Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol
Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Royal College of Physicians - ASM 24 / Tystiolaeth gan Coleg Brenhinol y Meddygon (Cymru) - ASM 24

Inquiry into alcohol and substance misuse

RCP (Wales) response

Key points

- The Welsh Government liver disease delivery plan must be implemented in full, supported by adequate funding
- Alcohol and substance misuse services should be established as a matter of urgency where there are service gaps and existing services should be integrated across primary, secondary care and public health teams
- The RCP strongly supports the introduction of a minimum unit price for alcohol as well as other measures including:
    - a major review of licensing legislation
    - restrictions on alcohol availability
    - an independent regulator for alcohol promotion
    - a reduction in the drive-drive limit
    - a public health licensing objective.

For more information, please contact:

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From the RCP vice president for Wales
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From the RCP registrar
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Dr Andrew Goddard FRCP
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09 January 2014

Dear colleague,

Thank you for the opportunity to respond to your inquiry into alcohol and substance misuse.

About us

The Royal College of Physicians (Wales) 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 Wales and across the world with education, training and support throughout their careers. As an independent body representing 30,000 fellows and members worldwide, including 800 in Wales, we advise and work with government, the public, patients and other professions to improve health and healthcare.

Our response

The RCP welcomes this inquiry into alcohol and substance misuse. In particular, we recommend:

Liver disease delivery plan

1. The Welsh Government liver disease delivery plan must be implemented in full, supported by adequate funding. Local health boards will not be able to deliver outcomes without resource. Health boards must all appoint clinical leads for liver disease and give them the power and budget to do the job effectively. Reporting mechanisms outlined in the plan should be clarified to ensure that the processes are accountable and transparent.

Alcohol and substance misuse services

2. Alcohol and substance misuse services should be established as a matter of urgency where there are service gaps and existing services should be integrated across primary, secondary care and public health teams. All health and community professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.

3. People who need support for alcohol problems should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment. This will require substantial investment in recruitment and service development in Wales: we know that there is historic underinvestment in alcohol treatment services. However, well-designed alcohol treatment services are highly effective in terms of clinical outcomes as well as being highly cost-effective.

There is an estimated return on investment of £5 (in the form of cost savings) for every £1 invested. The RCP therefore strongly supports increased investment in 'brief interventions' for alcohol, from which it is estimate that 7.1 million hazardous or harmful drinkers may benefit.

4. Every acute hospital should have a specialist, multidisciplinary alcohol care team tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions. This will require trained hepatologists in every hospital.

5. Health boards should be meeting NICE guidelines on harmful alcohol use eg NICE QS11 Alcohol dependence and harmful alcohol use quality standard[1] and NICE QS23 Quality standard for drug use disorders.[2]

Minimum unit pricing (MUP)

6. The RCP strongly supports the introduction of a minimum unit price for alcohol. We were instrumental in establishing the Alcohol Health Alliance, which, together with the University of Stirling, produced an independent, evidence-based alcohol strategy for the UK, Health First, in 2013. This strategy set out a series of recommendations to reduce alcohol consumption and harm from alcohol and was endorsed by over 70 organisations, including Alcohol Concern Cymru. At the heart of this strategy was the introduction of a minimum unit price of 50p together with a mechanism to regularly review the price. Canada has already introduced minimum unit pricing, where it has been shown that a 10% increase in average price results in approximate an 8% reduction in consumption, a 9% reduction in hospital admissions and a 32% reduction in deaths which are wholly attributable to alcohol.[3]

7. The UK's alcohol consumption has risen 80% in the last three decades.[4] In 2010, alcohol was 48% more affordable than in 1980[5] – the heaviest drinkers currently pay only 33p/unit of alcohol, with some high-strength ciders costing the equivalent of only 6p/unit.[6] The average low-risk drinker already pays around £1/unit of alcohol and so the impact of minimum unit pricing on low risk drinkers is negligible, and on pubs it is zero.[7] Indeed, recent research has found that patients with alcohol-related cirrhosis drink an average of 146 units of alcohol per week[8] and that alcohol misuse is the single greatest cause of working years of life lost in the UK – even more than tobacco.[9] We therefore believe that a minimum unit price of 50p/unit would precisely target the heaviest drinkers.

8. Moreover, evidence suggests that minimum unit pricing would play a pivotal role in tackling health inequalities without penalising moderate drinkers on low incomes: as lower income households disproportionately suffer the harms of alcohol, they would see the most benefits as a result. University of Sheffield data suggests that routine and manual worker households would account for over 80% of the reduction in deaths and hospital admissions brought about by a

[1] http://www.nice.org.uk/guidance/qs11
[2] https://www.nice.org.uk/guidance/qs23
[3] Stockwell, T. Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol. British Colombia, 2013.
[4] Ibid.
[5] University of Stirling. Health First: An evidence based alcohol strategy for the UK. March 2013.
[6] Sheron, N, Eisenstein, K. Minimum unit price — how the evidence stacks up. BMJ 2004;348:g67
[7] University of Sheffield. Modelled income group-specific impacts of alcohol minimum unit pricing in England 2014/15: Policy appraisals using new developments to the Sheffield Alcohol Policy Model (v2.5). July 2013. **Available online**.
[8] Sheron, N., et al. Minimum unit pricing impacts financially on patients with alcohol related liver disease four hundred times more than on low risk drinkers. Submitted for peer review to Clinical Medicine, 2014.
[9] Alcohol is attributable for 82,860 of working life years lost, compared to 61,210 for tobacco.

minimum unit price and yet the consumption of moderate drinkers in low income groups would only drop by the equivalent of 2 pints of beer a year.[10]

9. However, minimum unit pricing will only be effective if it is regularly reviewed and updated to take account of inflation and rising incomes. While 50p is a reasonable starting point, delays in implementation continue to erode the effect of this level, and the original work of Sheffield University showing a marked impact (nearly 3000 lives a year saved) were modelled on 2007-8 prices. With inflation, this would be equivalent to nearer 40p now.

Other measures to reduce harm

10. The RCP would also welcome the introduction of other measures to reduce the harms associated with excessive alcohol consumption, including a major review of licensing legislation, restrictions on availability, an independent regulator for alcohol promotion, and a reduction in the legal limit for blood alcohol concentration for drivers.[11] We support moves in Scotland to reduce the drink-drive limit to 50mg in every 100ml of blood. This must be accompanied by national publicity explaining the change and its implications.

Public health licensing objective

11. Public health and community safety should be given priority in all policy-making about alcohol. This is why we support the introduction of a public health licensing objective. This would empower local authorities to make alcohol licensing decisions which fully take into account the public health impact of licensed premises in their area. Licensing authorities must be empowered to tackle alcohol-related harm by controlling the availability of alcohol in their area.

The RCP in Wales also endorses the response from Alcohol Concern Cymru.

For more information

If you have any questions, please contact our colleague, Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at [redacted] or on [redacted].

With best wishes,

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Is-lywydd yr RCP dros Gymru

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[10] University of Sheffield. Modelled income group-specific impacts of alcohol minimum unit pricing in England 2014/15: Policy appraisals using new developments to the Sheffield Alcohol Policy Model (v2.5). July 2013. **Available online**.
[11] University of Stirling. Health First: An evidence based alcohol strategy for the UK. March 2013.