MRC/CSO Social and Public Health Sciences Unit Consultation Response

Title of consultation
Low Alcohol Descriptors: A consultation on the use of low alcohol descriptors

Name of the consulting body
Department of Health and Social Care

Link to consultation
Website: https://consultations.dh.gov.uk/healthy-behaviours/low-alcohol-descriptors/

Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?

The MRC/CSO Social and Public Health Sciences Unit at the University of Glasgow seeks to understand the social determinants of health inequalities and population health. We are an interdisciplinary institution, benefiting from public health physicians, epidemiologists, statisticians, sociologists, anthropologists, psychologists, political scientists, computer scientists, and others. Our research has a particular focus on alcohol-related harms and made substantial contribution to the Scottish Government’s Minimum Unit Pricing policy. We are funded by the Medical Research Council (core-funded), the Scottish Government Chief Scientist Office, and grant funding specific to individual projects.

Our consultation response

Main Response

As set out in the consultation, greater promotion of low strength alcohol is hoped to lead to reduced population alcohol consumption. This is envisaged to take place via consumers substituting low strength alcohol in place of the regular strength beverages that they would normally consume. However, evidence described in the consultation suggests that this ‘substitutive’ transition is not the most likely scenario. Instead, the research indicates that
increased promotion of low strength alcohol is more likely to result in an ‘additional’ transition, whereby individuals consume low strength alcohol in addition to their normal consumption of regular strength alcohol. Mechanisms identified in this research include both greater frequency of drinking in normally non-alcoholic contexts, and greater volume of alcohol consumed per ‘drinking session’ (Shemilt, 2017).

This is problematic on at least two counts. First and foremost, alcohol is a leading driver of disease in the UK (World Health Organisation, 2014). The effect exists outside the consequences of ‘problematic’ levels of consumption. For example, alcohol is a class 1 carcinogen with a proven dose-response effect for several cancers, including cancers of the oral cavity and pharynx, oesophagus, colorectum, liver, larynx and female breast (Bagnardi et al, 2015). As such, even the comparatively low increase in dosage represented by consuming low strength alcohol in addition to regular strength alcohol could increase cancer prevalence.

Further, our research strongly suggests that an ‘additional’ transition brought on by greater promotion of low strength alcohol will prove detrimental for health inequalities in the UK. We have found that, per unit of alcohol consumed, socially disadvantaged groups stand to experience far higher levels of alcohol-attributable harm, even given adequate analytic control. (see Lancet Public Health article by Katikireddi et al; 2017). Worse health outcomes for less privileged groups is a definition of inequality. As such, greater promotion of low strength alcohol resulting in an additive transition will be detrimental to the government’s efforts in reducing social and health inequalities. It is not in the interest of public health for those who do not consume low strength alcohol in addition to their consumption of regular strength alcohol to begin doing so.

Response to Specific Consultation Questions

Question 1 – Guidance vs Legislation
Changing the legislation on alcohol descriptors to guidance is insufficient to attain the substitutive profile envisaged by this consultation. In the first case, it is not clear where industry should derive the motivation to pursue the more difficult to attain substitution profile when addition appears immediately profitable. Further, there may be numerous channels through which the marketability of a low alcohol product could be improved through deviance from guidance (e.g. cutting costs on dealcoholisation steps while still using the lower strength labels). This is problematic because alcohol is not immediately comparable to any other
product besides tobacco, in that it is a class 1 carcinogenic psychoactive addictive substance. Systematic industry deviance would exacerbate the population level consequences discussed above. Our research suggests that guidance is insufficient disincentive, and that the industry motive for preferring guidance over legislation is not related to improving public health (Petticrew et al, 2017).

**Question 2** – New alcohol descriptors above 1.2%

As per above, a new category for alcohol of a strength between 1.2% and regular strength would be detrimental to public health unless it is consumed in place of, rather than additional to, normal consumption levels of regular strength alcohol. Further, there is evidence that low risk drinking guidelines are poorly understood by the public (Lovatt et al, 2015; Kerr & Stockwell, 2012). Introducing a further descriptor may exacerbate this issue.

**Question 4** – The de-alcoholised descriptor

We concur with the consultation’s emphasis on the clarity of information provided to the consumer, specifically via simplified descriptors and continuity of terms. The de-alcoholised descriptor refers to a specialised and esoteric process with which the public has little familiarity. We recommend it be relegated from the role of descriptor for simplification purposes.

**Question 5 & 6** – Non-alcoholic vs alcohol free descriptors

For ABV at or below 0.05%, we recommend consistent use of a single descriptor that could be either alcohol-free or non-alcoholic. These terms are effectively and semantically synonymic, attaching different meanings to them is counterproductive.

**References**


Petticrew, Mark, et al. "'Nothing can be done until everything is done': the use of complexity arguments by food, beverage, alcohol and gambling industries." *J Epidemiol Community Health* 71.11 (2017): 1078-1083. [Available at http://jech.bmj.com/content/71/11/1078, accessed 2nd May 2018]
