Tackling alcohol harm

Westminster Hall debate
02 February 2017

The BMA (British Medical Association) is a professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

The BMA has long been concerned about the levels of alcohol-related harm in the UK and welcomed the UK Chief Medical Officers’ recommendation, last year, to bring the guidelines for safe levels of drinking for men in line with the guideline for women as well as the advice for drink-free days.

Our members witness first-hand the harmful effects of excessive consumption of alcohol, which is a contributing factor in millions of hospital admissions and thousands of deaths each year. The scale of alcohol consumption in England represents a significant cause of medical, psychological and social harm, and is placing an unsustainable burden on the NHS. The BMA believes that by implementing the following policies the level of harm and cost associated with alcohol will be significantly reduced:

Key Asks

- Publish a new updated alcohol strategy
- Prevent the cheap sale of alcohol through implementing minimum unit pricing (MUP)
- Reduce the affordability of alcohol through taxation measures
- Ensure health is a key factor in licensing decisions
- Implement a comprehensive ban on all alcohol marketing communications
- Ensure alcohol education is delivered independently of the alcohol industry
- Provide consistent consumer information through mandatory labelling of alcoholic products
- Implement evidence-based measures to reduce drink driving levels
- Introduce a range of measures to reduce and better manage pregnancies affected by alcohol
- Support healthcare professionals in identifying and managing alcohol-related problems
- Provide adequate resources for specialist alcohol treatment services

Measures to reduce alcohol harm

*National alcohol strategy*
We believe strongly that the Government should publish a new alcohol strategy. While we welcomed the publication of the previous strategy, we were critical about the lack of content in areas such as population level measures to reduce chronic health harms and per capita consumption. In addition,
while the existing commitment to improve the identification of individuals at risk of harm is welcome, there should be greater emphasis in a new strategy on providing comprehensive treatment services for individuals who develop alcohol problems. Further assessments of the need for alcohol treatment services are required to ensure demand is matched by provision and funding.

**Minimum pricing and alcohol taxation**

There is good evidence that the affordability of alcohol drives consumption and harm. The BMA has therefore called for a dual strategy to address rising affordability through increasing taxation on alcohol above inflation and introducing a MUP at no less than 50p per unit to target the cheapest, highest strength alcohol. 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.

Further increases in alcohol duty are also needed, along with the rationalisation of the tax structure to target high strength ciders and spirits and encourage the production and purchase of lower strength products. We recommend addressing static low alcohol duty rates, 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 findings of evidence and reviews by the OECD (Organisation for Economic Co-operation and Development), WHO (World Health Organization), and PHE (Public Health England) that alcohol taxation is among the most effective and cost-effective approach to prevention.

**The availability of alcohol: Licensing**

The focus of changes to licensing legislation has predominantly been on regulating consumption of alcohol served in on-licensed premises, such as pubs, bars and restaurants. The BMA believes that this approach 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. There is 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, with the number of on-licensed premises increasing by 10% to 38,600, and the number of off-licensed premises increasing by 14% to 55,700.

To address this worrying trend there is a need for a new approach to licensing, which 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. While we recognise the development and continuing role out of the local alcohol action areas (LAAA) programme, we believe that this approach does not go far enough. 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.

**Marketing and labelling**

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. In light of the impact alcohol marketing has on young people’s drinking and the ineffectiveness of the existing regulatory framework, there should be a comprehensive ban on all alcohol marketing communications in line with that introduced for

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tobacco products. A UK modelling study estimates such a ban would result in a reduction in total alcohol consumption of 0.3%, with much greater effects in those aged 11-18 years, with equivalent reductions of 9%.9

One important aspect of consumer information is the labelling on alcoholic products, which provides a key opportunity to improve knowledge of drinking guidelines and help consumers know how much they are drinking. However, the impact of labelling in the UK has been limited by the reliance on voluntary industry commitments. In light of this we believe there should be a mandatory requirement to show unit information, alcohol guidelines, advice on alcohol-free days, and a health warning message on all product labels, printed and electronic marketing material, and at the point of sale.

**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.10 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.11 We therefore believe that there is clear justification by lowering the drink drive limit in England.

**Treatment: Alcohol and pregnancy**

A large number of children are born every year in the UK with lifelong physical, behavioural or cognitive disabilities caused by alcohol consumption during pregnancy. These disorders have a substantial impact on the lives of individuals affected, and those around them, but are completely preventable through the elimination of drinking during pregnancy. The recent BMA report, *Alcohol and pregnancy: Preventing and managing fetal alcohol spectrum disorders* outlined recommendations to address this issue including the provision of adequate time, resources, training and guidance to healthcare professionals involved in the provision of antenatal care. This would allow screening for maternal alcohol consumption to form part of routine antenatal care in the NHS and ensure that alcohol use among pregnant women is monitored and recorded appropriately. In addition to this there is a real need for investment in a high quality alcohol education programmes that include information on the risks of drinking whilst pregnant should be provided in schools throughout the UK.

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10 Department for Transport (2016) *Estimated number of reported drink drive accidents and casualties in Great Britain: 1979-2014.*