Alcohol pricing – could it improve men's health?

CORDELIA E.M. COLTART AND IAN T. GILMORE

The authors give an overview of the rationale for using alcohol pricing as a public health tool. They outline the background to government alcohol strategies, review recent moves by the government to acknowledge the problem, and contrast their proposed policy to the evidence base that underpins the advice of health professionals advocating for an urgent minimum pricing policy for alcohol.

You only have to go into an accident and emergency department on a Friday night to see the scale of the alcohol problem in the UK. The statistics are striking, with recent data reporting 30,000–40,000 deaths attributable to alcohol,1 more than one million alcohol-related hospital admissions in England each year,2 and the economic costs of alcohol-related health harms at something in the order of £20–55 billion.1

The evidence highlighting the scale of the problem is accumulating, as is evidence to support the association between affordability of alcohol and increased consumption (Figure 1).3 The consequences of alcohol-associated harm are largely preventable, or at least would be with effective and enforceable alcohol policies.

Figure 1. Making alcohol more expensive and less available would help reduce alcohol-related problems

Cordelia E.M. Coltart, MB BS, MRCP, MPH, Clinical Advisor to the President, Royal College of Physicians; Ian T. Gilmore, MD, FRCP, Consultant Physician and Gastroenterologist, Royal Liverpool University Hospitals; Honorary Professor of Medicine, University of Liverpool; Chair, Alcohol Health Alliance
However, as we all know, alcohol policies rarely feature highly on any health agenda.

THE PROBLEM
Harmful and hazardous use of alcohol is related to both the volume of alcohol consumed and the pattern of drinking. Britain has the highest binge-drinking culture worldwide (men more than women). The problems associated with alcohol consumption are well documented, with alcohol being shown to cause more than 60 medical problems (Box 1), in addition to the consequences of ‘passive drinking’ (the indirect harmful effects to a third party from alcohol use, eg the effect on the drinker’s family, colleagues, victims of violence and traffic injuries). Furthermore, domestic violence is strongly related to alcohol use, with some regions reporting 53 per cent of cases linked to perpetrators ‘under the influence’.

One way to monitor the impact of alcohol burden and the success/failure of alcohol policies is to measure one of these well-recognised health consequences. For instance, death rates from liver disease is a good surrogate marker of the damage to society by alcohol (liver disease accounts for 80 per cent of the mortality attributed to alcohol). The liver death rate trends have been increasing markedly over recent decades. These findings are particularly alarming when compared to countries with similar cultures, genetic background and drinking cultures (eg Australia, New Zealand, Netherlands, Sweden and Norway).

However, the most recent statistics suggest a small overall reduction in harm associated with alcohol, with a 6 per cent decline in alcohol-related deaths and 6 per cent reduction in consumption in 2009 (Figure 2). While this may be a genuine effect of the current recession, these data represent an isolated one-year snapshot and must be viewed in the light of overall trends, which have increased overwhelmingly since the 1990s.

Much of the information available on alcohol does not distinguish between men and women, but the data highlight that in all societies studied, men consistently drink more than women in both frequency and quantity. This leads to higher rates of adverse drinking consequences – men are twice as likely as women to die of alcoholic cirrhosis. Furthermore, alcohol affects testicular and sexual function in males, although it is unclear whether this alters reproductive outcomes or infant development.

UK ALCOHOL POLICY
The first move to acknowledge alcohol as a health concern in the UK came in 2001, when the Chief Medical Officer (CMO) reported that UK deaths from cirrhosis were rising disproportionately and set to overtake the European Union mean average. In 2004 the government set out an alcohol harm-reduction strategy, centred on increased education and public information on alcohol harm and increased voluntary partnerships with the drinks industry. However, these approaches were not successful and, in contrast, policy decisions driving alcohol use to rise were implemented (eg increasing alcohol availability by removing restrictions on sales and reduced relative price).

In the face of failing government policies, in 2009 the CMO recommended tougher policies to reduce the harmful effects of alcohol, such as a minimum unit price (MUP) for alcohol, although the government quickly rejected this last proposal. Further calls for action have been made by the Academy of Medical Sciences in their document ‘Calling time: the nation’s drinking as a major health issue’, the World Health Organization in the recently ratified Global Alcohol Strategy and the House of Commons Health Committee, who in 2009 reported that ‘we are concerned that government policies are much closer to, and too influenced by, that of the drinks’ industry and the supermarkets, than those of expert health professionals such as the Royal College of Physicians (RCP) or the CMO’.

Alcohol pricing policies
Alcohol price can be regulated in two ways: increased duty (including absolute increases in alcohol duty linked to taxation according to inflation, linking levels of taxation to alcohol strength including introduction of tax incentives for low-alcohol alternatives) and minimum unit pricing. Both of these approaches would impact upon and decrease price-based alcohol promotions.

Minimum unit pricing will differentially affect supermarket alcohol sales, where the trend in alcohol purchasing and consumption is growing as home drinking trends increase. In contrast, duty and tax policies will differentially impact on alcohol sales in pubs and clubs, as alcohol duty strategies can be, and often are, avoided by retail discount offers on alcohol, to offset the duty increase. There is international evidence to support the effectiveness of pricing strategies, reinforced by modelling data, to substantially reduce alcohol consumption and associated harms.

Lessons should be learnt from international strategies demonstrating the clear association between affordability and
consumption. For example, in 2004, the Finnish government reduced alcohol excise duty (to reduce the tax on alcohol sold within Finland and prevent excessive imports resulting in internal losses in alcohol tax revenues) by an average of 33 per cent. This led to an immediate 17 per cent increase in sudden deaths involving alcohol (equivalent to eight additional alcohol-related deaths per week).15

Current policy

In January 2011, UK ministers proposed plans to control alcohol pricing in England and Wales, by imposing a ban on selling alcohol for less than the combined tax and duty paid on it. This would result in prices from 21p per unit of beer and 28p per unit for spirits, which equates to 38p for a can of weak lager, £2.03 for a bottle of wine and £10.71 for a litre of spirits. This move may have been intended to demonstrate that the government is doing something tangible about this stark public health problem, but in reality, the proposals do not begin to tackle the problem, affecting a tiny proportion of drinks currently sold (estimated by the Guardian newspaper at less than 1 in 4000 sales). Therefore, this first move by the government sets an ineffectual floor to minimum price and disregards the evidence.

Recent UK estimates have shown that a £0.50 MUP would decrease alcohol consumption by 6.9 per cent, leading to 3393 fewer deaths, 97 900 fewer hospital admissions, 45 800 fewer crimes, 296 900 fewer sick days and a total saving of £15 billion over ten years.16 75–80% of alcohol is consumed by 20–25 per cent of people, who misuse it. Any pricing policy that targets the cheapest alcohol will target heavy drinkers, who buy 15 times more alcohol than the moderate drinker, spend 10 times as much per year and pay 40 per cent less per litre of pure alcohol due to cheaper preferences (eg discounted, multi-buy, super-strength alcohol).16

The Scottish Parliament last year rejected plans for an MUP, as the Scottish National Party (SNP) could not secure the support of coalition partners. However, as of May 2011, the SNP have a working majority and are committed to pursuing an MUP. They will first have to overcome anxieties about breaches of European competition law.

Opposition parties will claim that an MUP would penalise responsible moderate drinkers, but studies have shown this not to be the case and that an MUP in the range of £0.50 would not increase the average British family’s supermarket bill per week.17 For example, supermarkets could transfer the discounted bargains from alcohol to fruit and vegetables, thereby preventing moderate drinkers subsiding alcohol purchases for the harmful and hazardous drinkers, while increasing the health of the supermarket shoppers and balancing the modest increase in alcohol purchases such that the result is the same overall spend per week.

Several other recent policy developments have been proposed, such as approval to sell reduced measures of alcohol, eg wine in measures of under 75ml and a ‘schooner’ of beer (two-thirds of a pint).18 Furthermore, the government will introduce a new duty on ‘strong’ beers over 7.5 per cent alcohol by volume, aimed to decrease the consumption of cheap, ‘super-strength’ lagers, usually associated with hazardous drinking behaviours.19 However, once again, this will affect only a tiny proportion of beer sales.

Finally, the government hopes to achieve positive societal change through ‘responsibility deals’ by incorporating businesses into public health strategy decisions (including alcohol). While ‘nudging’ may have a role to play, it will most effectively alter the behaviour of the already health-conscious audience, who do not comprise the bulk of the alcohol problem. The drinks industry has not traditionally shown commitment to public health and a conflict of interest is inevitable.

CONCLUSION

Medical professionals have a key role to play in advocating for the implementation of alcohol policies to protect the health of the population. General practitioners are pivotal in this process, as the frontline interface of the profession, seeing patients on a daily basis. The UK has a strong track record in successfully campaigning for public health policy, most notably around the tobacco campaign. The success of this campaign, in part, was a consequence of strong medical pressure, both epidemiologically and on a
case-by-case consultation basis, where smoking was/is highlighted in virtually every medical encounter.

We should learn from these successes and every consultation should additionally include a discussion about alcohol usage, highlighting the harms associated with it. The former CMO (England) highlighted the urgent need for effective alcohol policy and professional support is crucial. It will be interesting to see if Scotland leads the way in introducing evidence-based policy into the UK, as they did with the ban on smoking in public places. In addition, a cultural change is needed to alter the acceptability and perception of drinking to excess. This will take time and is harder to achieve, particularly given the limited government budget for alcohol education, which is swamped in comparison to the drinks industry budget (45 times higher at £600–800 million/year).

As a profession we have a duty to advocate for responsible, sensible and evidence-based national action with a call for a £0.50 MUP for alcohol to reduce the preventable, but rising statistics of alcohol health harms in the UK.

Declaration of interests: none declared.

REFERENCES