The alcohol 'epidemic': What can be done?

We are all guilty of hyperbole when it comes to our own interests. Alcohol misuse may not fit exactly the Oxford English Dictionary definition of an epidemic as 'a sudden widespread occurrence of a particular unpleasant phenomenon', but the definition has a resonance with the visible consequences for law and order in British inner cities at night, and for the emergency departments of hospitals. The government's own figures, drawn together in the Interim Analytical Report produced by the Cabinet Office in 2003 (Prime Minister's Strategy Unit, 2003) to support a national strategy, were stark. Annual alcohol-related costs of crime and public disorder are £7.3 billion, workplace costs are £6.4 billion, and health costs are £1.7 billion, with hospital admissions of 150 000 each year. Alcohol accounts for up to one third of all accident and emergency attendances (and 70% between midnight and 6 am), and about 2.9 million, or 7%, of the adult population are dependent on alcohol (Prime Minister's Strategy Unit, 2003).

WHAT HAS CHANGED?

As a nation we are drinking more, our consumption having doubled since the Second World War and risen around 50% since the 1970s (Prime Minister's Strategy Unit, 2003). This still leaves consumption at about the same level as it was at the turn of the 20th century. It was the catastrophic effects of drinking on the war effort that brought about the introduction of licensing laws during the First World War – which, incidentally, were spectacularly successful. What is most striking is the way that escalating consumption in the UK in the new millennium is bucking the trend in continental Europe. In the last 25 years, per capita consumption in Europe has fallen from about 16 litres to 11 litres of pure alcohol per annum, and the UK's rising consumption seems set to overtake the European average (Prime Minister's Strategy Unit, 2003). The most striking fall in drinking has been in the wine-consuming countries of Italy and France, where there are complex reasons that probably include a move away from a rural economy (Babor et al, 2003). The effects of rising alcohol consumption are serious, and the Chief Medical Officer (CMO) of England, in his annual report of 2001, graphically showed how UK mortality rates for cirrhosis are mirroring those of consumption and are about to overtake the falling cirrhosis rates in the EU.

Perhaps the most striking change has been in the behaviour of young people in the UK and the widely-publicized phenomenon of 'binge-drinking'. The most recent data from the European School Survey Project on Alcohol and other Drugs (ESPAD) showed that UK 15–16-year-olds were at the top of the European league table and, for the first time, more girls (29%) had binged three or more times in the last month than boys (26%). The shift in age and gender patterns of drinking are also mirrored in the cirrhosis mortality rates given by the CMO, where the peak age is falling and the biggest rise has been seen in younger women. It is now commonplace to see patients in UK liver wards with advanced alcoholic liver disease in their 20s and 30s.

WHAT CAN BE DONE?

If it is easy to make the case for a growing crisis, it is less easy to provide solutions, and the whole area was debated at the Royal College of Physicians (RCP) in January this year at a conference entitled 'Alcohol-Related Harm – A Growing Crisis, Time for Action'. The RCP report (2001), which gave a blueprint for an alcohol strategy for acute hospitals in the UK, was reviewed and progress in its implementation found wanting – usually for lack of funding.

A report of a working party from the Academy of Medical Sciences, *Calling Time – the Nation's Drinking as a Major Health Issue* (2004), chaired by Sir Michael Marmot, one of the UK's most distinguished epidemiologists, found compelling evidence to support previous findings of a strong correlation between mean or median alcohol consumption and heavy or 'problem' drinking. These cross-sectional data are supported by time-series analyses which demonstrate that changes in per capita consumption are directly reflected in changes in harm. For instance, in Canada, a 1 litre per annum rise in mean alcohol consumption was associated with a 30% increase in alcoholic cirrhosis of the liver (Academy of Medical Sciences, 2004).

In other words, if general measures are put in place to reduce the nation's drinking, this will have a disproportionate effect on those who are drinking dangerously, and there is no evidence that moderate drinkers are turned into tee-totallers. Of course, this does not preclude targeting those at greatest risk as well, but it is important to understand that general measures can reduce harm without penalizing the moderate drinker.

MODERATE CONSUMPTION: BENEFITS AND CONCERNS

Many studies have shown that moderate consumption of alcohol has a beneficial effect on coronary heart disease in the individual, although it has been hard to show this convincingly at a population level. One concern about reducing the nation's drinking is that there would be a reduction in this cardio-protective effect. Robin Room, from Stockholm University, persuaded

the conference that, on a national level, the consumption of alcohol in the UK was well above that protective level. In both Spain and Canada, an increase in national consumption was accompanied by a rise in coronary heart disease (Room et al, 2005). Taking the international perspective, alcohol is a huge threat to public health in developing as well as developed countries, and falls just behind smoking and hypertension as the major cause of preventable premature death (Room et al, 2005).

THE NATIONAL ALCOHOL HARM REDUCTION STRATEGY

The international evidence gives a clear but unpalatable message – the best way to reduce alcohol-related harm is through the instruments of price and access. This was the message given to the government by its External Advisory Group and by the Academy of Medical Sciences before the *National Alcohol Harm Reduction Strategy* was released in March 2004 (Prime Minister's Strategy Unit, 2004). How did the final strategy measure up? It was strong on crime and disorder, but weak on health. It was strong on voluntary partnerships with industry, but weak on legislation. It was strong on models of good practice, but weak on how to fund them. It was voluble on the problems of binge-drinking youths in city centres, but not so on the growing numbers of adults silently developing cirrhosis at home on cheap and freely-available alcohol (Gilmore, 2004).

MISSED OPPORTUNITIES

Of course it is valid, indeed important, to target high-risk groups, and attention on the young is welcome, especially as there is abundant evidence that early drinking is more likely to lead to longer-term alcohol problems. But the government's second opportunity, through its public health White Paper, *Choosing Health* (DH, 2004), again sets too much store on voluntary partnerships with the drinks industry – for instance in a public information campaign. A third opportunity, through a review of the regulation of broadcast advertising by OFCOM, seems set to make little difference, and it is more likely that there will be a ban on advertising junk food than alcohol before a 9 pm watershed. A final recent opportunity has been the revision of the Road Safety Bill, where several MPs, backed by the British Medical Association, have encouraged the government to take the opportunity to bring the UK into line with most of Europe by reducing the blood alcohol limit for driving from 80 to 50 mg/dl. There seems no government appetite for this eminently sensible change.

Meanwhile the changes in licensing legislation, passed in 2003, are due to be implemented later this year, and seem to be in direct conflict with the known twin drivers of alcohol-related harm, price and availability. That there is likely to be a marked increase in the number of licensed premises (both on- and off-licence sales) that will drive down prices and encourage special offers, and 24-hour availability will extend to corner shops and petrol stations (Room, 2004).

CONCLUSIONS

What can be done? For a start, a better understanding of the reasons for this drinking culture and the ways in which it might be modified is despedrately needed. There is a dearth of funding for social and medical research into alcohol-related issues. The strategies that are already known to work and be cost-effective need to be urgently implemented, such as early detection and brief interventions in primary and secondary care and the implementation of specialist alcohol workers in acute hospitals. The public needs to be engaged in a better understanding of the issues and whether it makes sense that 'our favourite drug' has never been cheaper or more widely available. **HM**

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KEY POINTS

- The current burden of health and social damage from alcohol misuse in the UK is unparalleled in the last three quarters of a century and is a major public health issue.
- The biggest increases are seen in women and the young, and this Is mirrored in changing patterns of cirrhosis.
- International evidence strongly supports the link between total per capita consumption and the burden of harm, and the key drivers of national levels of drinking are price and availability.
- Alcohol in the UK has never been cheaper or more available, and recent Government initiatives, including the National Harm Reduction Strategy, and changes to the licensing regulations, will not tackle these fundamental drivers.
- There is need for UK research programmes to better understand our drinking culture and ways to influence it.