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Royal College of Physicians Evidence Submission to the Health Select Committee Inquiry into Alcohol, 2009

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

1. Executive Summary

1.1 We welcome the opportunity to comment on the scale of alcohol related health harm and the measures which could be taken to reduce it. The RCP believes that in the same way that doctors use evidence-based medicine to treat individual patients, the Government must implement a strong evidence-based approach that is aimed at reducing overall alcohol consumption and alcohol-related health harm. The cornerstones of this approach must be strong public policy measures on price and the availability of alcohol, better commissioning of treatment services, underpinned with greater investment in prevention.

1.2 To support our submission we carried out a survey together with the Royal College of Nursing of over 200 doctors and nurses asking their views on what public policy measures they felt would be effective in tackling alcohol related harm, reference is made to the survey throughout our submission¹.

2. Scale of the problem

2.1 In the UK the health harms caused by alcohol misuse are underestimated and continue to spiral:

- 8,724 people died from alcohol-related causes in 2007. This has doubled since 1991, where 4,144 deaths were recorded²
- 13 children a day are hospitalised as a result of alcohol misuse³
- More people die from alcohol related causes than from breast cancer, cervical cancer and MRSA combined⁴

¹ Royal College of Physicians and Royal College of Nursing Survey on Alcohol Treatment Services, March, 2009, www.rcplondon.ac.uk

² Office for National Statistics bulletin 27 January, 2009.

³ Caroline Flint: Response to parliamentary question, Liver disease: alcoholic drinks, 13 March. 2007.

- Over a third of adults (37%) exceed the recommended maximum alcohol guidelines on their heaviest drinking day⁵.
- 6.4 million people consume alcohol at moderate to heavy levels (between 14 and 35 units per week for women and 21 and 50 units per week for men)⁶
- 2.9 million (7%) of the adult population are alcohol dependent⁷
- The ‘passive effects’ of alcohol misuse are catastrophic – rape, sexual assault, domestic and other violence, drunk driving and street disorder - alcohol affects thousands more innocent victims than passive smoking⁸.

2.2 One of the clearest barometers of alcohol related ill health is the change in patterns of liver disease. The Chief Medical Officers’ annual report in 2001 highlighted this very starkly, ‘In the last 30 years of the 20th century deaths from liver cirrhosis steadily increased, in people aged 35 to 44 years the death rate went up 8-fold in men and almost 7-fold in women, in 25–34 year olds a 4-fold increase was seen over the 30 year period’⁹. The most recent analysis published in July 2008 showed that liver disease is the commonest cause of alcohol related death in men and women between the ages of 35 and 75 in England.¹⁰

2.3 Much of the alcohol debate and media attention since then has centred on the problems of binge drinking amongst young people, and in particular the link between alcohol use and anti-social behaviour. The degree of health harm at all ages caused by alcohol has generally escaped the attention of the media. There are potentially a large number of people who are unknowingly consuming well over the recommended limits in their own homes, and storing up problems for the future.

2.5 There are also a number of groups in society where the extent of alcohol related harm is only just beginning to emerge, for example amongst older people and ethnic minorities. Alcohol related hospital admissions in England for the over 65 showed a huge increase from 197,584 in 2002 to 323595 in 2007¹¹.

2.6 In the UK there is a link between alcohol-related mortality and areas of social deprivation. Self-reported average consumption differs little across socioeconomic groups, however in the General Household Survey, for men there are five-fold higher age-standardised alcohol-related deaths in the most deprived areas as compared to the least deprived, using the Carstairs deprivation categories. The same trend applies to women¹².

⁴ Cancer Research UK: Cancer mortality statistics, 2004.

⁵ Office for National Statistics bulletin 27 January, 2009.

⁶ Ibid.

⁷ Ibid.

⁸ Prime Ministers Strategy Unit, Interim Analytical Report, 2003. .

⁹ Department of Health, on the state of the public health: the annual report of the Chief Medical Officer, 2001.

¹⁰ Jones, L, et al, ‘Alcohol attributable fractions for England; alcoholattributable mortality and hospital admissions. North-West Public Health Observatory and Dept of Health; 2008–<http://www.nwph.net/nwpho/publications/forms/disform.aspx?ID=186>

¹¹ Dawn Primorolo: Response to parliamentary question, The elderly and: alcoholic drinks, 26 February, 2009.

¹² Office for National Statistics, General Household Survey, 2008.

3. The consequences for the NHS

3.1 It is estimated that the annual financial cost of alcohol harm to the NHS in England is £2.7bn in 2006/07 prices¹³

3.2 In 2006/07, there were 57,142 NHS hospital admissions in England with a primary diagnosis specifically related to alcohol. This number has risen by 52% since 1995/96. Of these admissions 4,888 (9%) involved patients under 18 years of age¹⁴.

3.3 The burden of alcohol misuse affects all parts of the NHS: primary care services and most hospital services including Accident and Emergency, medical and surgical inpatient services, paediatric services, psychiatric services and outpatient services¹⁵. In many cases these services are not geared up to cope with this vast increase putting them under severe strain. Over 75% of respondents to our survey stated that current NHS facilities for treating patients with alcohol related health problems were inadequate or very inadequate¹⁶.

3.3 Access to alcohol services in both primary and secondary care across England is still unequal and patchy even though there is good awareness of the services. The main gaps in service provision that were identified include:

- A lack of screening in primary care and active intervention when problems are apparent.
- Incorrect early identification leading to referral to already overcrowded services
- Poor liaison or integration between acute services and follow on and support services in the community
- Huge gaps between acute detoxification and community addiction services, in addition to long waiting times between treatment for alcohol withdrawal symptoms and addiction services input¹⁷.

3.3 In 2006 the Department of Health and the National Treatment Agency issued guidance on alcohol treatment commissioning 'Models of Care for Alcohol Misusers' to help commissioners develop more integrated and effective services. In 2008 Alcohol Concern's report 'The Poor Relation' showed that the MoCAM guidance was having a limited impact¹⁸. The recent National Audit Office report highlighted that commissioning of alcohol services is still poor, and that many PCTs were yet to develop more consistent and effective commissioning strategies based on local demographics despite the fact that the data to enable them to do this is available in Local Alcohol Profiles for England. A further complicating factor which hampers good commissioning is that PCTs often look to Drug and Alcohol Action Teams to

¹³ Department of Health, 'The cost of alcohol harm to the NHS in England - An update to the Cabinet, 2008,

¹⁴ NHS Information Centre for Health and Social Care, Statistics on Alcohol: England, 2008.

¹⁵ Royal College of Physicians, 'Alcohol can the NHS afford it', 2001.

¹⁶ Ibid 1.

¹⁷ Ibid 1.

¹⁸ Alcohol Concern, 'The Poor Relation - has the emphasis on 'localism' really improved alcohol commissioning', 2008.

take the lead in commissioning. However these teams are almost entirely to focus on the treatment of dependent users of alcohol and drugs¹⁹.

4. The role of the NHS

4.1 The role of the NHS to date has focused very much on treating the consequences of alcohol related-harm rather than active prevention. However it is now widely acknowledged that the factors which influence alcohol misuse are complex and that a multi-stranded and holistic approach which brings together early detection and intervention, education and treatment may be more effective in tackling health harm. Therefore the NHS must think about refocusing its role on prevention and early intervention and work in partnership with services in local communities to raise awareness of alcohol related harm.

4. Central government policy

4.1 Central government policy has only just started to seriously address issues of alcohol related harm. The National Alcohol Harm Reduction Strategy for England in 2004 was a positive step but it relied heavily on voluntary partnerships with drinks producers and retailers and emphasised the importance of information and education for the public while failing to address the association between price, availability and heavy consumption. In 2007 the Government published Safe, Sensible, Social -The Next Steps in the Alcohol Strategy (SSS), which moved policy forward by addressing the needs of harmful and hazardous drinkers but still failed to address the links between price, availability and consumption. What has also been lacking to date is a coherent cross-Departmental approach required to reduce the scale and impact of alcohol related health harm. In our survey 88% responded that overall, current national alcohol strategies are not effective and 84% responded that public health campaigns have not been effective in changing drinking behaviour.²⁰.

5. Recommendations

Alcohol related health harm is a complex issue involving a range of determinants which are socio-economic, cultural and educational as well as health related. A future alcohol strategy must therefore take account of this complexity by being integrated and overarching, bringing together education, treatment and enforcement. What is also needed is large scale and lasting social and cultural change, to engrain sensible and healthy attitudes to alcohol consumption in the population that must be instigated by a comprehensive package of public policy measures.

5.1 Retailing

In order to reduce overall consumption and the resulting health harms the issue of price must be addressed. Alcohol can currently be bought in the off trade at a very low price. The latest review of alcohol price, promotion and harm conducted by Sheffield University showed that there is strong relationship between pricing and consumption and that pricing policies can be effective in reducing harm related to health, crime and unemployment. It also demonstrated that pricing policies can be targeted, so that

¹⁹ National Audit Office, Reducing Alcohol Harm: Health services in England for alcohol misuse, National Audit Office, 2008.

²⁰ Ibid 1.

people who drink within recommended limits are hardly affected whereas very heavy drinkers, who cause by far the most alcohol-related harm, pay the most. One way of achieving this would be to set a minimum price for a unit of alcohol to reduce alcohol consumption and related harm²¹. In our survey over 70% of respondents felt that action on the sale of low priced alcohol would be effective in tackling alcohol related health problems²².

Other evidence suggests that increasing tax on alcohol by only 10% could decrease alcohol related deaths of various forms by 10-30%, yet alcohol has become over 50% more affordable in the last 25 years²³. Increases in overall alcohol related taxation would fall predominantly on those at risk whose consumption in any case needs to be reduced. The impact of duty increases on truly moderate drinkers would be negligible even more so when staged over a number of years. The revenue from increased duty could also provide more than enough funding for the exchequer, to bring alcohol treatment and prevention services up to the level of services provided for users of illegal drugs. A combination of the two options, a minimum price and stepped duty increases provides the single most effective solution to the UK alcohol problem.

5.2 Regulation

The review of alcohol industry standards by KPMG found that ‘the standards are not operating as the Government originally hoped. They are not a catalyst for self-regulation, self-improvement and social responsibility’²⁴. This has shown that the voluntary self-regulation approach adopted by Government towards the industry had failed. The College therefore believes that a mandatory code is necessary. The ground for the code has been laid by the enabling power included in the Policing and Crime Bill 2009. A mandatory retailing code should be accompanied by appropriate sanctions, as this the only way to ensure that the safe sensible drinking message is taken seriously and promoted by the industry. The College believes that the best way of doing this would be to set up an independent central agency to regulate the industry. This body could have enforcement powers and a range of sanctions to oversee and monitor practice within the industry

5.3 Investment in services

In our survey 87% of respondents felt that investment in NHS staff and services for treating alcohol related health problems had either not kept up with demand or had been seriously under-invested²⁵. Currently there is no ring fenced funding for alcohol treatment services. The funding which exists is often part of the pooled treatment budget for drugs and alcohol. The budget for these services in 2009-10 will be £406 million²⁶. Within these budgets most of the funding is dedicated to drug treatment.

²¹ Meier et al, ScHARR, University of Sheffield - ‘Independent review of the effects of alcohol pricing and promotion: Part B – Modelling the potential impact of pricing and promotion policies for alcohol in England, 2008.

²² Ibid 1.

²³ Academy of Medical Sciences, ‘Calling Time on the Nation’s Drinking’, Academy of Medical Sciences, 2004.

²⁴ Home Office & KMPG, ‘*Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks Volume 1*’, 2008.

²⁵ Ibid 1.

²⁶ National Audit Office, *Reducing Alcohol Harm: Health services in England for alcohol misuse*, National Audit Office, 2008.

The NAO report showed that on average PCTs were only spending 0.1% of their money on alcohol services every year working out at £197 per dependent drinker where as the amount spent on dependent drug users every year equated to £1744 per dependent person.

5.4 Access to alcohol treatment services

5.4.1 More needs to be done to improve earlier diagnosis of alcohol use disorders and ensure prompt referral. This could be incentivised through including a measure in the Quality and Outcomes Framework for GPs that screened in groups that are high-risk for alcohol-related harm and for alcohol use disorders.

5.4.2 The qualitative findings from our survey suggest there are huge regional variations in access to services and very poor integration and links across and between services. More must be done to convince PCTs that commissioning integrated care pathways based on the needs of the local demographic will result in cost savings across its primary and secondary care operations.

5.4.3 The waiting times for alcohol treatment are often far longer than for drug treatment. The Department of Health should consider demanding of local commissioners that waiting times for alcohol treatment match targets for drug treatment in the next NHS operating framework.

5.4.4 Every acute hospital should have a Consultant/Senior Nurse Lead for Alcohol Misuse to ensure early detection by any doctor/nurse and to work with Alcohol Nurse Specialists to provide intervention as well as education, audit, and liaison with the community²⁷.

5.4.5 There is an urgent need to train clinicians working across primary and secondary care how to use early identification toolkits such as the Paddington Alcohol Test (PAT)²⁸ to assess levels of consumption and harm and utilize brief interventions which are a quick and effective means of engaging with large numbers of drinkers who are not dependent, but are still harming their health. Our survey showed that 60 % of respondents had received no specific training in this area. Alcohol screening and brief psychological interventions supported by alcohol nurse specialists have also been shown to be clinically effective and cost effective in reducing unscheduled alcohol related re-attendance in A&E.

5.5 Health information

Many people underestimate the amount of units they are drinking. A YouGov survey of 1,429 drinkers in England found more than a third did not know their recommended daily limit - 2-3 units for women and 3-4 for men²⁹. The public must

²⁷ Royal College of Physicians, 'Alcohol can the NHS afford it', 2001.

²⁸ Huntley, J. S., Blain, C., Hood, S. and Touquet, R.' Improving detection of alcohol misuse in patients presenting to an accident and emergency department. *Emergency Medicine Journal* **18**, 2001 99–104.

²⁹ <http://news.bbc.co.uk/1/hi/health/7399192.stm>

have the knowledge and information to enable them to make sensible choices about what they are drinking and this can only be achieved by making it mandatory for all promotional material and labelling to carry health and unit information, 91% of respondents to our survey believe that this would make a difference to attitudes towards alcohol. In the USA tobacco product labelling was shown to lead to a change in behaviour. Warning labels on tobacco products are large and we believe that there should be a mandatory requirement for alcohol warning labels to occupy at least 10% of the printed area. A label of this size would be about twice the size of the bar code on cans and bottles which currently occupies approximately 4% of the printed surface.

5.7 Tougher licensing conditions, considering health implications

The RCP recommends amending the Licensing Act 2003 to insert a fifth licensing objective ‘protecting and improving public health’ which would enable licensing authorities to consider public health matters when making decisions about licensing the sale of alcohol. It would also enable local authorities to take steps to restrict sales where there are particular public health problems, and so help address some of the worst regional health inequalities in liver disease and in the other health-related problems relating to alcohol. This type of provision is already in operation in Scotland, where the Licensing (Scotland) Act 2005 includes the protection and promotion of public health as a primary objective. In our survey 65% of respondents felt that this would help to tackle alcohol related health problems³⁰.

5.8 Advertising

The recent increase in alcohol related problems in the UK can be explained in part by increased marketing and promotion of alcohol that occurred from the early 1990’s onwards. The UK alcohol industry currently spends a huge amount on promotion – compared with tiny sums of social marketing. Much tighter regulation of promotion is urgently needed. The RCP firmly believes that a starting point for this would be to ban alcohol advertising on TV before 9 pm and in cinemas unless films are 18 rated in a move towards total ban on broadcast advertising.

Further information

The Royal College of Physicians is a member of the Alcohol Health Alliance.

We would like to request that the RCP is invited to give oral evidence to the Inquiry.

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³⁰ Ibid 1.

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