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Response to ‘Safe, Sensible, Social – consultation on further action’ by AIM – Alcohol in Moderation

Background on AIM:

Alcohol in Moderation was founded in 1991 as an independent, not for profit organisation whose role is to communicate ‘The Responsible Drinking Message’. AIM publishes an online journal of peer-reviewed key research papers, articles on alcohol, health and associated social and policy issues.

AIM is funded by subscription to its journal and social responsibility advisory services and works with a prestigious (unpaid) Council of eighteen leading Professors and Medical specialists from around the world committed to promoting the responsible and moderate use of alcohol. (See annexe 1 for Council members and background). AIM is independent and does not lobby,

AIM promotes a better understanding of healthy, balanced lifestyles which include moderate drinking and works to discourage excessive drinking and its associated physical and social harms.

NB - Elements in bold type are extracts from the report. Responses to the questions raised and statements made are made in red.

2.5 In the past, hospital admissions statistics have only reported on the 3 most common types of alcohol-related diseases: alcoholic liver disease, alcohol poisoning and mental and behavioural disorders. These figures have more than doubled and rose from 93,459 admissions in 1995/96 to 207,778 in 2006/07. Between 2003/04 and 2006/07, they rose at a rate of 12% or 20,000 a year.

2.6 New and more accurate statistics released to coincide with this consultation show the full range of health conditions which give rise to alcohol-related hospital admissions.

2.7 The new statistics are based on best practice established through peer-reviewed and international research. They cover a total of 44 conditions, which

research shows are caused or strongly associated with alcohol consumption. As well as the diseases included in earlier statistics, the statistics now cover conditions such as stroke, heart disease and cancers, and road traffic and other accidents, alongside liver cirrhosis, poisoning and mental health admissions covered in the earlier statistics.

2.8 As a result, we now have a truer estimate of how excessive consumption of alcohol is affecting the health of the nation. The new data reveal that in 2006/07 there were 811,443 hospital admissions that were directly related and attributable to alcohol. This is an increase from 473,529 in 2002/03 – and the figure is still rising by around 80,000 admissions every year. This is a huge number, comprising 6% of all NHS hospital admissions.

Response to points 2.5 – 2.8

AIM –Alcohol in Moderation and it’s Council of eighteen Professors and Medical Specialists have serious concerns as to the new accounting methods used to assess alcohol related hospital admissions and deaths in England. We would like to see evidence of the peer review cited above. We have questioned the attribution to women, by the authors , of alcohol related hospital admissions and deaths at consumption levels of 1-20 grams of alcohol per day (1 –2 drinks) in a letter to The Department of Health and to The Minister of State (see Annexe 2). This letter voices our disquiet at the selection of evidence suggesting women drinking within the government responsible drinking guidelines are accumulating risk, and are counted in the figures cited above. We support the assertion that AAF risks increase among males at consumption levels of 40g a day and higher. The most recent and comprehensive research by international authors referenced in the NWPHO report cite:

'At 10 grams per day, lifetime risk for women is actually lower than that for men, but increases to over 50% higher (96 versus 60 per 1000) at 100 grams. Overall, risk increases by about 10% with each 10-gram (one drink) increase in alcohol consumption. The risks for men and women are quite similar at average daily volume levels below 40 grams per day, while at higher levels of drinking large differences by sex are seen'.

Importantly, in the same paper a relative risk ratio, or alcohol attributable fractions for ischaemic heart disease and stroke are given as 0, this is due to alcohol's protective effect against cardiovascular disease at moderate levels, demonstrated in many hundred's of studies, evident in men over 40 and post menopausal women, as recognized in the Government Sensible drinking guidelines.

Source: 'Method for moderation: measuring lifetime risk of alcohol-attributable mortality as a basis for drinking guidelines' Jürgen Rehm, Robin Room, Benjamin Taylor Reference; International Journal of Methods in Psychiatric Research Int. J. Methods Psychiatr. Res. 17(3): 141–151 (2008) Published online in Wiley InterScience (www.interscience.wiley.com) DOI: 10.1002/mpr.259

The comprehensive Alcohol and Cancer report from Australia also cited in the report states 'The report finds that: according to published evidence from eight studies, moderate alcohol consumption corresponding to approximately two drinks of alcohol per day does not increase the risk of cancer in general. However, the average intake of approximately four drinks per day increases the risk of cancer by 22%. High alcohol consumption averaging approximately eight drinks per day increases the risk of cancer at any site by 90%'. The report can be downloaded via: http://www.cancerinstitute.org.au/cancer_inst/publications/pdfs/pm-2008-03_alcohol-as-a-cause-ofcancer.pdf.

We therefore seriously question the readjusted figures of 811,443 hospital admissions attributable to alcohol and wonder why there is a perceived need to increase the figures when there is a real problem to be resolved for people regularly drinking more than 40g a day.

We note in point 2.7 that the statistics and accounting methods were subject to peer review. We would call for a much more open method of peer review, to include at least one epidemiologist, a cardiologist and an oncologist to ensure balance in the International research cited and selected and proper dialogue and debate before such a radical and complicated formula is adopted without open consultation, as per the above.

2.11 Of these, analysis suggests that it is the increasing affordability of alcohol that has played the most significant part and that it is in the off-licence trade where the increase in relative affordability has been particularly strong. Figure 3 shows the increase in affordability, i.e. the increase in households' real disposable income, compared with alcohol prices in each type of retail. Further analysis is needed to understand the relationships between changes in availability, consumption and harm in the UK.

Although relatively, the price of alcohol has decreased, this has not automatically led to an increase in consumption in the UK. Indeed, consumption has peaked and fallen since 2004 from 9.4 litres per capita of pure alcohol to 9.2 litres in 2007 with an estimated further fall in 2008 (source HMRC), or for those over 16 in England, from 10.1 litres in 2005 to 9.9 litres in 2007 (SHAAP/AC Nielson).

Increase in consumption in the UK since 1980 was led predominantly by an increase in drinking by women. Many complex reasons have contributed to increase post 1980, including the regeneration of city centres, the increasing equality in aspects of women's lives, the increasing appeal of drinking venues to women, wealth, career development and marrying later. The context of motivations for drinking alcohol (aspiration, rite of passage, peer pressure, and availability) have not changed significantly during this period. During this period of increased affordability, beer sales have fallen consistently in favour of wine a more expensive beverage relatively. It should also be noted that in a sixteen year comparison, 1991 to 2007, per capita consumption has changed little. Alcohol consumption per capita (15 and over) was 10.39 litres of pure alcohol in 1991, 10.39 litres in 2001 and 9.9 litres in 2007.

Evidence over the last decade, and specifically over the last three years suggests consumption amongst almost every sector of the population is declining. More importantly patterns of drinking are improving, suggesting that the English population are naturally moving towards drinking within the government daily sensible drinking guidelines of 2- 3 units for women and 3-4 for men without the need for market intervention.

Amongst 16-24 year olds, the four key indicators of weekly drinking, frequent drinking, immoderate drinking and binge drinking have all fallen for both

women and men since 1998. Of note, is that young men drinking more than 21 units of alcohol a week fell from 41% in 2000 to 27% in 2005, and the proportion of young women drinking more than 14 units of alcohol a week fell from 33 to 24% (Goddard, 2006).

Countries where alcohol is cheaper than in the UK and equally available, do not have higher levels of alcohol consumption or alcohol related harm, in fact it is lower, suggesting levels of consumption are driven by motivations far more complex than affordability.

This is not to say that AIM- Alcohol in Moderation supports the selling of alcohol below cost, but requests recognition that alcohol is relatively expensive in the UK in comparison with most of the EU, and that consumption trends are not rising as implied in the above statement.

2.12 The rise in alcohol consumption has led to the current rapid rise in alcohol harms. These harms are concentrated in the smaller share of the population who drink very large shares of the total alcohol consumed. Analysis by DH suggests that 7% of the UK population who regularly drink more than twice the recommended limits drink 33% of all the alcohol consumed in the country.

We whole heartedly agree with this analysis and strongly recommend that specific interventions are targeted towards the different sectors of the 7% of the population who need help and support in different ways. It should also be recognized that alcohol dependency is often just one symptom of the illnesses and dependencies affecting this segment of the population, including mental illness and drug addiction.

NB Total alcohol consumption has been falling in the UK, not rising. Average weekly consumption by men fell from 17.2 units in 1998 to 14.9 in 2006. For women consumption has fallen from 6.5 units to 6.3 in the same period, falling from a high of 7.6 units in 2002.

The rise is in alcohol related hospital admissions rather than to alcohol consumption per se. This may be due to many factors and not solely to alcohol consumption, including better recording of alcohol related admissions and the attribution of more conditions to excessive alcohol consumption,

increasing obesity in the UK, which (combined with heavy drinking or not) increases risk of fatty liver and cirrhosis. As recognised, the 7% particularly at risk must be targeted through better recognition of symptoms and referral.

More than 10 million adults (26% of the population) drink regularly at levels that exceed government health guidelines. This accounts for 76% of UK alcohol consumption.

We earnestly believe that the extremely comprehensive measures that have only just been put in place will effectively assist this section of the population to reduce their current drinking to sensible levels. The tools recently sent to GP's, practice care nurses and now in accident and emergency wards, for the first time offer clear well laid out advice as to 'How much is too much?' This reinforced with the 'Know your limits' campaign, the work of Drink AWARE and work from organizations such as ourselves, is making the 10 million adults who sometimes exceed government guidelines, far more aware of how many units are in their drinks as well as how (context and pattern) they drink.

Already the percentage of people drinking over the recommended weekly guidelines has fallen from 29% to 23% for men and from 17% to 12% for women – a significant success. Amongst 16-24 year olds, the four key indicators of weekly drinking, frequent drinking, immoderate drinking and binge drinking have all fallen for both women and men since 1998. Of note, is that young men drinking more than 21 units of alcohol a week fell from 41% in 2000 to 27% in 2005, and the proportion of young women drinking more than 14 units of alcohol a week fell from 33 to 24% (Goddard, 2006).

We would like to see more positive suggestions to follow this up, such as tips to moderate your consumption – to eat before drinking, or to drink while eating, to pace yourself, to alternate soft and alcoholic drinks etc.

There is a case for moderate drinking within our society, culturally, religiously, to relax and unwind and psychologically it is important not to demonise or 'sanitise' alcohol in consumer communications. We would like to a more whole balanced lifestyle approach' as a 'next step' to include promoting a

Mediterranean style diet, maintaining a low BMI, encouraging exercise, not smoking and drinking in moderation.

We also ask for recognition that drinking in moderation is medically recognised as having health benefits for men over 40 and post menopausal women. The UK guidelines state that middle aged or elderly non drinkers and especially those at risk of heart disease ‘may wish to consider the possibility that light drinking may be of benefit to their overall health and life expectancy’.

Recent work by the Department of Health suggests that alcohol misuse costs the NHS in England £2.7 billion per year, in terms of inpatient stays, A&E visits, ambulance journeys and more. This work is linked to the new methodology used in the alcohol-related hospital admissions statistics.

Next steps

To monitor and track progress, new data on alcohol-related hospital admissions within each local authority area, will be published quarterly from autumn 2008.

See notes above and Annexe 1.

The review found that price significantly influences young people and those drinking at heavier levels – but it has less of an impact on moderate and occasional drinkers. The emerging evidence from SCHARR’s work points to the evidence of links between price, particularly for heavy drinkers, alcohol consumption and medical impacts.

We would argue it is far more effective to counter supply for underage drinkers. Price is important in that this age group has less disposable income, and to heavy drinkers as proportionately they are spending a greater percentage of their income on drink. However, there is little evidence to suggest raising the price of alcohol would lower consumption in these population sections, as England already has some of the highest duty rates globally, i.e. alcohol is relatively expensive currently by European standards.

Influencing decision making and attitude among young teenagers to alcohol is key, for example, just 3% of 11 year olds think it is okay to try getting drunk or be drunk weekly, rising to 48% of 15 year

olds and 32% thinking it’s okay to get drunk once a week (The Information Centre, 2005).

A recently published survey (Talbot and Crabbe, 2008) commissioned by Positive Futures, of 1,250 of 10-19 year olds living in deprived communities found that age 13 was a “tipping point” with 42% of respondents beginning to drink alcohol by age 13. Motivations for drinking include increasing confidence and enjoyment in social situations; getting a “buzz”, having something to do or forgetting one’s problems; social norms and influences including peer influence, gaining respect and enhanced image.

Recent research from Sweden shows the danger of raising alcohol prices for the young. The consumption of smuggled alcohol is three times more common among those aged 16-18 than other age groups in Sweden. Figures from CAN show that 30% of girls and 26% of boys in class nine admit to drinking smuggled spirits at least once in the past year. This represents an increase of 18% and 22% respectively on 2000. © Esmerk

2.31 The findings of this report are disappointing: only 57% of products contained information on alcohol unit content (10 years after the alcohol industry first agreed to provide this) and only 3% contained the labelling scheme information in its entirety.

2.32 The Government plans to proceed with second-stage monitoring late in 2008. We very much hope that the majority of labels will carry the required information by the end of 2008, but there is now real doubt as to whether the agreement can be implemented to the extent that was originally expected. Therefore, we believe it is only prudent to plan for our next steps, should the agreement not be delivered.

This seems an unfair observation as we are aware that retailers and producers are implementing the back label recommendations, and were given until the end of 2008 to do so. The creation of bespoke back labels for one market by producers (as UK units are not used in any other market) has made this a costly and time consuming process. We hope the second stage monitoring will be postponed to honour this deadline.

This measure would affect many small high quality

independent producers who export to the UK, the fine wine market, historic stocks held in the UK.

2.33 If necessary, this would mean a further consultation on the detail of a regulatory requirement for health information on alcohol labels followed by notification to the European Commission, since the EU has competence in the area of food and drinks labelling.

The possibility of agreement on an EU wide compatible label is complicated in that the size of units varies significantly throughout the EU, from 8g in the UK, 12g in Denmark, with no unit definition in Belgium or Germany for example. Similarly advice on alcohol and pregnancy varies as do government sensible drinking guidelines, where they exist.

Next steps

This consultation seeks views on when and if the Government should take action to require health and unit information to be included on all bottles and cans.

See above.

Question 1

How might a new code be made effective in stopping licensed premises from engaging in practices that encourage people to drink excessively and irresponsibly?

The devolution of licensing powers should deal with this possibility effectively. Local authorities have powers to close, revoke the license and punish stores or on trade premises who break the terms of their license. We have seen this for Tesco in Dorchester for example (alcohol license suspended for a set period) as punishment for selling alcohol to a person under the legal drinking age. These powers are strong and effective.

As serving an obviously intoxicated customer, or a customer overtly buying by proxy is also an offence, the three strikes (or two strikes) and you lose your license power is the most effective tool possible. The fact that few licensing authorities or local enforcers were aware, according to the KMPG report, of the Social Responsibility standards, means they should

more effectively embraced, publicized and adopted locally as bench marks for good practice and terms for licensees.

Question 2

If there continues to be slow progress in implementing a voluntary labelling scheme, should the Government take the next steps to make it a legal requirement to include health and unit information on all bottles and cans?

NO, this should be achieved without the legal requirement as discussed above, the assessment must wait until the deadline given of 2008 year end. This measure would affect many small high quality independent producers who export to the UK, the fine wine market and older vintages of wine, port, cognac for example would also be negatively affected.

The possibility of agreement on an EU wide compatible label is complicated in that the size of units varies significantly throughout the EU, from 8g in the UK, 12g in Denmark, with no unit definition in Belgium or Germany for example. Similarly advice on alcohol and pregnancy varies as do government sensible drinking guidelines, where they exist.

Question 3

What are the most important issues that need to be addressed in an alcohol retailing code?

Not selling to those under age,
Not selling to obviously intoxicated customers,
Not knowingly selling to someone buying by proxy,
Not promoting on the basis of alcohol level,
Complying with Article 15 of the EU Audio visual code and The Social Responsibility standards

Question 4

Should the same restrictions be applied to:

- all premises selling alcohol;
 - all premises with some exemptions;
 - only certain types of premises (if so, how would you define these?);
 - all premises within an area experiencing problems;
- or
- a combination of these?

Those which repeatedly flout the social responsibility

standards or their licensing agreement should be dealt with locally, and as necessary have their license revoked or suspended.

4.8 The Government considers that there are 3 possible ways in which a code could be adopted more widely, effectively and visibly by those within the alcohol industry.

1. Government works with the licensed trade and alcohol producers to draw up and publish a revised standards code. It makes no statutory changes but encourages enforcement agencies to take adoption of the code into account when assessing premises during inspection and review.

Yes

If this option were taken forward, we would expect to see a modest increase in compliance by those selling (and those producing) alcohol. The KPMG report (see page 17) showed that there was very little understanding or adherence to the current standards (by enforcement agencies). While we might expect this to improve, there is no strong evidence to suggest a strengthened voluntary code would be likely to have a significant impact on levels of crime and disorder, harms to young people or health.

Furthermore a large minority (about 40%) of those who sell or produce alcohol are not members of one of the 16 signatories to the code. As such, there is little or no incentive for these groups to comply – and the incentive to comply is reduced even for those who do belong to trade associations. Should the code apply on a case-by-case basis or to all those who sell alcohol?

The revised code should be adopted at local level by enforcement agencies as part of the criteria for licensing applications.

Question 5

Should an alcohol retailing code be made mandatory through further legislation? If so, how should it be applied?

No.

Question 6

Should a mandatory code, if introduced, cover proportionate and necessary actions to prevent health harm as well as crime and disorder?

No.

5.6 There are many self-help books, DVDs, magazine articles and over-the-counter medicines to help with other health issues, such as smoking or weight loss, but this is not yet true for alcohol.

People who want to cut down may find it difficult to identify what help is available and what is effective. Additionally, drinkers who find they cannot simply cut down without help may be reluctant to ask their GP or other professionals for help, which can mean they develop serious personal or health problems before they get the support they need.

The recently introduced 'How Much is too much?' guide for GP's and primary care should help significantly with delicately crafted questions from GP's and nurses as to patients diet and lifestyles. The ability to refer hazardous drinkers to local schemes, and alcohol services which are growing significantly will help. There are an increasing number of local alcohol services, charities and phone lines operating in this sector.

Support should be given to the DRINK AWARE trust to carry out this role.

5.12 As well as refining and expanding the range of materials available, DH is also exploring commercial and public sector partnership, with the likes of pharmacies and retailers, to raise awareness of the risks associated with harmful drinking and make advice and support as widely available as possible. An excellent initiative

Question 7

Do you think there is enough advice available for those who want to drink less? What other kinds of help are needed and who should provide them?

The government should support Drink AWARE, set up specifically for this purpose. This, together with the historic work of Drink line, talk to FRANK and the recent work of Know Your limits and the Department of Health initiatives should be evaluated for effectiveness

before more initiatives are introduced.

Question 8

Should alcohol advertising include health and unit information? How could this be achieved?

Most advertising includes a moderation strap line and a link to www.drinkaware.co.uk which contains detailed information on responsible drinking.

5.17 For many people a ‘wake-up call’ of one kind or another helps them reduce their drinking back to sensible levels. One in 8 people drinking at higher-risk levels will reduce their consumption to within government guidelines as a result of advice from their GP or a nurse. DH is funding programmes to ensure all new doctors receive training in how to identify higher-risk drinking and in providing related advice. It is running schemes and training to encourage the take-up, training and delivery of this approach across the country.

Excellent.

Question 9

In addition to providing alcohol treatment for the small number of drinkers with a serious dependency problem, what else could be done, and by whom, to support people who find it difficult to cut down on their drinking?

See comments above, we believe the myriad of new initiatives, including the alcohol support team, Know your limits, How much is too Much?, the regional Big Drink Debate and the new Drink AWARE campaigns should be evaluated before further initiatives are undertaken.

For a full list of references, contact Helena. Conibear@aim-digest.com

Key references are below:

International Journal of Methods in Psychiatric Research Int. J. Methods Psychiatr. Res. 17(3): 141–151 (2008) Published online in Wiley InterScience (www.interscience.wiley.com) DOI: 10.1002/mpr.259 Copyright © 2008 John Wiley & Sons, Ltd

Method for moderation: measuring lifetime risk of alcohol-attributable mortality as a basis for drinking guidelines Jürgen Rehm,1,2,3,4 Robin Room,5,6 Benjamin Taylor1,2

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5 School of Population Health, University of Melbourne, Melbourne, Australia

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Annexe 1- Background to AIM

Alcohol in Moderation was founded in 1991 as an independent organisation whose role is to communicate 'THE RESPONSIBLE DRINKING MESSAGE'. AIM publishes an online journal of peer-reviewed key research papers, articles on alcohol, health and associated social and policy issues.

AIM is funded by subscription to its journal and advisory services and works with a prestigious Council of eighteen leading Professors and Medical specialists from around the world committed to promoting the responsible and moderate use of alcohol.

AIM MISSION STATEMENT

- To promote the moderate and responsible consumption of alcohol
- To encourage informed and balanced debate on alcohol, health and social issues
- To communicate and publicise relevant medical and scientific research in a clear and concise format, contributed to by AIM's Council of 18 Professors and Specialists
- To publish information via www.alcoholinmoderation.com on moderate drinking and health, social and policy issues – comprehensively indexed and fully searchable without charge
- To educate consumers on responsible drinking and related health issues via www.drinkingandyou.com and publications, based on national government guidelines
- To inform and educate those working in the beverage alcohol industry regarding the responsible production, marketing, sale and promotion of alcohol
- To distribute AIM Digest Online without charge to the media, legislators and researchers involved in alcohol issues
- To direct enquiries from the media and others towards full and accurate sources of information
- To work with organisations, companies and associations to create programmes, materials and policies that promote the responsible consumption of alcohol.

AIM Council:

Julian Brind, MW Chairman, Wine and Spirit Education Trust

Prof. Alan Crozier Prof. of Plant Biochemistry and Human Nutrition, University of Glasgow

Prof. R Curtis Ellison Epidemiologist, founder of Institute of Lifestyle, Boston University School of Medicine

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Prof. Dwight B Heath Anthropologist, Brown University

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Dr. Thomas Stuttaford Medical Correspondent to the Times and Author

Dr. Elisabeth Whelan President American Council on Science and Health

Annexe 2 - Letter sent to The Right Honourable Dawn Primarolo, Minister of State (response received 4th September 2008), Mr Crispin Acton, Department of Health, The Right Honourable Vernon Coaker MP (joint response 4th September)

4th August 2008

Concerns regarding the North West Public Health Observatory calculations for alcohol attributable fractions

Dear

As you may know, AIM- Alcohol in Moderation has strived, since 1991 to maintain a sense of balance and accuracy in the information and programmes globally that pertain to the promotion of the responsible and moderate use of alcohol. We are not for profit, independent and work with a team of 18 professors and specialists in the field of alcohol from around the world, who include:

Professor O F W James	Julian Brind MW	Christopher Jarnvall
Professor R Curtis Ellison	Tedd M Goldfinger DO	Ellen Mack MD
Dr Thomas Stuttaford	Dr Erik Skovenborg	Creina Stockley
Arthur L Klatsky MD	Stanton Peele PhD	Alfred A de Lorimier MD
Professor Alan Crozier	Professor J M Orgogozo	Dr Philip Norrie PhD
Harvey E Finkel MD	Dr Geoff Lowe	Dr Elizabeth Wheelan

Part of our remit is to analyse the accuracy and usefulness of papers and reports on the medical, social and policy issues relating to drinking. As such we have looked at the findings of Dr. Mark Bellis and colleagues at the NW observatory released recently, and have some serious concerns as to the AAF calculations and the evidence base drawn upon, as the report has far reaching consequences by calculating AAF hospital admissions and mortality for England.

After careful analysis, we find the report presents the adverse effects of excessive drinking among the young and among males specifically well. However, it places a large burden of alcohol attributable fractions in females at levels of consumption at between 1-19g a day - questionable; of necessity, since the large majority of women report average intake at this range, most adverse outcomes among women, for all causes, will occur in this group. Current scientific data, however, demonstrates that, with the exception of breast cancer, light-to-moderate drinking that does not include "binge drinking" has little effect on the risks of these diseases.

Further, the report fails to account for the protective effects of moderate consumption against the diseases of ageing, such as ischaemic heart disease (IHD), ischaemic stroke and late onset diabetes, that have been repeatedly shown for men over 40 and post menopausal women and are recognized in the Government sensible drinking guidelines.

While there are valuable data on alcohol and health presented in this paper, the report includes many summary statements and assumptions that are not supported by the data, or otherwise tend to indicate a biased interpretation.

Such statements limit the direct usefulness of the report for making decisions regarding national alcohol policy, and we would ask you to consider our findings and respond accordingly.

Yours sincerely,

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