**BMA**

# Reducing alcohol-related harm: a blueprint for Government

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As a society, our relationship with alcohol is normalised. Alcohol is readily available, increasing affordable and heavily marketed as an accepted part of modern life. Yet, the health harms of alcohol are widely known. Doctors witness these harms in their everyday working lives. In England in 2016, there were over 5,500 alcohol-specific deaths[1] and over 1.1 million alcohol-related hospital admissions,[2] while there is a well-established association between alcohol and violence (in 40% of violent incidents, victims perceived the offender to be under the influence of alcohol).[3] As well as the health harms, there are significant economic and societal costs - alcohol is estimated to cost £21 billion a year in England, including £3.5 billion a year to the NHS (2009-10 costs).[4]

The forthcoming alcohol strategy in England represents an important opportunity for the Government to commit to a comprehensive and effective range of measures to tackle alcohol-related harm. This should include population measures to tackle the affordability and availability of alcohol, action to tackle key influences such as marketing and education, as well as targeted measures such as supporting the medical profession to help those in need and reducing levels of drink driving. Specifically, a new strategy should include the following measures:

### Increasing duty on all alcohol products

The evidence that price (affordability) drives consumption is well established and conclusive – as highlighted in the 2016 PHE (Public Health England) alcohol review.[5] Alcohol is around 60% more affordable now than in 1980, while beer and wine bought in supermarkets and convenience stores is 188% and 131% more affordable than in the 1980s.[6] In order to reverse this, an increase in duty on alcohol by at least 2% above the rate of inflation is needed. The rate should then be annually reviewed.

### Legislating for a minimum unit price in England

A MUP (minimum unit price) is needed to specifically target the cheapest, high-strength drinks. These are increasingly popular among lower income, high dependence drinkers, and their sale limits the effectiveness of duty-based approaches. While duty increases may not necessarily be passed through to the point-of-sale, MUP is paid directly by the consumer. PHE conclude a MUP would improve the health of the heaviest drinkers, while having a limited impact on moderate drinkers and pubs, bars and restaurants,[7] while the University of Sheffield's modelling shows that a 50p MUP would lead to around 27,500 fewer hospital admissions per annum from heavy drinkers per 100,000 population.[8] As well as the health outcomes, this would reduce pressures on the NHS and help new investment as part of the long-term plan to go further. Following the lead of the other devolved nations in introducing or supporting MUP, England has been left behind. The Government should address this, bringing England in line with the rest of the UK, and legislating for a MUP.

### Implementing consistent mandatory labelling of all alcoholic products

Consumers are being denied their right to know the health harms of alcohol by a persistent reliance on voluntary commitments by industry, despite good evidence that these voluntary approaches do not work.[9,10] The current approach of industry self-regulation, through the Portman code of practice,[a] has led to inconsistency and confusion — a recent review by the AHA (Alcohol Health Alliance) found that only 24 labels out of 320 informed consumers of the Chief Medical Officers' low-risk weekly guidelines,[b] more than two and a half years after the guidelines took effect.[11] As a consequence there is a general lack of awareness of the

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a   The Portman Group — made up of the UK's biggest alcohol producers — uses a self-regulatory code of practice to regulate the promotion and packaging of alcohol sold or marketed in the UK.
b   In 2016 the UK Chief Medical Officers' introduced new weekly guidelines stating safe levels of drinking, advice to ensure drink-free days and warning of the harms from drinking during pregnancy.

guidelines – a 2017 AHA poll found that over 80% of those surveyed were not aware of the chief medical officers' recommendation on safe level of drinking.[12] This demonstrates the need for mandatory labelling to ensure consistency and to ensure the public are provided with the information they need to make informed choices. Labelling of all alcoholic products should clearly state alcoholic content in units, advice on recommended drinking levels and include a health warning.

### Introducing regulations to limit alcohol advertising

Increased exposure to marketing is associated with a greater likelihood of individuals starting to drink alcohol and increasing their consumption if already a drinker. Current regulations and partial bans on alcohol marketing in the UK have proven to have little effect on overall consumption and leave children in particular heavily exposed to promotional activities directly targeted at them.[13] For example, the England national football team recently announced a new marketing relationship with an alcohol brand, therefore building an association between football and drinking for a whole generation of fans.[14] 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 marketing communications as a long-term ambition. As an immediate measure, alcohol advertising should be limited to factual information in adult press about brand, provenance and product strength.

### Ensuring alcohol education messages are delivered independently of industry

Public health education and messaging is an important tool to raise awareness and change attitudes, but evidence shows that without a strong regulatory framework, these measures only have a small and short-term impact on behaviour.[15] When these messages are delivered jointly with industry, as has been the case recently with PHE and Drinkaware, their public health impact is fatally flawed.[16,17] Another recent example demonstrates the way the alcohol industry has attempted to mislead the public about the risks of alcohol and cancer through mis-information and unclear messaging.[18] In order to counter this and provide evidence-based, clear and consistent information to the public, it is vital that the government ensure alcohol education messages are delivered independently of industry.

### Establishing public health as a licensing objective

Alongside affordability, another key driver of alcohol consumption is availability.[19] Since 2010 the number of on and off-licensed premises in England and Wales both increased by around 12% to 39,500 and 54,900 respectively.[20] A recent study by the University of Sheffield found areas with a high density of alcohol outlets have higher drink-related hospital admissions.[21] Given the trend in recent years of purchasing cheap alcohol to consume at home, the increase in off-trade premises is particularly concerning. Current licensing regulations mean that applications are rarely rejected on the grounds of public health, despite the wide-ranging impact of alcohol-associated harm. A specific licensing objective to protect and improve public health would give licensing authorities the grounds to reject applications if they did not meet this criteria.

### Legislating to reduce the legal drink driving limit to 50mg/100ml

The UK has the joint-highest legal drink driving limit (80mg/100ml blood alcohol content) in Europe, matched only by Malta.[22] This is despite strong evidence from PHE, NICE and a Department for Transport review that setting and lowering a legal drink-driving limit would lower fatalities and casualties.[23,24,25] Since reducing the limit in Scotland to 50mg/100ml in 2014, police data shows that within the first nine months, offending fell by 12.5% compared to the same period a year earlier.[26] Given the increase in drink driving fatalities and casualties in 2016 compared to 2015,[27] there is a strong case to lower the drink driving limit to 50mg/100ml, enforced by random testing in line with NICE guidelines.

### Promoting CMO guidance to not drink during pregnancy

Alcohol consumption during pregnancy is associated with a wide range of health outcomes, as highlighted in the BMA report, Alcohol and pregnancy: preventing and managing fetal alcohol spectrum disorders. The revision of the chief medical officers' guidelines to recommend not drinking at all during pregnancy is welcome in providing clear reliable guidance for expectant mothers. This should be widely communicated by all healthcare professionals — including GPs, obstetricians and midwives — and 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 adequate services and referral pathways for the diagnosis, management and support of people with prenatal alcohol exposure.

### Training all healthcare professionals in early identification and brief interventions

Research shows the effectiveness of healthcare professionals in identifying alcohol-related problems at an early stage and then delivering brief interventions.[28] It is therefore important that all healthcare professionals receive adequate training — at an undergraduate level as medical students and as part of their postgraduate continual development — and are supported to be able to deliver this in their roles.

### Adequately funding alcohol treatment services

The BMA's 2018 briefing, Feeling the squeeze, highlighted the impact that cuts to public health budgets are having on the delivery of services in England. Alcohol treatment services are seeing their budgets cut as a consequence, including cuts of up to 90% in areas that experience high levels of harm. Less than 20% of dependent drinkers are currently accessing alcohol treatment, while the number in treatment has fallen by 19% over the last five years despite an overall increase in need.[29] It is therefore vital that cuts to public health funding are reversed and common, minimum standards for the provision of alcohol treatment services in England are established.

**More information and a UK-wide perspective is available in the BMA's 2016 report 'Tackling alcohol related harm'.**

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