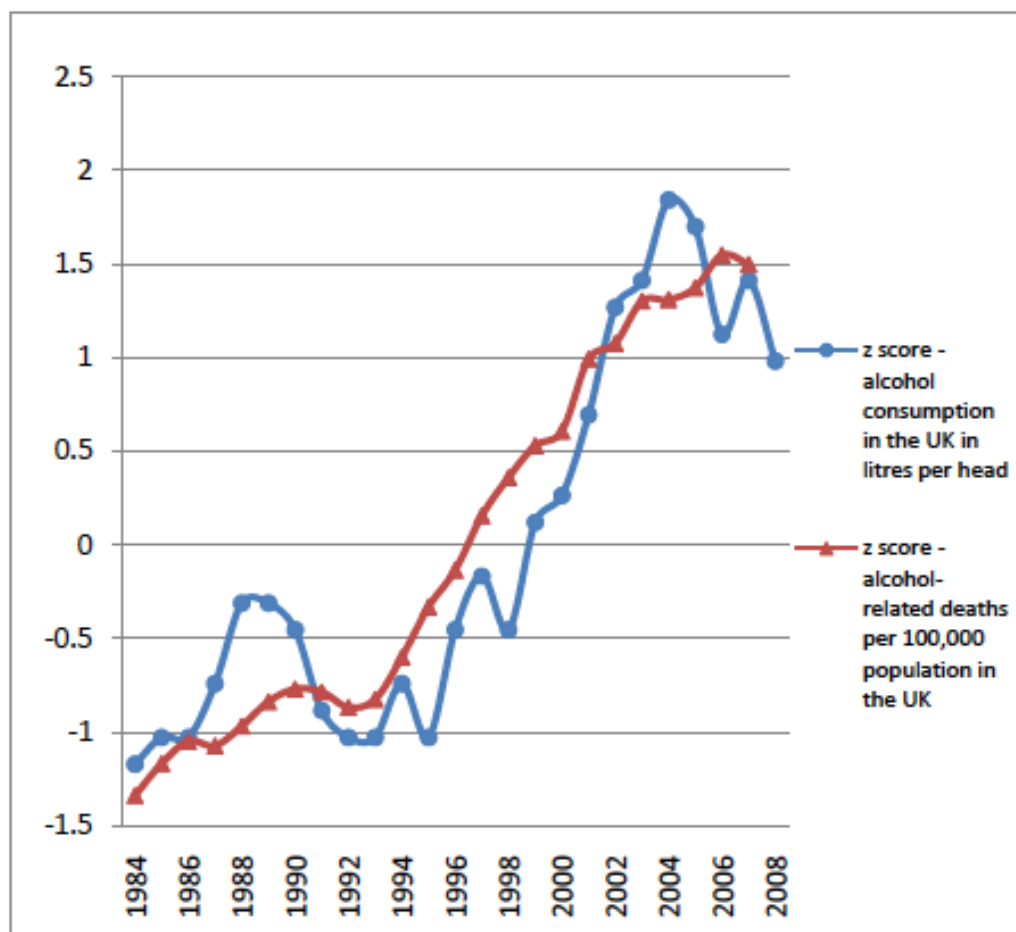


Figure 1: Trends in per capita alcohol consumption and alcohol-related deaths for the UK 1984 – 2008.

Source: 'Future Proof: Alcohol Consumption, Mortality and Morbidity - Key Findings' Professor Martin Plant 2009^{viii}

At present, death rates from liver disease in the UK are increasing at a time when the mortality rates from many other diseases such as cancer, heart disease, stroke and respiratory disease have fallen since the early 1990s (Figure 2):

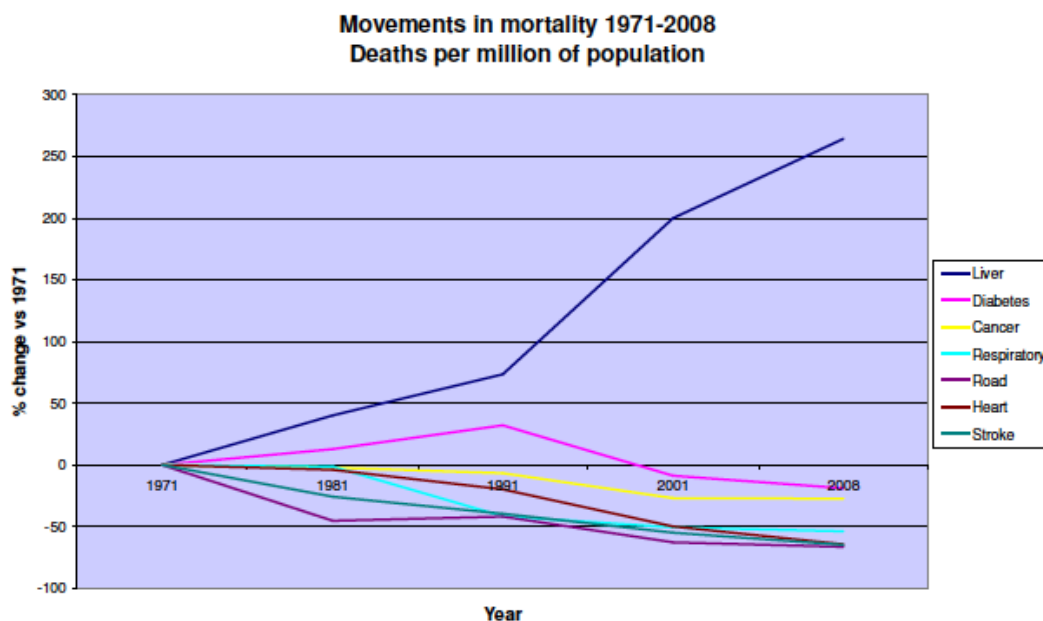


Figure 2: Changes in mortality rates per million population for selected diseases in England and Wales 1971-2008 (1970 = 100%)

Source: British Liver Trust, 2010^{ix}

Alcohol consumption levels have fallen in recent years most likely because of the current economic climate and the reduction in disposable income. It is likely that this reduction in consumption levels, if sustained for whatever reason, may be reflected, after a lag time of about 18 months, in a reduction in the levels of alcohol-related harms

The IAS would recommend that the Department of Health commissions research into future projections for alcohol health harms, paying particular attention to the impact on different demographic groups and communities. We would also recommend that attention be drawn to the health (and social) **harms to others** caused by alcohol, as well as to individual drinkers.

7. **Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services** (*presumably as specified in the national liver strategy but not spelt out in the Strategy document*).

The Strategy focuses strongly on binge drinking and alcohol-related crime with little if any recognition of the appalling personal, societal and fiscal costs associated with the health consequences of long-term alcohol misuse. Clearly measures taken to reduce alcohol consumption, such as minimum unit pricing, will impact on the heaviest drinkers but will not in the short to medium term have any effect on the health burden imposed by those already damaged. Reductions in population consumption levels, if sustained, will be followed, after a lag time of approximately 18 months, by a fall in mortality rates from alcohol-related cirrhosis. This, however, simply reflects the fact that survival improves if patients reduce their alcohol intake but does not detract from the fact that these individuals still have a serious chronic condition that will continue to incur significant health-related costs.

Many of the chronic health problems associated with long-term alcohol misuse take 10

to 15 years to develop and often do so silently. **There is no provision within the Strategy for the early detection of the health problems associated with alcohol misuse.** Thus, although much is made of the opportunities within the health services to identify individuals drinking excessively and to provide a brief intervention there is nothing about screening for the health consequences. It is well established that the more information individuals receive about the damage they may be causing themselves the more likely they are to change behaviour. Thus, alcohol identification and brief advice is simply not enough; those who have an established pattern of heavy drinking should be screened further to identify alcohol-related damage at an earlier and potentially reversible stage.

As there are no clear plans within the Strategy to specifically target and hence reduce the health consequences of alcohol misuse it is unlikely that the burden of alcohol-related problems on health and social services will be alleviated significantly within the foreseeable future.

8. Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm.

The availability and quality of services for people with alcohol-related harm vary widely across the country. Services are provided by a variety of statutory and non-statutory agencies. Within the statutory sector there is a tendency for services to be commissioned from private agencies many of whom do not employ clinical staff but rely on ex-service users. There are some examples of good practice but very few integrated services. Many health authorities combine Drug and Alcohol Services and invariably the provision for alcohol come a poor second despite the much greater need. General practitioners have not embraced the problems of alcohol misuse as well as they should have done evidenced by the fact that any screening etc. is only undertaken, and then not particularly effectively if it attract additional payment via Quality and Outcome Framework initiatives.

Given the above **it is difficult to see how the proposed reforms of the NHS and public health systems would facilitate let alone help integrate services for people who experience alcohol-related harm.** From April 2013 upper tier and unitary local authorities will receive a ring fenced public health grant, including funding for alcohol services. However, unless a proportion of these funds are in turn ring-fenced for alcohol services there will be no guarantee of proportionate funding analogous to the situation with Drug and Alcohol Services mentioned above. The situation relating to the Health Service reforms is less clear: much of the commissioning will be in the hands of the GPs and it is difficult to be clear about where on their landscape alcohol services will figure. What is clear is that these lines of commissioning will do nothing to ensure uniformity in the availability and quality of services for people with alcohol-related problems.

Clearly there should be dialogue between the various sectors responsible for commissioning of alcohol services in a given area if not nationally. Of value would be a series of directive on service provision from central Government better still with identification of ring-fenced funding.

9. International evidence of the most effective interventions for reducing consumption of alcohol

There is a substantial evidence base on the effectiveness of different policies in reducing the harm done by alcohol (Table 2). Effective policies include those that (i) regulate the

environment in which alcohol is marketed (economic and physical availability) (ii) reduce drinking and driving and (iii) are individually-directed at already at-risk drinkers. On the other hand, the evidence shows that information and education-type programmes do not reduce alcohol-related harm, although they have a role in providing information, reframing alcohol-related problems, and increasing attention to and acceptance of alcohol on the political and public agendas.^x

Based on a WHO report in 2009, *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*, Table 2 summarizes the evidence to support policy measures that reduce alcohol-related harm:

Table 2. Summary of the evidence of the effectiveness of alcohol policies

<i>Degree of evidence</i>	<i>Evidence of action that reduces alcohol-related harm</i>	<i>Evidence of action that does not reduce alcohol-related harm</i>
Convincing	Alcohol taxes Government monopolies for retail sale Restrictions on outlet density Restrictions on days and hours of sale Minimum purchase age Lower legal BAC levels for driving Random breath-testing Brief advice programmes Treatment for alcohol use disorders	School-based education and information
Probable	A minimum price per gram of alcohol Restrictions on the volume of commercial communications Enforcement of restrictions of sales to intoxicated and under-age people	Lower taxes to manage cross-border trade Training of alcohol servers Designated driver campaigns Consumer labelling and warning messages Public education campaigns
Limited-suggestive	Suspension of driving licences Alcohol locks Workplace programmes Community-based programmes	Campaigns funded by the alcohol industry

Source: *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*, WHO report, 2009^{xi}

Drink Driving

IAS is concerned about the omission in the Strategy of drink drive policy commitments. Despite the gradual decline in drink drive accidents over the last 25 years, drink drivers still kill and injure thousands of people each year. **In 2010 250 people were killed and 9,700 were injured in drink drive accidents in Britain^{xii}.**

A person's ability to drive is affected if they have any alcohol in their blood. Drivers with blood alcohol concentrations of between 20-50mg/100ml have at least a x 3 greater risk of dying in a vehicle crash. This risk increases x6 with blood alcohol concentrations of 50- 80mg %, and x11 at 80-100mg%^{xiii}.

IAS supports a reduction in the legal blood alcohol limit for drivers to 50mg in line with the majority of European Countries. Lowering the legal blood alcohol level to 50mg/100 ml in Great Britain would save **up to 303 lives** during the first six years of implementation^{xiv}. **Implementation of this scheme in Northern Ireland should be carefully monitored.**

There is ample evidence that high profile police breath testing of drivers cuts casualty rates^{xv} and there is a clear inverse relationship between the number of breath tests carried out and the number of drink-drive casualties. **IAS supports the Association of Chief Police Officers (ACPO) in their request for the removal of restrictions on Police powers to breath test drivers.** This would help the Police to use their powers more effectively both as a deterrent and also to target drinking drivers who remain undeterred.

Institute of Alcohol Studies
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ⁱⁱⁱ Wagenaar A. C., Salois M. J., Komro K. A. Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction* 2009; 104: 179–90

^{iv} Purhouse, R et al, 2009. Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group.

^v *ibid*

^{vi} Health Committee, First Report of Session 2009-10, *Alcohol*, House of Commons 151-I Back. 2010.

^{vii} Commission of the European Communities v French Republic, 2004

^{viii} Coghill, N, Miller, P, Plant, M, Future Proof: Can we afford the cost of drinking too much? Mortality, morbidity and drink driving in the UK, report by Alcohol Concern, 2009

^{ix} data accessed at <http://www.britishlivertrust.org.uk/home/about-us/media-centre/facts-about-liver-disease.aspx?searchId=682> 2/5/2012

^x WHO, Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm, Geneva, 2009

^{xi} *ibid*

^{xii} Department for Transport. Reported Road Casualties Great Britain. DoT, 2009.

^{xiii} NICE, Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths, March 2010

^{xiv} Department for Transport, Report of the Review of Drink and Driving Law, June 2010

^{xv} *ibid*