ROYAL COLLEGE OF PHYSICIANS OF IRELAND

The Royal College of Physicians of Ireland Policy Group on Alcohol

Submission on Public Health (Alcohol) Bill 2015

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Introduction

About the Royal College of Physicians of Ireland

The Royal College of Physicians of Ireland (RCPI) represents over 10,000, Members and Fellows who work as hospital consultants and in other healthcare settings at home and abroad, as well as postgraduate doctors who are training in Irish hospitals to be the next generation of specialists.

Our doctors work in 27 specialities, treating medical conditions that include cancer, liver disease and Chronic Obstructive Pulmonary Disease. They work on the frontline of the health services with nurses and other colleagues caring for patients.

Our specialists also regularly travel abroad to meet with international colleagues to learn about developments in the treatment of diseases and the public health measures being implemented in other countries to reduce illness.

At international meetings of liver specialists our physicians were increasingly expressing concern about the sharp increase in cirrhosis and other disease caused by alcohol use in Ireland. The number of deaths due to liver disease has doubled in the last 20 years, and alcohol is associated with occupation of approximately 1500 beds each night in Irish hospitals.

Alcohol-related disorders accounted for one in 10 first admissions to Irish psychiatric hospitals in 2011 and alcohol is a leading cause of cancer in Ireland. A quarter of all injuries presenting to accident and emergency departments are alcohol related. It is a factor in suicide, domestic abuse and accidents. There is also evidence that alcohol has a reinforcing effect on poverty. Alcohol harm costs the taxpayer an estimated €3.7 billion a year in health, crime and public order costs in addition to other ancillary costs such as work-place absenteeism.
In a recent report the WHO highlights that almost half of all Irish drinkers engage in heavy episodic drinking on a regular basis, putting Ireland close to the top in binge drinking worldwide[1]. Thus, Ireland has a major problem in both the quantity of alcohol consumed and the pattern of that consumption.

The RCPI Policy Group on Alcohol

The College has a long tradition of advocating for public health measures and to improve the standard of care offered to patients. In 2012 RCPI gathering experts working as healthcare professionals treating all aspects of care required for people affected by alcohol use in Irish society to work together to research and recommend evidence-based policies to reduce health harm. It also has policy groups on tobacco and on obesity.

Since 2012, the RCPI Policy Group on Alcohol has focused on highlighting alcohol health-harm, proposing solutions to reduce this harm, and influencing decision makers to take action to address the damage caused by problem alcohol use.

The RCPI's Policy Group on Alcohol has engaged in action on alcohol health harm in several ways:

- Spokespersons from the Policy Group have provided accurate evidence-based information to the public on alcohol health dangers.
- In 2013, the Policy Group published a policy statement, *Reducing Alcohol Health Harm*, which proposed a number of evidence based actions to reduce alcohol consumption.
- The Policy Group has made pre-budget submissions to the Department of Finance recommending the introduction of a minimum unit price for alcoholic beverages and an increase in excise duties on alcohol.
- Spokespersons from the Policy Group have presented research and information on alcohol health harm at public meetings, in the media, Faculty Scientific Meetings and other RCPI events.
- The Policy Group is represented on the organizing committee of Action on Alcohol Week.
- The Policy Group is working in an advisory capacity to the National Programme Office for Traffic Medicine on a health leaflet giving advice on alcohol and driving.
- The policy group highlighted and publicly criticised Arthur's day as a drinking festival with significant harms. It was subsequently cancelled.

Members of the RCPI Policy Group on Alcohol

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Executive Summary

Alcohol consumption in Ireland remains at very high levels in comparison to other European countries. Despite a reduction in per capita consumption in recent years, at an estimated 10.7 litres of alcohol consumed per adult in 2013[2], consumption of alcohol is still well in excess of recommended low risk limits and the Healthy Ireland target of 9.2 litres[3]. Irish people continue to binge drink more frequently than most other nationalities; a recent report by the WHO highlights that almost half of all Irish drinkers engage in heavy episodic drinking on a regular basis, putting Ireland close to the top in binge drinking worldwide[4]. Thus, Ireland has a major problem in both the quantity of alcohol consumed and the pattern of that consumption.

The RCPI's Policy Group on Alcohol fully supports the approach set out in the Department of Health 2012 Steering Group Report on a National Substance Misuse Strategy (NSMS)[5] and it is our view that implementation of the Public Health (Alcohol) Bill, the first of its kind, will set a strong precedent for further changes that will positively impact the health and well-being of the nation for many years to come. In March 2004, Ireland made history by becoming the first country in the world to ban smoking in the workplace. Since then countries all over the world have followed Ireland's example. As a small country, we now have a unique opportunity to lead the way internationally on alcohol harm reduction and facilitate the implementation of similar legislation in the UK and further afield.

We fully support the legislation which addresses the issues of Labelling of Alcohol Products and Minimum Unit Pricing (MUP) in detail. Based on our review of the Bill, and informed by the most recent published research on the effects of underage drinking and the impact of MUP, there are a number of additional recommendations we would like to see included in the final legislation:

- **Commencement of provisions (Head 1, 6, 15 & 16)**

  - The Bill lacks detail on the commencement of important provisions including MUP (Head 6) and the 2-year pilot of the Statutory Code for the display of alcohol (Head 15). We understand that different provisions of the Bill will commence at different stages, and in some cases some time after the enactment of the Bill. We strongly recommend, however, that:

    - Section 9 of the *Intoxicating Liquor Act 2008* (Head 15, 16) be commenced immediately

    - Short to medium term dates are provided for each provision in the Bill. We understand it is the intention to bring in MUP at the same time as Northern Ireland. While this is the ideal, we believe it should be brought in in this jurisdiction in any case if there is a delay in Northern Ireland.

    - Explanations are provided for provisions without fixed commencement dates and dates in the longer-term.

- **Enforcement mechanisms and penalties (Heads 10, 11, 12, 13, 17, 18)**

  - In order to ensure oversight and rigorous implementation at a local level, further detail is needed on enforcement mechanisms, penalties, and dedicated resources particularly to address the sale and supply to minors. We recommend the following:

    - A mandatory obligation on the Executive to appoint authorised officers so that Head 10(1) to read 'shall appoint' to replace current provision 'may appoint'.

    - Head 12 should provide an additional 12(1)(d) as follows: (d) such other substituted service as the District Court Rules provide.

    - The establishment of statutory training standards for staff involved in the sale of alcohol, in the on-trade and the off-trade, for existing licensees and as a condition of the licensing process.

- Indicators should be identified and monitored to evaluate the level of enforcement and overall impact and effectiveness of the new regulation.
- Onerous penalties particularly around the sale and supply of alcohol to minors should be implemented.

- **An effective and realistic MUP level (Heads 6 & 7)**
  - The Irish Independent reported on February 4th 2015 that the Department of Health was examining an alcohol unit price of between 90c and €1.10[6]. Given the average price of a litre of milk is over €1, we support setting the MUP at least at this level. We believe that this single step is the most important aspect of this legislation. Modelling suggests that there will be an immediate positive societal and individual impact from the introduction of a high MUP[7].
  - Evidence shows that young people are likely to be price responsive given their limited resources[8]. There is consistent evidence from the US that increased alcohol prices reduced overall alcohol consumption and episodic heavy drinking amongst high school students[9]. We believe that introducing a high MUP will be an effective means to address the problem of underage drinking.
  - Revenue raised from MUP should be ring-fenced for resourcing enforcement measures around the sale of alcohol.
- **Restrictions on the sale of alcohol (Heads 15 & 16)**
  - Environmental Health Officers (EHOs) have responsibility for the enforcement of the tobacco ban in public houses, a task they carry out very well. Similar powers and resources will be required to enforce the proposed statutory code of practice for the display of alcohol products.
  - The Bill should include provisions for strict regulation and enforcement around online drinks promotions.

- The number of outlets where alcohol can be purchased should be reduced and further restrictions imposed on opening times of alcohol outlets.

- The 2-year pilot phase of the Statutory Code on the display of alcohol should be systematically monitored and evaluated by EHOs or by an independent body.

- **Phasing out alcohol sport sponsorship (Head 9)**

  - The existing voluntary code of practice on sports sponsorship, incorporating audience profiling, was written by the alcohol industry. We believe it is a mistake to give audience profiling a legal basis. The idea that sponsorship will be permitted until sports organisations secure alternate funding is not effective. The EU wide ban on tobacco advertising and sponsorship imposed by EU legislation in 2003[10] was opposed by industry at the time on the grounds that it would result in damage to sport. As anticipated by regulators, other industries were eager to take the place of the tobacco industry, with no ill effects to the sport. The phasing out of sponsorship will ensure the reduction of harm for the next generation – the longer we delay, the longer the tail of alcohol related harms extends into the next 20 years. We strongly recommend that a commencement date is set for the phasing out of alcohol sponsorship of sport in the medium term, and a target date to end all alcohol sport sponsorship in the longer-term.

- **Education campaign on safe drinking guidelines (Head 5)**

  - Labelling alone will not be sufficient to encourage the public to track their alcohol intake as understanding of recommended units of alcohol per week is still weak[11]. Compulsory labelling should be implemented alongside a comprehensive education campaign on guidelines for safe drinking. We suggest an additional provision to this Act as follows:

    The Executive shall have as its objective –

The promotion of public awareness of matters relating to alcohol consumption and health harm. This will include an educational role in the awareness of the dangers of the consumption of alcohol to include the consumption during pregnancy and be particularly directed at people under the age of 30 years.

- **A strategy for underage drinking**

  - A strategy to address underage drinking is significantly absent in the Heads of Bill. Alcohol is a factor in suicide, domestic abuse, accidents, workplace absenteeism and crime[12]. There is also evidence that alcohol has a reinforcing effect on poverty[13]. The Policy Group proposes strong enforcement of the measures included in the Bill around the sale of alcohol to minors.

- **Provision for increases in excise duty**

  - There should be a provision to increase excise duty on alcohol in future budgets at least in line with inflation to ensure that alcohol does not become more affordable. Due to the high cost of treating patients suffering from alcohol-related harm, we recommend that Government allocate revenue raised through increased excise duty for research into alcohol-related harms.

Alcohol Consumption and Health Harm

The Department of Health NSMS aims to promote 'healthier lifestyle choices throughout society in relation to alcohol'[4]. It recommends:

- The development of a system to monitor the enforcement of the intoxicating liquor legislation with respect to the sale, supply or delivery of alcohol to minors.
- The establishment of standards for server training programmes in the on-trade and the off-trade.
- Phasing out through legislation drinks industry sponsorship of sport and other large public events in Ireland.

The RCPI Policy Group on Alcohol strongly supports the inclusion of the above provisions in the new Public Health Bill. Alcohol is a psychoactive substance that impacts on individual health and on wider society. In large amounts, alcohol has a toxic effect and can be fatal. Long term heavy consumption of alcohol is associated with mortality from wholly alcohol attributable diseases such as alcoholic liver disease, the majority of these deaths being from alcoholic liver cirrhosis.[14]

There is a proven health, social and economic impact associated with excessive alcohol consumption in Ireland. The number of deaths due to liver disease has doubled in the last 20 years, and alcohol is associated with occupation of approximately 1500 beds each night in Irish hospitals[27]. A quarter of all injuries presenting to accident and emergency departments are alcohol related. It is a factor in suicide, domestic abuse and accidents. Alcohol harm costs the taxpayer an estimated €3.7 billion a year in health, crime and public order costs in addition to other ancillary costs such as work-place absenteeism[11,15].

Data presented by the RCPI's Policy Group on Alcohol in its policy statement *Reducing Alcohol Health Harm* highlights:

- In Ireland, between 2000 and 2004, it was estimated that 4.4 per cent of deaths were caused by alcohol (includes deaths from chronic alcohol-related conditions such as alcoholic liver disease and liver cancer, and accidental and non-accidental deaths while under the influence of alcohol)[16].

- A report by the National Drug Related Deaths Index which focuses on deaths in alcohol dependent people found that in 2008, there were 88 deaths every month which were directly attributable to alcohol[17]. The same report also showed that between 2004 and 2008, alcohol caused nearly twice as many deaths as all other drugs combined.

- Mortality related to cirrhosis, the commonest cause of which is alcohol, doubled from 1994 to 2008 and hospital admissions in Ireland for alcoholic liver disease almost doubled between 1995 and 2007[18].

- Alcohol-related disorders accounted for 1 in 10 first admissions to Irish psychiatric hospitals in 2011[19].

- Alcohol is classified as a group 1 carcinogen and it is one of the most important causes of cancer in Ireland[14]. In 2007, the International Agency for Research on Cancer concluded that there was a causal link between alcohol and cancer of the oral cavity, pharynx, larynx, oesophagus, liver, colon, rectum and female breast, and that there was evidence of a dose–response relationship with respect to all these cancers – the greater the volume consumed, the greater the risk of cancer[20].

- The 2002 Sexual Abuse and Violence in Ireland (SAVI) study of over 3,000 Irish adults found that alcohol was involved in almost half of the cases of sexual abuse that occurred in adulthood (53% of men and 45% of women)[21]. To add to this, a 2010 study for the HSE reported that since 1998, public order offences, many of which are alcohol related, have risen from 77 per 10,000 of the population to 139 per 10,000 of the population in 2005[11].

- The results of an extensive study recently published in the BMJ[22] suggest that previous associations indicating a protective effect of low alcohol consumption and all cause mortality is limited to women drinkers aged 65 years or more, and is likely to be due to selection bias and other confounders. Little to no protection was found to be present in other age-sex groups.

Underage Drinking

- In 2002, 1 in 4 injuries presenting to accident and emergency departments was related to alcohol and over half of these injuries occurred in people younger than 30 years of age[23].
- Irish adolescents with serious drug and alcohol problems had commenced alcohol use at a much earlier age than their counterparts without significant drug or alcohol problems[24].
- Alcohol is strongly linked to suicide, particularly suicides in young men[25,26]. A 2006 study showed that more than half of all people who died from suicide had alcohol in their blood[27]. From 2000 to 2004, alcohol was estimated to be the major contributing factor in 823 suicides[15].
- In Ireland between 1995 and 2007, the rate of discharges for Alcoholic Liver Disease increased by 247 per cent for 15-34 year olds, and by 224 per cent for 35-49 year olds[28].
- In an Irish study 45 per cent of men and 26 per cent of women stated that alcohol consumption contributed to having sex without using contraception[29].

Evidence for Recommendations

Enforcement

The Policy Group endorses tighter regulation around the sale, supply and consumption of alcohol products especially concerning underage drinkers. In order for the new legislation to be really effective, further clarity is needed on the resources that will be provided and the procedures for enforcing the new legislation. Valuable learnings should be taken from the STAD-project (Stockholm Prevents Alcohol and Drug Problems)[30] on the key issue of enforcement:

- Evaluation of the 10-year STAD-project (Stockholm Prevents Alcohol and Drug Problems) has demonstrated that a collaborative approach between the licensing board and local police was effective to better regulate and enforce established laws and Responsible Beverage Service Training. As part of the STAD project, a licensing board distributed letters to licensed establishments informing them of any reported occurrences of over-serving alcohol to patrons within their establishment.

- The STAD-project also provides evidence that Community Mobilization involving important stakeholders from the community, local police, local council, licensing board, owners of licensed establishments, health authorities and trade unions for licensed premises and their staff, is an effective mechanism to raise awareness and increase knowledge around alcohol health harm, and to help develop policy at local and national levels.

Minimum Unit Pricing

Minimum unit pricing targets problems caused by cheap alcohol and mainly affects problem drinkers and young adults. It has little or no impact on the vast majority of drinkers.

The evidence from states with minimum prices suggest that they lead to significant reductions in consumption and harm:

- Evidence from British Columbia, Canada showed that between 2002 and 2009, introduction of minimum pricing reduced the percentage of alcohol-related deaths. Alcohol related deaths fell by 32% within a year of the first introduction of a minimum price for alcohol[31.] Introduction of minimum

pricing in Saskatchewan province in Canada also reduced alcohol consumption, with a 10% increase in minimum price associated with an 8.4% reduction in total consumption[32]. In addition, there was a 19% reduction in alcohol related crime following introduction of MUP in Saskatchewan.

- Preliminary research findings by Prof Tim Stockwell, University of Victoria, based on 9 years of crime data for 89 local health areas in British Colombia suggest a 10% increase in average minimum price is associated with decreases of 19.5% in alcohol-related traffic offences, 18.5% in property crimes and of 10.4% in violent crimes[33].

- In the Tennant Creek area of Australia an initiative which controlled the sale of cheap alcohol to communities with a high Aboriginal population found that in the two years following the restrictions on cheap alcohol sales, there was a 19% reduction in alcohol consumption and a commensurate reduction in alcohol related hospital admissions and alcohol related crime[34].

- In the United Kingdom, it has been estimated that a 10% rise in the minimum prices of alcoholic beverages would lead to a drop of 7.0% in male and 8.3% in female cirrhosis mortality, a drop of 5.0% for male victims and 7.1% for female victims of homicide, and a drop of 28.8% for male and 37.4% for female deaths from explicitly alcohol-involved causes (alcohol dependence, poisoning, etc)[35].

The Sheffield Alcohol Research Group (SARG) has done extensive work in modelling the impact of minimum pricing in the UK[36]. Researchers looking at the impact of a 70p MUP in Scotland concluded the following effects[37]:

- Population consumption of alcohol would decrease by 16.9%.

- 26% decrease in annual consumption of alcoholic beverages among harmful drinkers

- Reduction in healthcare costs of £11m and a reduction in unemployment costs of £181.8m for harmful drinkers in the 1st year following implementation.

SARG conducted a model-based appraisal of MUP for Northern Ireland and found that it would be an effective mechanism in reducing alcohol consumption, alcohol-

related deaths and hospitalisations, crime, workplace absences, and associated costs[6]. SARG concluded that with a 75p MUP policy in Northern Ireland:

- Consumption per drinker per week will decrease 19.4%, with a 26.9% reduction among high risk drinkers.
- Hospital admissions per 100,000 population deemed 'in poverty' will decrease by 1,114 annually and admissions for alcoholic liver disease are estimated to reduce by 535 cases annually.
- Costs of crime are estimated to reduce by £72.3million in the 1st year following implementation of this policy, and by £1,063m over 20 years.
- An estimated £3,364million saving in total societal value from the harm reductions in health, crime and workplace absence over the 20 year period modelled.

A similar modelling exercise is currently underway by SARG for the Republic Ireland. It is reasonable to assume that introduction of MUP here will result in similar trends in reduced alcohol consumption and alcohol health harm as seen in the Northern Ireland and UK estimates. Given pricing disparities, differences in unit measures, and other regulatory and contextual differences between UK and Ireland, we should set our own level of MUP based on research in Ireland, independent of levels proposed in the UK.

Restrictions on the sale of alcohol

The placement of alcohol in mixed retail outlets alongside groceries gives the impression that alcohol is an ordinary commodity, and normalises alcohol as part of a weekly shopping list. In the long term, we are in favour of off trade alcohol only being sold in specialist off-licences rather than in all types of shops. However, Section 9 of the *Intoxicating Liquor Act 2008,* which provides for structural separation of alcohol products from other beverages and food products in premises which are engaged in mixed trading, such as supermarkets, convenience stores and petrol stations, should be commenced immediately if it has not been commenced before the enactment of this Act. We welcome the proposed statutory code of

practice for the display of alcohol products but it is important that the legislation set out robust procedures for the monitoring and evaluation of this provision.

Recent years have seen a shift from alcohol sales in pubs to sales in the off-trade sector. Between 1998 and 2010 there was a 161 per cent increase in the number of full off-licences, while pub licences decreased by 19 per cent over the same period[4]. Supermarkets, convenience stores and even petrol stations sell alcohol, often at discounted prices. The abolition of the Restrictive Practices (Groceries) Order in 2006 allowed for a variety of goods to be sold below cost price, including alcohol. Studies from both Finland and Sweden showed linkages between alcohol-related harm and the number of outlets selling alcohol[38]. We support the recommendation of the NSMS report that the HSE should be allowed to object to the granting of new licences and the renewal of licences. To date these matters have been dealt with from a criminal justice perspective but this recommendation emphasises that alcohol and the harm it causes is a health issue as well.

Alcohol Sponsorship

A ban on alcohol sponsorship of sporting events would make a significant contribution to reducing alcohol related harm in Ireland by reducing the age at which many Irish children start to consume alcohol and also by increasing public support for other measures.

Research findings suggest a ban on alcohol sponsorship will limit people's exposure to alcohol advertisement, thereby reducing the association of alcohol with a sporting event and possibly overall consumption[39]. The case of *Loi Evin* in France [40] shows that since the introduction of the sponsorship ban alcohol consumption has declined. In addition, if we consider alcohol companies invest heavily in alcohol advertisement and sponsorship this suggests, *a priori,* that advertisement and sponsorship is important for attracting customers and any ban on alcohol sponsorship will ultimately reduce alcohol consumption.

- A study by Gordon, MacKintosh and Moodie concluded that, it is up to policymakers and regulators to shape the direction of alcohol marketing policy and regulation[41].
- In addition, an alcohol sponsorship ban is also largely supported by the Irish public. According to a 2012 HRB survey, on public attitudes to alcohol, two-fifths (42 %) support a ban on the alcohol industry sponsoring sporting

events and over one-third (37%) support a ban on sponsoring musical events[42].

- The effect of alcohol advertising on youth alcohol consumption is noted in a WHO[43] report: *"in markets where alcohol is more widely advertised young people are more likely to continue to increase their drinking as they move into their mid-twenties, whereas drinking declines at an earlier age among those who are less exposed"*.

- Considering that the exact amount spent by the alcohol industry on sports sponsorship is not available it is therefore impossible to establish the full impact a ban on alcohol sponsorship of sporting events would have. However, there is evidence from the sponsorship ban of sporting events by tobacco companies in Australia to suggest that there would be no loss of funding to sporting organisations/events[44].

According to the European Sponsorship association[45], the largest sponsors of sporting events in 2009 were telecommunications, clothing, banking and finance, cars, airlines, insurance companies, electronics, energy, oil, and credit cards. Alcohol sponsorship was not present in the top ten industry sponsors indicating that there are other sources of revenue apart from alcohol companies. There is evidence from Ireland[46] to suggest that alcohol sponsorship is not the only funding available to sporting organisations. For example in 2008, the GAA rearranged its sponsorship deal with Guinness, whereby the drinks company was no longer the only sponsor of the GAA hurling championship, instead it was one of three sponsors, the other two being Centra and Etihad.

RCPI is in favour of implementing this ban on a phased basis, whereby all current sponsorship deals will be allowed to operate until 2019. We believe that this time frame will allow all sporting organisations to acquire new sponsors without harming revenues or resources. We firmly support a complete ban on any new alcohol sponsorship deals from coming into operation.

Guidelines on safe drinking

There should be a statutory obligation on the HSE to perform a public awareness campaign on the consumption of alcohol and health harm as indicated above. The HSE has published Guidelines on safe drinking[47], however, knowledge of standard drink measures and weekly low-risk consumption amounts remains weak. A broad public health information campaign is required to increase public knowledge as a prelude to behaviour change. Education campaigns, which are mentioned in the NSMS recommendations, together with the proposed legislation around labelling, will help individuals to make more informed choices.

There has never been health labelling on alcohol products before therefore it will take people time to get used to pure alcohol content displayed in grams. This is however, a key step towards clarifying recommended weekly consumption as set out in the HSE guidelines (e.g. ½ pint = 10 grams alcohol = 1 Standard Drink = 1 'Irish' unit). Better information from health sources will help individuals make more informed choices, as will a restriction on information from commercial sources.

RCPI will also play its part in developing and implementing more detailed clinical guidelines and clinical information to provide extra information for the population in interpreting these guidelines.

Excise duty to offset cost of alcohol harm

The maintenance of alcohol excise duties at existing rates in Budget 2015 indicates that the voice of industry is being heard loud and clear over the calls of public health advocates. While the Drinks Industry argues that taxes on alcohol in Ireland are high compared to other countries, alcohol is relatively cheap and affordable in Ireland because consumer purchasing power increased more rapidly than alcohol prices over the past 20 years. The increase in excise duty on alcohol in the 2012 Budget, for example, only restored the rates to their pre 2009 level. Between 1994 and 2012, excise duties were not increased in line with inflation or consumers' income, which led to alcohol becoming significantly more affordable.

Excise increases alone will not result in the level of change in alcohol consumption necessary to bring us within Healthy Ireland targets, but making alcohol less affordable is a key component of an alcohol reduction strategy. Excise duty

increases have successfully been used to reduce cigarette smoking. Between 1994 and 2010, excise on tobacco was increased by 171% which led to a reduction in cigarette sales of 31% and an increase in excise duty receipts from cigarettes of 149% or €1.1 billon in 2011[48]. There is a strong case to be made that the Government commit to increasing excise duties in future budgets at least in line with inflation. Increasing excise or other tax on off-sales of alcohol would serve the twin aims of reducing consumption and increasing revenue for Government.

There is very little funding available for research into alcohol-related harm, especially alcoholic liver disease. Despite the high associated mortality for alcoholic liver disease, it is an unpopular subject with funding bodies, and as a result, there have been no advances in treatment and no new drugs have been developed in recent years. We therefore call on the Government to allocate specific funding for research into alcohol-related harms. We propose that a proportion of the revenue generated through MUP and increased excise duty be allocated to research bodies to help offset the cost of alcohol harm. Based on the polluter pays principle, the Government should also use social responsibility levies on the alcohol industry to support this research. It is important to emphasise that any research conducted should be independent of the alcohol industry, and the funds should be spent on front-line research; both clinical and epidemiological.

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