

# Alcohol control strategies:

the gap between evidence and practice



### THE PROBLEM

*'Intoxicating liquor creates lawlessness, makes criminals, wrecks homes and brings trouble to innocent women and children.'* This quote from Thomas Jordan Jarvis (1836–1915) is as true now as it was in the 19th century. While our consumption per capita in the UK has not quite reached Victorian levels, it has more than doubled since World War II and alcohol-related illnesses, injuries, and deaths are now at an all-time high. Representatives of the drinks industry are quick to point out that data from national surveys have shown a fall over the past few years (during the financial downturn) in consumption figures. However, this has coincided with increasing ethnic diversity and more abstainers in the UK population, and those that are drinking are doing so in a more harmful way. It is also well known that there is a marked disparity between alcohol consumption figures from self-reported national surveys and from alcohol sales data. It has been estimated by Bellis *et al*<sup>1</sup> from the volume of pure alcohol taxed in 2007/2008 that the average consumption of a drinking adult in England is 26 units per week, higher than surveys suggest and well above recommended limits of 14 units per week for women and 21 for men.

### WHAT WORKS IN REDUCING ALCOHOL-RELATED HARM AND WHAT BARRIERS EXIST?

The evidence for effective public health policies is clear and well documented.<sup>2,3</sup> Just as with tobacco, there is strong evidence that changes in price affect the amount of alcohol consumed and the levels of harm seen in that population. Regulating the physical availability of alcohol has been also shown to be an effective public health

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intervention. This includes measures such as placing restrictions on the hours and days of sale of alcohol and on the density of licensed premises in an area but also improving the enforcement of prohibiting sales to underage drinkers and those already intoxicated. Measures such as random breath testing and lowering blood alcohol concentration limits for driving have been shown to reduce alcohol-related road crashes in many countries. A study by RAND Europe<sup>4</sup> showed that 10–15 year-olds in the UK are exposed to more television advertising than adults, and the evidence base shows that alcohol advertising is having an adverse effect, particularly on adolescent alcohol use.<sup>5</sup> The existing industry self-regulation of alcohol advertising in the UK is clearly inadequate.

A recent example where the evidence is strongly in favour of public health intervention is setting a minimum unit price (MUP) for alcohol in the UK, where a minimum price would be set for every unit of alcohol sold. Extensive modelling by the University of Sheffield<sup>6</sup> and studies from Canada<sup>7,8</sup> (where this policy has been introduced in several provinces) have both highlighted the benefits of setting a minimum unit price in reducing alcohol consumption, hospital admissions, and deaths caused by alcohol. This is currently the top alcohol policy recommendation from the UK public health community,<sup>9</sup> with the aim of increasing the price of the cheapest drinks that are often chosen by the heaviest drinkers and underage ones. This policy would affect the heavily discounted drinks available in off-licences

and large supermarket chains rather than the price of a pint of beer or glass of wine in a pub, bar, or restaurant. Within the UK, the Scottish Government has passed MUP into law but is still embroiled in legal challenges from the Scotch Whisky Association and, potentially, the European Commission. In Northern Ireland there seems an appetite for pursuing MUP, but government in England and Wales appears to be bowing to industry and backbencher pressure in going back on the commitments it made to minimum pricing only 18 months ago. This is a watershed moment when policies with cast-iron evidence are in danger of being sacrificed. It was only last May that the UK Prime Minister, David Cameron, famously said:

*'We are going to introduce a new minimum unit price — so for the first time it will be illegal for shops to sell alcohol for less than this set price per unit. Of course, I know this won't be universally popular. But the responsibility of being in government isn't always about doing the popular thing. It's about doing the right thing.'*

Will he?

### WHAT IS THE POTENTIAL ROLE FOR GPs IN REDUCING ALCOHOL-RELATED HARM?

Even though there is a strong evidence base for population-level interventions to reduce alcohol consumption and related harm, with the size of the problem in the UK there is no time to wait for such measures to either be implemented or for the long-term benefits

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to ensue. ‘Upstream’ measures of regulation on price, availability, and marketing may have the largest effect but, as we see, are unlikely to find political favour.

Primary care is an ideal setting for early intervention and it is a cost-effective option. There is strong evidence to show that opportunistic early identification and brief advice administered by GPs and other health professionals is effective in reducing alcohol consumption.<sup>10</sup> It has been shown that identification and brief advice is even more successful than smoking cessation programmes with one in eight people reducing their alcohol consumption to within safer levels after receiving simple advice.<sup>11</sup> For patients identified through the screening tools as having dependence problems, referral to specialist alcohol treatment services should be sought. In addition to face-to-face training days offered by the RCGP in the management of alcohol problems in primary care, an online e-learning resource on identification, and brief advice in primary care has recently become available to primary care professionals.<sup>12</sup>

There is such a gap between effective, evidence-based policy and the realities

of what our governments can deliver, particularly in Westminster, that we need to mobilise the healthcare workforce to target individuals as well as populations. This can be done in partnerships between primary and secondary care. An increasing number of acute hospitals have alcohol care teams, and the challenge is to make these available 7 days a week and to integrate these services with community alcohol services, as advocated by the British Society of Gastroenterology.<sup>13</sup> Perhaps the recent move of public health into social care in England will be an opportunity to make the services ‘joined up’ for the millions of patients with alcohol problems and stop them ‘falling through the gap’.

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