Tackling alcohol-related harm

Alcohol is a normal part of life for many in the UK. It is readily available, increasingly affordable and heavily marketed as an established part of modern society. Despite this, the significant harms caused by alcohol are widely recognised and well known. Doctors witness first-hand this harmful impact on their patients. Faced with an increasingly unmanageable and unsustainable workload, and rising demand for healthcare services, tackling the underlying causes of alcohol-related harm should be a key public health focus. There is now a well-established evidence base to support a range of different alcohol-related interventions. This briefing summarises the latest key data and evidence on the scale of harm, before setting out a range of key policy responses.

Ten key action areas to reduce alcohol-related harm

1. Reduce the affordability of alcohol through taxation measures
2. Prevent the cheap sale of alcohol through the implementation of minimum unit pricing
3. Ensure health is a key factor in licensing decisions
4. Implement a comprehensive ban on all alcohol marketing communications
5. Ensure alcohol education is delivered independently of the alcohol industry
6. Provide consistent consumer information through mandatory labelling of alcoholic products
7. Implement evidence-based measures to reduce drink driving levels
8. Introduce a range of measures to reduce and better manage pregnancies affected by alcohol
9. Support healthcare professionals in identifying and managing alcohol-related problems
10. Provide adequate resources for specialist alcohol treatment services

The scale of the problem

Drinking alcohol is an established weekly activity for the majority of adults in the UK. Fifty-eight per cent of the population report drinking alcohol in the previous week, and despite a decline in number of people drinking weekly, overall consumption remains at a historically high level. In 2014, over 10 million adults were regularly drinking more than 14 units of alcohol each week (which is above the recommended weekly intake for men and women). In England, 18% of men and 13% of women drink at increased levels of harm, with similar proportions in Scotland, Wales and Northern Ireland. The UK’s relationship with alcohol is normalised from an early age – one in 10 school pupils in England report drinking alcohol in the last week, and two fifths say they have drunk alcohol at some point. Despite some progress to reduce the number of school pupils drinking, a significant number still drink alcohol from an early age.

Alcohol causes significant harm. It is causally linked to over 60 different medical conditions including liver damage, brain damage, poisoning, stroke, abdominal disorders and certain cancers. Partially attributable alcohol-related cancer, liver disease and kidney problems are the cause of a rising number of alcohol-related hospital admissions. Cardiovascular disease has risen particularly rapidly, more than doubling to reach over 1.5 million related admissions every year. While liver disease is responsible for 86% of directly attributable mortality from alcohol in the UK.
Deaths and hospital admissions
Alcohol causes thousands of deaths every year in the UK. In 2015 there were 8,758 alcohol-related deaths in the UK.17 The rate of alcohol-related mortality for men in 2015 (19.2 per 100,000) is more than double the rate for women (9.7 per 100,000). There is also significant regional variation, ranging from the highest rate in the North East (39.4 per 100,000) to the lowest in the East of England (19.3 per 100,000).17

Alcohol is also a leading factor in over a million hospital admissions every year. In England, there were an estimated 1,085,830 admissions related to alcohol consumption in 2014-15, increasing for the tenth consecutive year.14 In Scotland, there were 35,059 alcohol related hospital stays,18 15,114 in Wales19 and 26,236 in Northern Ireland.20 Almost half (47%) of all hospital admissions occur in the lowest socioeconomic groups.7 Mental and behavioural disorders due to alcohol use, account for over 200,000 (19%) alcohol-related hospital admissions every year.7

Other alcohol-related harms
Domestic violence is routinely linked to drinking. Alcohol is particularly associated with incidents of physical and severe domestic violence, as well as incidents of sexual assault. The most recent annual data show that in 53% of violent incidents in 2013/14, victims perceived the offender to be under the influence of alcohol.21 Children are especially vulnerable to alcohol-related harm in the home. Drinking is a contributory factor in family and relationship breakdown. Over 2.5 million children in the UK are living in a home where their parents are drinking hazardously.22 Nearly four thousand children in the UK contact ChildLine every year worried about their parents’ drinking or drug use.23

Alcohol is also a significant factor in violence outside of the home. Drinking is particularly prevalent in violent incidents involving strangers – 64% were perceived to be alcohol related, as well as 70% of violent incidents which took place in a public space. This compares to 40% of incidents that occurred in the home, and 43% of incidents that happened in and around the workplace.21

Costs of alcohol-related harm
The cost of alcohol-related harm in the UK is substantial. Various estimates have considered the total social and economic cost – for example, to cost £21 billion a year in England and Wales;24 £7.2 billion a year in Scotland;25 and £680 million a year in Northern Ireland.26 Within these total costs, the costs to specific services are equally significant. In England, alcohol costs the NHS £3.5 billion a year (2009-10 costs) and £11 billion a year to the criminal justice system (2010-11 costs), as well as £7.3 billion a year in lost productivity across the UK.27 The cost of alcohol increases further when, as well as the societal cost, the costs to the individual from alcohol misuse are included. This is wide ranging and may include tobacco and illicit drug use; accidents and injuries; malnutrition and eating disorders; unemployment; self-harm and suicide.28 Alcohol and homelessness also have a complex relationship – dependence can lead to homelessness while for others alcohol problems may develop as a result of being homeless.29

Alcohol harm reduction strategies
The overarching objective of alcohol policy should be to reduce the total volume of alcohol across the population in the UK. This reflects that the greatest burden of harm is suffered by the large population of regular drinkers, and not just confined to the minority of heavy drinkers.30 Thus a comprehensive approach is required, involving a range of interventions. Population measures are needed to tackle the main drivers of alcohol consumption (accessibility and availability), as well as address key influences such as alcohol marketing. These measures should be complemented by more targeted actions, such as drink driving restrictions and measures to support heavy drinkers.
Drivers of consumption

The affordability of alcohol

There is very good evidence that the affordability of alcohol drives consumption and harm. In the UK, the affordability of alcohol increased between the 1980s and 2014, with household disposable income rising significantly faster than the cost of alcohol over this period (Figure 1). The BMA has consistently called for a dual strategy to address this rising affordability; increasing taxation on alcohol above inflation and introducing an MUP (minimum unit price) for alcohol to target the cheapest, highest strength alcohol.

Figure 1 – Alcohol price index relative to Retail Price Index (all items) compared to real household disposable income, UK, 1980-2014

Alcohol taxation measures

The increasing affordability of alcohol in the UK has predominantly resulted from low alcohol duty rates, which remained relatively static between 1997 and 2007. While the introduction of the duty escalator saw annual increases of 2% above inflation between 2007 and 2014, this was repealed in 2013 for beer and in 2014 for cider and spirits. Action is needed to reverse this trend through a significant increase in duty on all alcohol products (in the region of 10%), with continued annual increases above the rate of inflation. This reflects the large body of evidence and reviews – by the OECD (Organisation for Economic Co-operation and Development), WHO (World Health Organization), NICE (National Institute for Health and Care Excellence) and PHE (Public Health England) – that alcohol taxation is among the most effective and cost-effective approach to prevention.

There is also a need to consider the inconsistencies and anomalies in the way different alcohol products are taxed to reduce the comparative affordability of high-strength spirits and cider. According to homeless charities, these super strength drinks have become one of the biggest causes of premature death of homeless people in the UK. There is also evidence that these products are targeted at young people. For cider, excise duty is applied through duty bands in a system which is not proportional to alcohol content; thus, stronger ciders are taxed at the same rate as weaker ones. With spirits, while these are taxed proportional to alcohol content, the absence of duty bands means that high strength products are relatively inexpensive compared to lower strength versions. Rationalisation of the duty structure is therefore needed to incentivise the production and purchase of lower strength products.
Reduce the affordability of alcohol through taxation measures

There should be a significant increase in duty levels on all alcohol products (in the region of 10%), with continued annual increases above the rate of inflation. This should be supported by rationalisation of the alcohol duty system, particularly in relation to high strength ciders and spirits.

Minimum unit pricing

Raising duty above inflation increases the overall cost of alcohol to the whole population. A separate, complementary measure is required to tackle the cheapest, high strength drinks on the market. These are increasingly popular among lower income, high dependence drinkers, and their sale undermines the effectiveness of tax-based approaches. While a ban on below-cost sales of alcohol (for less than the cost of excise duty plus VAT) was introduced in England and Wales in 2014, this has had minimal impact on consumption – this approach only affects the price of a very small proportion of the alcohol sold in the UK and the prices that are affected are only affected to a small degree. A more effective approach should therefore be taken, through the implementation of an MUP.

In addition to the limited empirical evidence of the effectiveness of minimum pricing in British Colombia in Canada, UK-specific modelling supports this policy approach. A modelling comparison shows only 1% of units drunk by harmful drinkers were affected by a ban on below-cost sales compared to 43.6% of units under a 50p minimum pricing policy. This results in a reduction of over 5% or 200 units per year per person with MUP, compared to 0.1% or three units under a ban on below-cost sales. Evidence from Newcastle supports this, showing that 26.2% of price discounts result in alcohol being sold at or below a 50p MUP, compared to only 1.4% of alcohol sold at below-cost price.

It is projected that a 50p MUP would lead to over 2,000 fewer deaths and nearly 40,000 fewer hospital admissions in the first 20 years of the policy. NICE conclude that minimum pricing would encourage producers to reduce the strength of their products and the cost saving of alcohol-related problems would be £9.7 billion.

Critics of MUP cite evidence that it would disproportionately affect consumption among low income groups, with smaller reductions in high income groups, while not dealing with the issue of harmful drinking. However, modelling shows that MUP would specifically target harmful drinkers, thus reducing health inequalities. This is supported by data that show the impact of minimum pricing falls almost entirely on the heaviest drinkers irrespective of income.

Prevent the cheap sale of alcohol through the implementation minimum unit pricing

A minimum price for the sale of alcohol should be introduced at no less than 50p per unit throughout the UK.

The availability of alcohol

Another key driver of consumption is the availability of alcohol – the hours in the day it can be purchased as well as the number of outlets selling alcohol. There is comprehensive evidence that the more widely alcohol is available, the higher the levels of consumption and harm. Despite this, licensing legislation in the UK has been increasingly liberalised – over the last six years, the number of on-licensed premises in the UK increased by 10% to 38,600, and the number of off-licensed premises increased by 14% to 55,700.

The focus of changes to licensing legislation has also predominantly been on regulating consumption of alcohol served in on-licensed premises, such as pubs, bars and restaurants. This has failed to address the wider availability of alcohol in the off-trade. A significant impact of this has been a shift from drinking alcohol in regulated environments, to the purchase of cheaper alcohol that is consumed at home.
This highlights the need for a new approach to licensing, focused on reducing alcohol consumption and harm at a population level. Broadly this should focus on an overall reduction in licensing hours for on and off-licensed premises, as well as the total number of premises selling alcohol. At a local level, licensing authorities need to consider the impact of licensing decisions on the health and wellbeing of the local population, and should have the power to control the total availability of alcohol in their local area. This should be achieved by making public health a core objective and statutory obligation of licensing. While this is the case in Scotland, similar arrangements do not exist across the rest of the UK.

Ensure the impact on health is a key factor in licensing decisions
Public health should be a core objective and statutory obligation of licensing throughout the UK, and licensing authorities should have greater powers to reduce alcohol-related harm by controlling total availability of alcohol in their local area.

Influences on drinking
Alcohol marketing is widespread, normalised and unavoidable in modern society, with companies using a wide range of tactics to influence consumer behaviour. 53

Alcohol promotion
A key aspect of a company’s marketing strategy is promotion of its product through various coordinated marketing communications. This includes mass media and online advertising, sponsorship, sales and promotions. It is estimated that each year more than £800 million is spent on advertising alcoholic beverages in the UK. 54

Increased exposure to marketing has been shown to be associated with an increased likelihood of individuals starting to drink, and if they already do, drinking more. 55 Advertising is a primary tool, used to market products. Evidence links advertising expenditure to increased consumption. 56 Children in particular are vulnerable to the effects of advertising. Analysis by Ofcom show that children’s exposure to alcohol advertising in the UK is increasing – rising from 2.7 adverts per week in 2007, to 3.2 in 2011. 57 Independent research shows 10-15 year olds were 11% more likely to see alcohol adverts on television than adults. 58

Current regulations and partial bans on alcohol marketing in the UK have been proven to have little effect on overall consumption levels and leave children, in particular, heavily exposed to different promotional activities directly targeted at them. 59,60 Systematic reviews demonstrate the ineffectiveness of self-regulating approaches. 61,62 A 2009 Health Select Committee inquiry supporting this conclusion, highlighting how current restrictions do not protect children from alcohol, do not prevent the promotion of drunkenness and excess, and do not address sponsorship, or the link between alcohol, youth culture and sporting prowess. 63 UK and international modelling data support a total ban on eliminating exposure of television based advertising in those aged under 8 years. 24,64,65

Another tactic employed by the industry is sponsorship of events, linking alcohol consumption to success and lifestyles. A systematic review including over 12,500 participants shows a positive link between exposure to alcohol sports sponsorship and increased alcohol consumption. 66 Yet alcohol sponsorship is widespread in sport and popular culture. During the Euro 2016 football competition, people watching saw alcohol marketing on average once every 72 seconds. 67 Current regulations are weak and do little to prevent these marketing activities.

There are also a number of sales promotion strategies used to encourage consumers to purchase products – these include multi-buy promotions, end-of-aisle displays, in-pack premiums (e.g. free gifts) and special features (e.g. limited editions). There is good evidence that these marketing techniques are effective. 28,53 For example, end-of-aisle displays have been shown to increase sales of beer by 23%, wine by 33% and spirits by 46%. 68 As with other areas of marketing, existing restrictions on promotional marketing leave consumers exposed.
Current regulations do not take account of the cumulative impact of different marketing techniques (e.g., the way sponsorship of a particular event aligns with a company’s advertising campaign to enhance their brand), or the wide range of marketing tactics beyond traditional advertising, such as social media and sales promotions. In recognition of the cumulative impact of different marketing tactics and ineffectiveness of partial restrictions, there is a strong case for a complete ban on all alcohol marketing communications.

**Implement a comprehensive ban on all alcohol marketing communications**

A comprehensive ban on all alcohol marketing communications – including mass media advertising, sponsorship, sales promotions and online advertising – should be introduced and rigorously enforced.

**Education and consumer information**

Education and information measures are often favoured over regulatory policies because they can reach large audiences and do not impose direct restrictions on individuals. This approach does have a role to play in raising awareness and changing attitudes, but evidence shows that without a strong regulatory framework, these measures are ineffective. They should only therefore be used to supplement the policies set out previously that are effective at altering drinking behaviour, and to promote public support for comprehensive alcohol control measures.

The ineffectiveness of educational approaches is compounded by the absence of sustained and high-impact educational messages around alcohol. Campaigns that have been run in the UK – such as the Change4Life initiative in England and Wales and the Alcohol Awareness Week in Scotland and Northern Ireland – are typically short-lived and do not counter the pervasive industry marketing of opposing messages. Similarly, there is an over-reliance on the voluntary contribution of the alcohol industry. This is evident in the government’s continued commitment to working with Drinkaware (which is funded by voluntary donations from major UK alcohol producers, pub operators, restaurants, major supermarkets and other retailers). This approach has been shown to coincide with a softer approach taken to regulation and more industry-friendly measures. The best approach to counter this is the establishment of an independent public health body to oversee alcohol education, funded by a compulsory levy on the alcohol industry.

**Ensure alcohol education is delivered independently of industry**

An independent public health body should be established to oversee alcohol education in the UK, funded by a compulsory levy on the alcohol industry.

**Labelling**

One important aspect of consumer information is the labelling on alcoholic products, which provides a useful opportunity to improve knowledge of drinking guidelines and helps consumers know how much they are drinking. However, the impact of labelling in the UK has been limited by the reliance on voluntary commitments by industry. For example, the Public Health Responsibility pledge on alcohol calls for the inclusion of unit content, the CMO’s guidelines and a pregnancy warning. It does not require any specific health warning beyond advice not to drink above recommended levels or during pregnancy, such as highlighting the increased risk of cancer associated with alcohol consumption. And the voluntary measures are also not consistently adhered to. For example, industry guidance encourages companies to use a font size not smaller than the main body of information on the label. In the 2/3 of products for which relevant information is available, 60.3% used a smaller font than the main body of the text. These limitations of a voluntary approach highlight the need for mandatory labelling to ensure consistency and raise awareness of the potential harms of alcohol.
Provide consistent consumer information through mandatory labelling of alcoholic products
It should be a legal requirement to prominently display a common standard label on all alcoholic products that clearly states: alcoholic content in units; advice on recommended drinking levels; and a health warning.

Harms to others
Tackling drink driving
Alcohol is a significant cause of road traffic casualties and deaths. In 2014, there were an estimated 8,270 road traffic casualties as a result of drink driving in Great Britain, in which 1,070 were serious injuries and 240 were fatal. There are a range of measures that could help reduce this burden, principally lowering the drink drive limit. In England, Northern Ireland and Wales, the BAC (blood alcohol content) limit is set at 80mg/100ml. Scotland lowered the limit to 50mg/100ml in 2014. In the first 9 months, offending fell by 12.5% compared with the same period the previous year.

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Evidence from Scotland is supported by studies which demonstrate the effectiveness of a lower limit. A comprehensive review in 2010 by NICE concluded there is sufficiently strong evidence of the effectiveness of lowering the legal limit to help reduce road traffic injuries and deaths in certain contexts, resulting in around 25 lives being saved and 95 people from suffering serious injury.

Reducing the legal limit in isolation would limit its impact. It should be supported by the introduction of randomised testing to support its enforcement. NICE guidelines support random breath testing and selective testing of ‘sobriety checkpoints’, which would have a powerful deterrent effect. There is good evidence from Australia that randomised testing can be effective as the perceived risk of being detected is considered greater.

Introduce evidence-based measures to reduce drink driving levels
The legal drink driving limit should be reduced from 80mg/100ml to 50mg/100ml in England, Northern Ireland and Wales. Random testing should be introduced in line with NICE guidelines.

Alcohol and pregnancy
Alcohol consumed during pregnancy can adversely affect fetal development, resulting in a wide range of intellectual and physical disabilities classified under the umbrella term FASD (fetal alcohol spectrum disorders). While there are no comprehensive data on FASD in the UK, studies suggest that the prevalence may be as high as 2-5% among school-aged children in North America and Western Europe.

Action is needed to reduce the number of children born with FASD and provide support to those that have been affected through strengthened preventative, medical and social care measures. Broad preventative measures that aim to reduce alcohol consumption at a population level include the actions set out in this briefing to address the accessibility, availability and promotion of alcohol. There is also a need to provide clear, reliable guidance for expectant mothers about the risks of drinking during pregnancy. The revision of the CMO’s drinking guidelines to recommend not to drink at all during pregnancy is welcome in helping support women and those around them in having an alcohol-free pregnancy.

This should be complemented by targeted measures for women with alcohol use problems, including providing health promotion and advice, screening, referral for brief interventions and targeted prevention for women ‘at risk’. There is also a need for comprehensive services and referral pathways for the diagnosis, management and support of people affected by prenatal alcohol exposure.
Introduce a range of measures to reduce and better manage pregnancies affected by alcohol
There should be:
– targeted action to support women and those around them in having an alcohol-free pregnancy
– the development of a framework for the clinical management of FASD, including comprehensive services and referral pathways for diagnosis, management and support.

Preventing and managing alcohol use problems
Early identification and intervention
Healthcare professionals have an important role in the early identification of patients with an alcohol problem, and in delivering brief advice to help them to reduce their consumption. Embedding this as a routine part of care would reduce the overall costs of alcohol to the NHS and wider society. All healthcare professionals should therefore receive adequate training to provide early identification and brief alcohol interventions. Research shows that this can produce clinically significant effects on drinking behaviour and related problems. In addition to robust training, there is a need for adequate resourcing to ensure healthcare professionals have sufficient time with patients to identify and manage any alcohol problems.

Support healthcare professionals in identifying and managing alcohol problems
All healthcare professionals should receive comprehensive training in early identification and brief interventions for alcohol problems, which should be supported by adequate resourcing to allow sufficient time for this part of their role.

Specialist services
Some individuals with alcohol use problems require referral to specialist treatment services. These include therapeutic and management components, such as relapse prevention, detoxification facilities, inpatient residential programmes and outpatient clinics. There is, however, inadequate provision of these services across the UK. For example, a PHE survey in 2014 found that of the 191 district general hospitals estimated to be an appropriate size to merit specialist services, 139 (73%) had treatment teams in place. Of the 40 largest hospitals, 5 did not have any alcohol service at all. Similar studies show a comparable level of inadequate service provision in Wales, Northern Ireland and Scotland. This highlights the need for a greater focus on ensuring specialist alcohol services are adequately funded and accessible across the UK.

Provide adequate resources for specialised alcohol treatment services
Funding for specialist alcohol treatment services should be significantly increased and ring-fenced to increase provision for all individuals with severe alcohol problems or who are alcohol dependent.
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