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Editorial

Alcohol – is the evidence-base guiding public policy?

There is strong international evidence from many different countries, cultures and patterns of drinking on what works in reducing alcohol-related harm, but sadly there is also evidence that far too often is not translated into effective public health policies.

Babor et al.[1] and Stockwell[2] are among those that have reviewed and presented the evidence-base for policy relevant strategies. Studies in a number of countries have consistently shown that even small increases in alcoholic beverage price reduce both consumption and its related harms (long-term and short-term). Restriction on the physical availability of alcohol is also well known to work. This can be achieved by a number of measures, with the most successful known to be restricting hours and days of sale, restricting the legal drinking age for purchase or consumption of alcohol, restricting density of licensed outlets and restricting service to intoxicated patrons. Random breath testing, reducing blood alcohol concentration (BAC) limits and setting BAC limits of zero for drivers under the legal alcohol purchase age are all drink driving countermeasures that have been shown to be effective. There is also a growing evidence-base showing that young people who are exposed to alcohol advertising are more likely to start drinking and those that already drink are likely to drink at higher levels[3], yet the control of alcohol advertising in many countries remains an industry self-regulated system.

Two clear examples of where there is strong evidence for the effectiveness of public health intervention in reducing alcohol-related harm, and how politics can get in the way of the evidence, are price regulation and trading hour restrictions:

Price regulation

In the UK the regulation of alcohol price has historically been through taxation and excise duty. Another approach, that will specifically raise the price of the cheapest drinks commonly sold in off-licence settings, is to move towards a minimum unit price (where a minimum price is set for every unit of alcohol sold). Cheap drinks are favoured by the heaviest drinkers and by young people, some of those most at risk of harm. The University of Sheffield have used the extensive evidence-base and modelled the potential impact of minimum pricing in England[4]. A minimum unit price of 50 pence (at 2008-9 prices, now equivalent to 60 pence) would be expected to see the following health outcomes each year after ten years of policy implementation: 3,000 saved lives, 41,000 fewer chronic illnesses, 8,000 fewer acute illnesses and 92,000 fewer hospitalisations. There is now evidence from Canada that the impact on deaths and hospitalisations directly caused by alcohol is even greater than modelling predicted[5,6].

The UK government's alcohol strategy[7] was released in 2012 and it committed to following the lead of Scotland and implement minimum pricing. Twelve months on, plans for minimum pricing in England and Wales are now looking uncertain and the Prime Minister, who previously gave this policy his personal backing, seems to be bowing to industry and backbencher pressure. While Government in Scotland remains committed, they are embroiled in challenges by the Scotch Whisky Association in their High Court, facing the prospect of further challenges from the European Commission and fielding submissions from the alcohol industry replete with questionable interpretations of the evidence[8]. And so at a time when evidence on the benefits of a minimum unit price for alcohol is strengthening and public opinion swinging behind it, political will is being tested to the full.

Trading hour restrictions

There has been a lot of research on the effectiveness of trading hour restrictions. The UK's relaxation of licensing laws in 2003 (enacted in 2005), allowing 24-hour trading, went against the international evidence at the time. Indeed the BBC suggested that reference to some international studies highlighting the negative impact of later trading on levels of violence were dropped from the final draft of the 2003 UK Government White Paper[9]. One such study from Perth, Western Australia[10] found that monthly assault rates associated with premises that obtained only a one to two hour trading extension past midnight increased by about 70%.

Subsequent studies[11,12] from Western Australia showed that road traffic crashes due to drink driving (following drinking at a premise with late trading) increased by 49% and breath alcohol levels among young males were particularly affected. A more recent Australian study[13] followed the trading hour restrictions imposed on 14 premises in Newcastle central business district. A 37% reduction in assaults in the area was shown to have occurred when compared to a control locality, equivalent to approximately 132 assaults a year. Furthermore an international review by Stockwell and Chikritzhs[14] including studies from Canada, the US and the UK concluded that the best available evidence points to increased consumption and harm arising from longer trading hours. In the face of this evidence, there are still moves to increase availability in Australia via further deregulation of the industry. In South Australia for instance, legislation has been passed to facilitate small bars to be licensed and there are plans to make wine available through more outlets. There is currently a review of liquor licensing laws in Western Australia where the trading hours of premises and the role of current extended trading hours are being considered (among other issues) but it is unclear the extent to which scientific research evidence will inform the deliberations of the review committee (to which no health representative has been appointed http://www.rgl.wa.gov.au/).

Where does this leave evidence-based alcohol policy? An independent group of experts (steered by the UK Alcohol Health Alliance) has recently published a comprehensive evidence-based alcohol strategy[15] as a model for the UK and beyond, with clear recommendations on how to reduce alcohol-related harm among the population. The policy options set out in this report follow the 'Four Ps' of the marketing framework that alcohol producers and retailers use to make sales (product, price, place and promotion). The suggestion is that the same framework can be used by governments to reduce alcohol sales, consumption and related harm. Top of the list of ten key, evidence-based recommendations is a minimum unit price, but there are many additional measures for reducing alcohol-related harm, including those that do not fit the marketing framework, such as drink driving countermeasures.

For the moment, then, the public health community is 'going it alone', in the hope that regulators will follow as the public opinion strengthens and the political climate becomes more propitious. We may be disappointed but should not be surprised when our political leaders are influenced by wider considerations than the evidence.

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