

Consultation on the Government's Alcohol Strategy

January 2013

Response by Cancer Research UK

Cancer Research UK welcomes the opportunity to assess the effectiveness of the proposed measures introduced in the Government's Alcohol Strategy. We welcome the Government's Alcohol Strategy which sets out the commitment to reduce alcohol consumption and alcohol harm. Cancer Research UK has assessed the effectiveness of the proposed measures introduced in the Strategy and recommends that they be strengthened. Measures such as minimum unit pricing (MUP) have been shown to not only reduce drinking levels but reduce the burden of ill-health caused by alcohol.

Alcohol and Cancer Risk

With 26% of men and 17% of women reportedly drinking above recommended guidelines, Government is right to focus on reducing alcohol consumption across the population.ⁱ A sustained reduction in alcohol consumption can provide significant benefits to individuals' health and help reduce the incidence of alcohol-related cancers.

Alcohol is one of the most important modifiable risks for cancer after smoking and obesity. The International Agency for Research on Cancer classified alcohol as a group 1 substance, meaning that it is known to cause cancer in humans.ⁱⁱ Alcohol can cause seven cancers - mouth, pharyngeal, laryngeal, oesophageal, breast, bowel and liver.

In 2010, 12,500 cases of cancer in the UK (4%) were attributable to alcohol.ⁱⁱⁱ Although, another study suggested that the number could be even higher.^{iv} In addition, data for England show that since 2002/03 the number of admissions to hospital for alcohol-related cancer has increased by 28% to 37,600 in 2010/11. This is more admissions than those attributed to alcohol-related violence and transport accidents combined for that year.^v

Cancer risk is associated with total alcohol consumed over time. Current evidence shows that the less alcohol people drink, the lower the risk of cancer.^{vi} However, no level of drinking has been found to be free of cancer risk.^{vii} Therefore measures to improve health should tackle the amount of alcohol consumed by individuals over time. The introduction of a minimum unit price has been shown to reduce drinking at the population level^{viii}. Therefore, with an effective mechanism to increase the price, minimum pricing should lead to sustained reductions in alcohol consumption and thus should reduce the long term health harms associated with drinking.

Minimum Unit Pricing

1. Do you agree that this MUP level (45p) would achieve these aims?

No.

The Government's aims are to have a price which can reduce harm significantly and which is targeted and proportionate. While a minimum unit price (MUP) of 45p will make a positive contribution towards these aims, the evidence suggests that a MUP of 50p will be more effective at reducing alcohol harm.

Minimum unit pricing is considered an effective measure because it targets the most harmful and hazardous drinkers. Research by Sheffield University shows that the relationship between price increases and harm reduction is not linear. Therefore the difference between a MUP of 45p and 50p is substantial. The research demonstrates that a MUP of 50p could lead to a 6.7% reduction in drinking and could avoid 3,000 premature deaths after 10 years. By comparison they estimate a MUP of 45p will lead to a 4.3% reduction and avoid 2,000 premature deaths after 10 years.^{ix} Therefore, the model suggests that a slightly higher price will be around 50% more effective in reducing the health harm associated with drinking.

The case for a higher MUP is also justified by real world experience. The impact of a marginal increase in minimum price is demonstrated by its use in Canada. Research shows that a 10% increase in the minimum price in Saskatchewan, Canada led to an 8.43% reduction in alcohol consumption.^x

Therefore the balance of evidence suggests that a minimum unit price of 50p would be the most effective level, if Government wanted to minimise alcohol harm without any disproportionate effects.

2. Should other factors or evidence be considered when setting a minimum unit price for alcohol?

The main factor to consider when setting a minimum price will be its impact on total alcohol consumption and long term health harm. The price should be set at a level that reduces consumption the most without unnecessarily penalising those who drink within the UK's national guidelines.

3. How do you think the level of minimum unit price set by the Government should be adjusted over time?

In the long term, it is not the price but the affordability of alcohol that shapes consumer behaviour. Despite increases in duty, over the last 30 years the affordability of alcohol has risen. This has primarily been due to alcohol prices rising at a slower rate than incomes. As affordability has risen, consumption has increased. Therefore without a method to increase the price level, the impact of minimum unit pricing will diminish over time.

Therefore the minimum unit price should be reviewed regularly i.e. every two years. Such a review would take into account rises in incomes, inflation and examine other factors affecting alcohol consumption. This process should be systematic, transparent and undertaken independently of Government.

4. The aim of minimum unit pricing is to reduce the consumption of harmful and hazardous drinkers, while minimising the impact on responsible drinkers. Do you think that there are any other people, organisations or groups that could be particularly affected by a minimum unit price for alcohol?

No. The research from Sheffield University suggests that there will be benefits across the population.^{xi} Beyond harmful and hazardous drinkers, the current evidence has not identified other groups that will be particularly affected by the introduction of this policy.

Multi Buy Promotions

5. Do you think there should be a ban on multi-buy promotions involving alcohol in the off-trade?

A ban on multi-buy promotions would also be beneficial to public health. Evidence from Sheffield University suggests that a well-designed ban could reduce consumption by 2.8%^{xii}. Government should complete a thorough assessment of price promotions, in order to assess which promotions encourage over-consumption of alcohol. Decisions to include other promotions, in addition to the ones suggested by Government, should focus on how they may contribute to excessive consumption and affect health.

6. Are there any further offers which should be included in a ban on multi-buy promotions?

See response to Question 5

7. Should other factors or evidence be considered when considering a ban on multi-buy promotions?

See response to Question 5

About Cancer Research UK

Every year around 300,000 people are diagnosed with cancer in the UK. Every year more than 150,000 people die from cancer. Cancer Research UK is the world's leading cancer charity dedicated to saving lives through research. Together with our partners and supporters, Cancer Research UK's vision is to bring forward the day when all cancers are cured. We support research into all aspects of cancer through the work of over 4,000 scientists, doctors and nurses. In 2011/12 we spent £332 million on research. The charity's pioneering work has been at the heart of the progress that has already seen survival rates in the UK double in the last forty years. We receive no government funding for our research.

i NHS Information Centre (2010) Statistics on Alcohol: England, 2010, The Health and Social Care Information Centre

ii <http://monographs.iarc.fr/ENG/Monographs/vol100E/index.php>

iii Parkin, DM (2011) Cancers attributable to consumption of alcohol in the UK in 2010. British Journal of Cancer 105 (S2):S14-S18; doi: 10.1038/bjc.2011.476

iv Schutze M, Boeing H, Pischon T et al. Alcohol attributable burden of incidence of cancer in eight European countries based on results from prospective cohort study. BMJ 2011;342:d1584.

v NHS Health and Social Care Information Centre. Statistics on alcohol: England, 2012 (Table 4.1). London: NHS Health and Social Care Information Centre, 2012.

vi Corrao G et al. (2004) A meta-analysis of alcohol consumption and the risk of 15 diseases Prev Med. 2004 May;38(5):613-9

vii Corrao G et al. (2004) A meta-analysis of alcohol consumption and the risk of 15 diseases. Prev Med. 2004 May;38(5):613-9

viii Purhouse, R et al, (2009) Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group

ix Purhouse, R et al, (2009) Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group

x Stockwell et al, (2012) The raising of minimum alcohol prices in Saskatchewan, Canada: impacts on consumption and implications for public health *Am J Public Health*. Dec; 102(12):e103-10. doi: 10.2105/AJPH.2012.301094. Epub 2012 Oct 18

^{xi} Purhouse, R et al, (2009) Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group

xii Purhouse, R et al, (2009) Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group