ALICE RAP and the risk of alcohol

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ADDICTIONS AND LIFESTYLES IN CONTEMPORARY EUROPE
Alice Rap
www.alicerap.eu
- REFRAMING ADDICTIONS PROJECT -

Three new actions:

1. Margin of Exposure should be the driver and monitor of alcohol policy
2. Toxicity of the product should be reduced through an alcohol reduction initiative
3. DALYs should be used as a health footprint to apportion responsibility for harm

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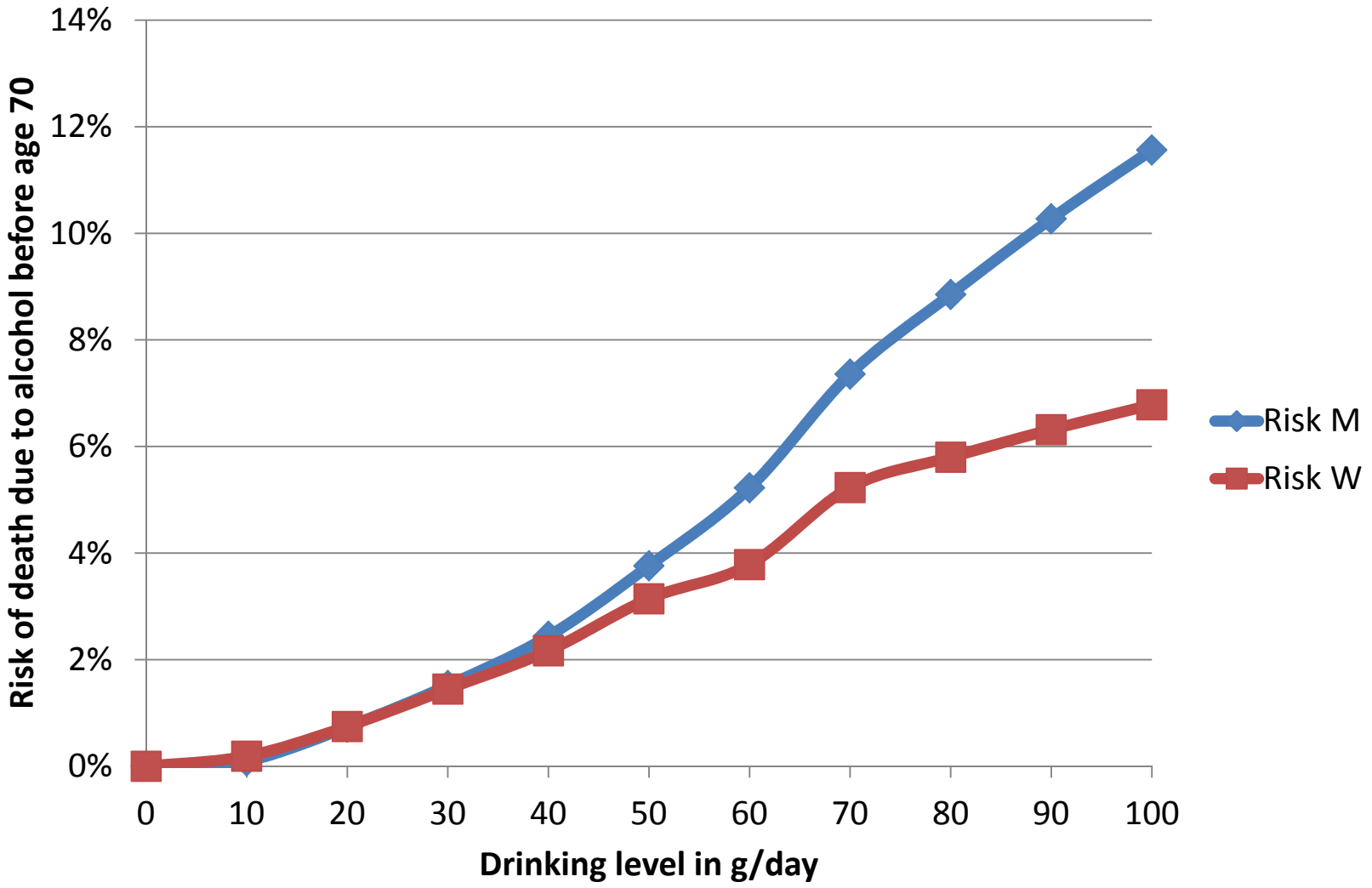
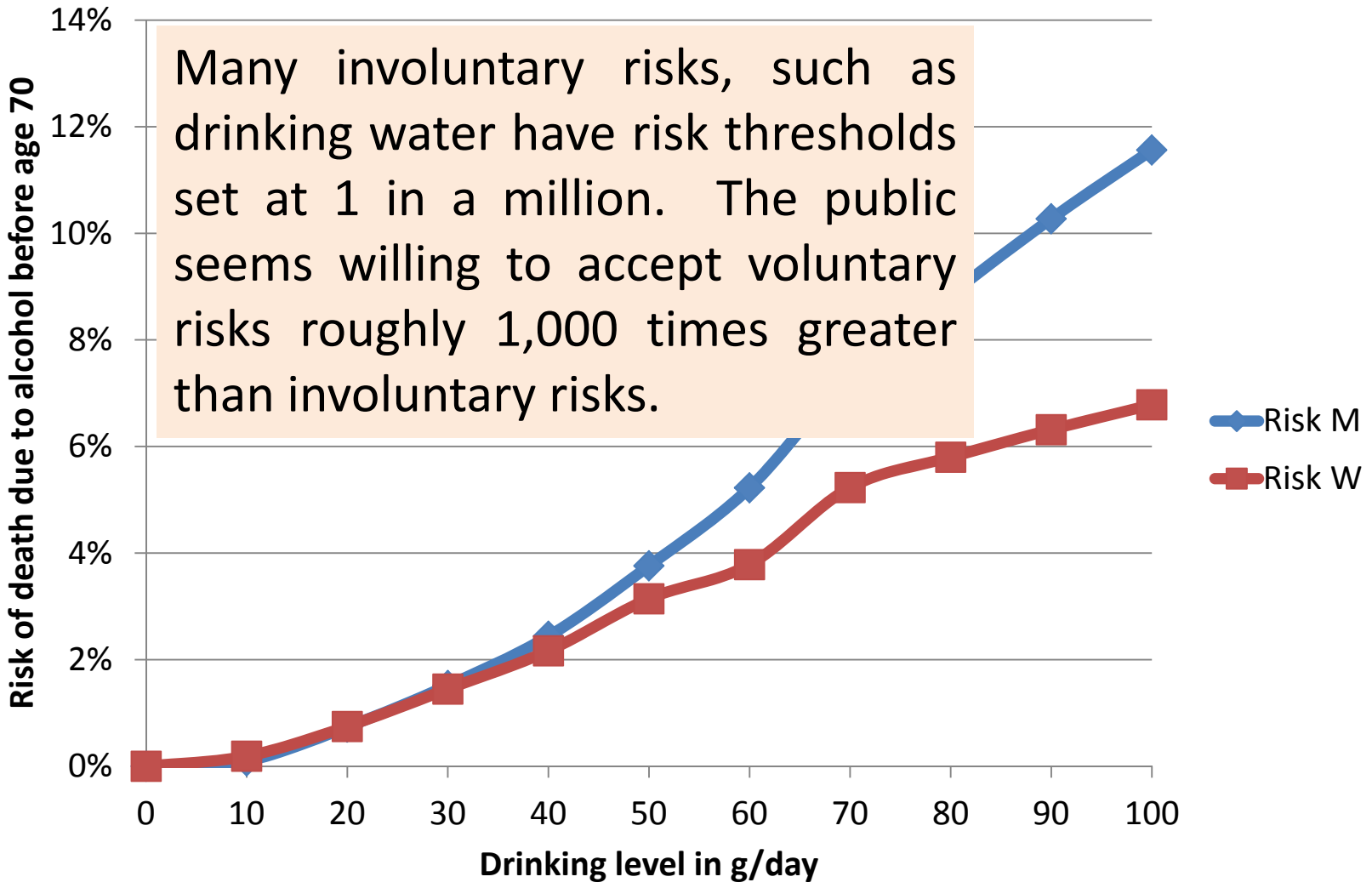


Risk of dying prematurely (up to age 70) due to alcohol consumption in European Union



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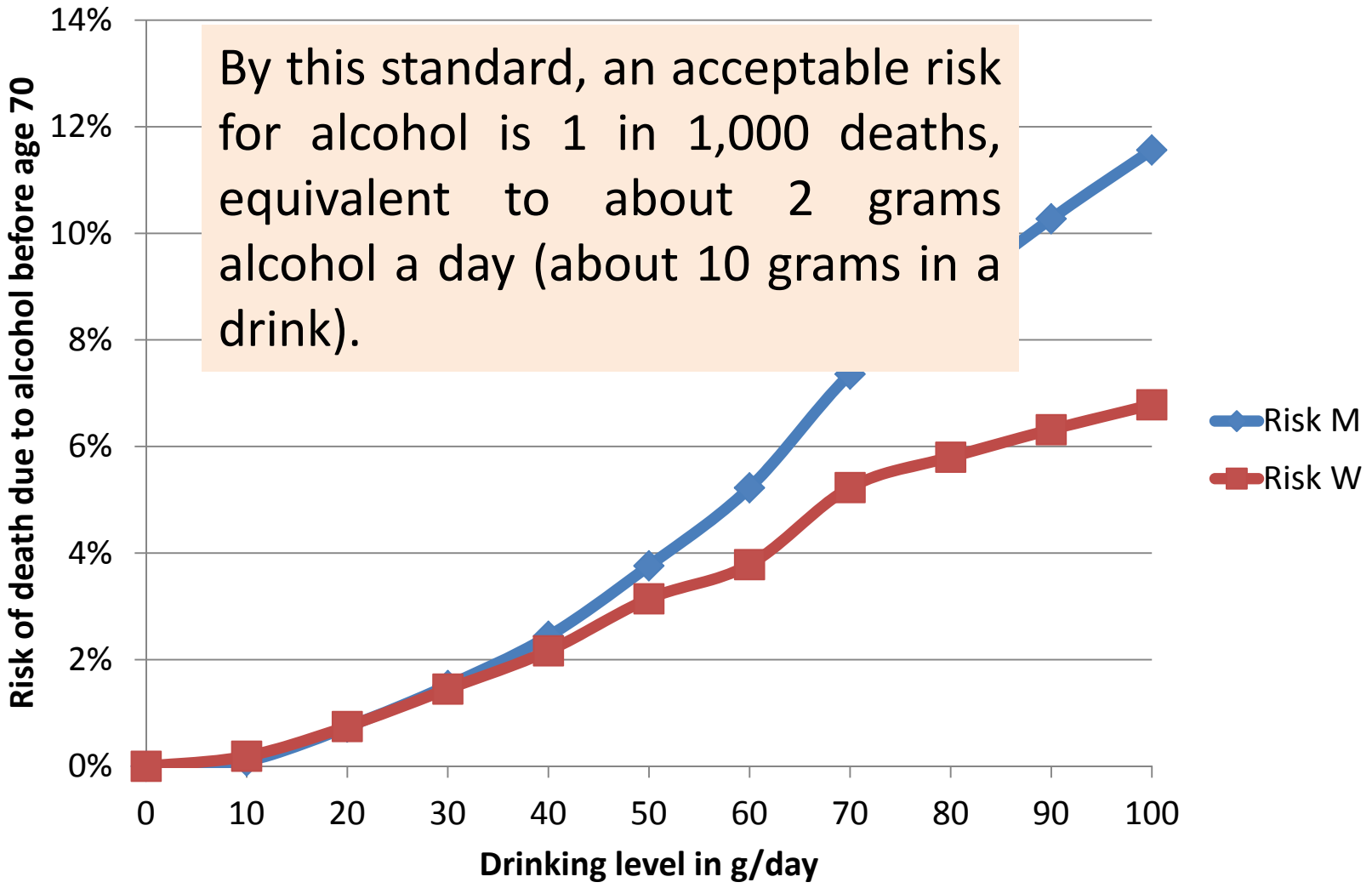

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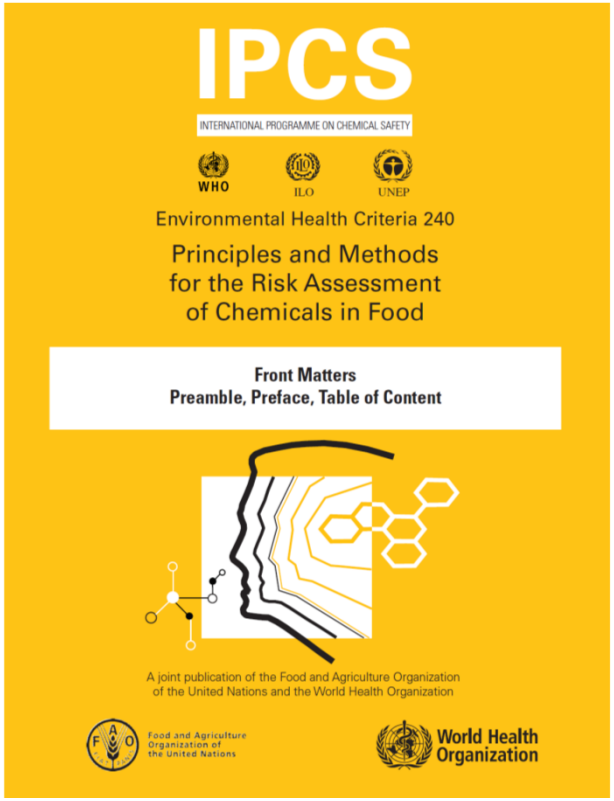
Margin of Exposure (MOE)



Opinion of the Scientific Committee on a request from EFSA related to

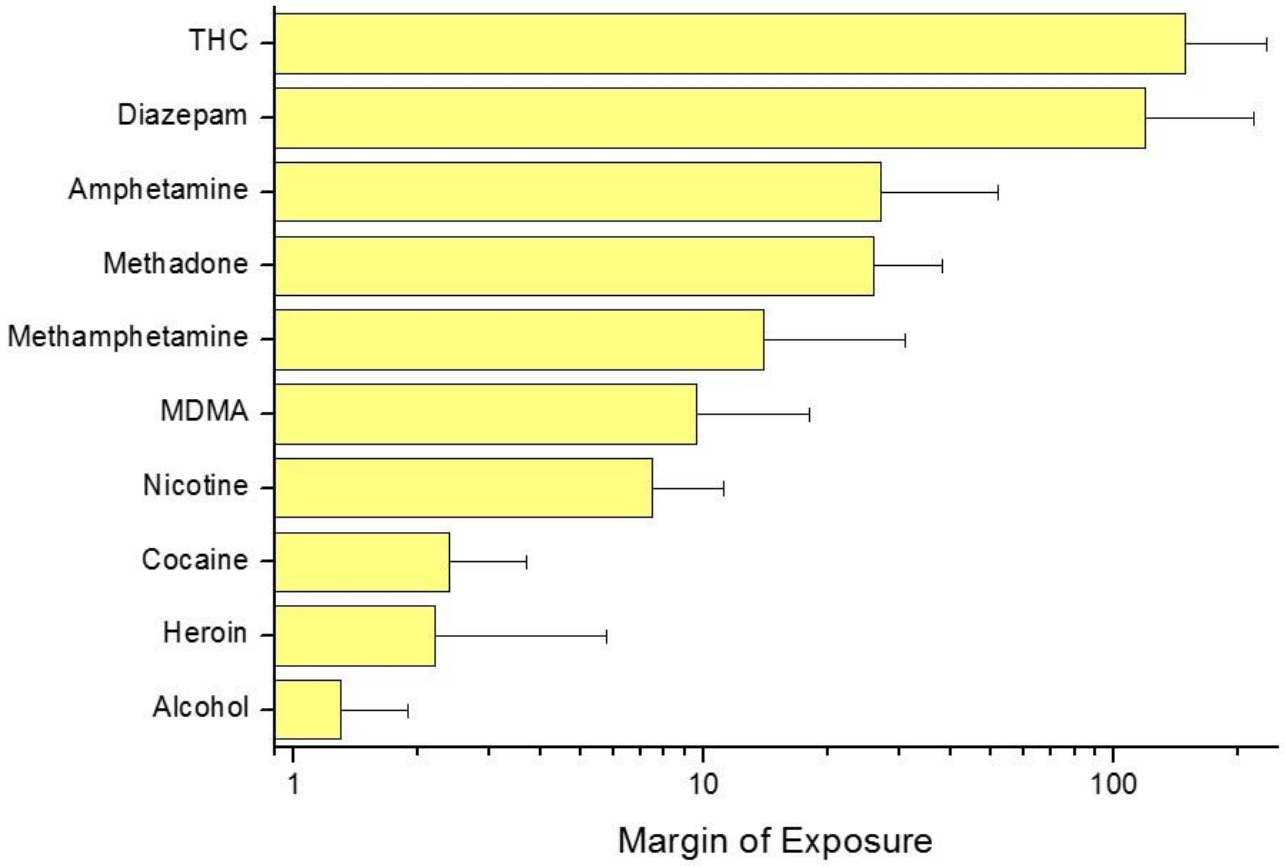
A Harmonised Approach for Risk Assessment of

Substances Which are both Genotoxic and Carcinogenic

A MOE of 100 means that an individual is consuming 1/100th of the benchmark (toxic) dose (that which, with 95% certainty leads to a 10% occurrence of the health effect).

A MOE of 1 means that the individual is consuming the benchmark (toxic) dose.

MOE: daily exposure European adults



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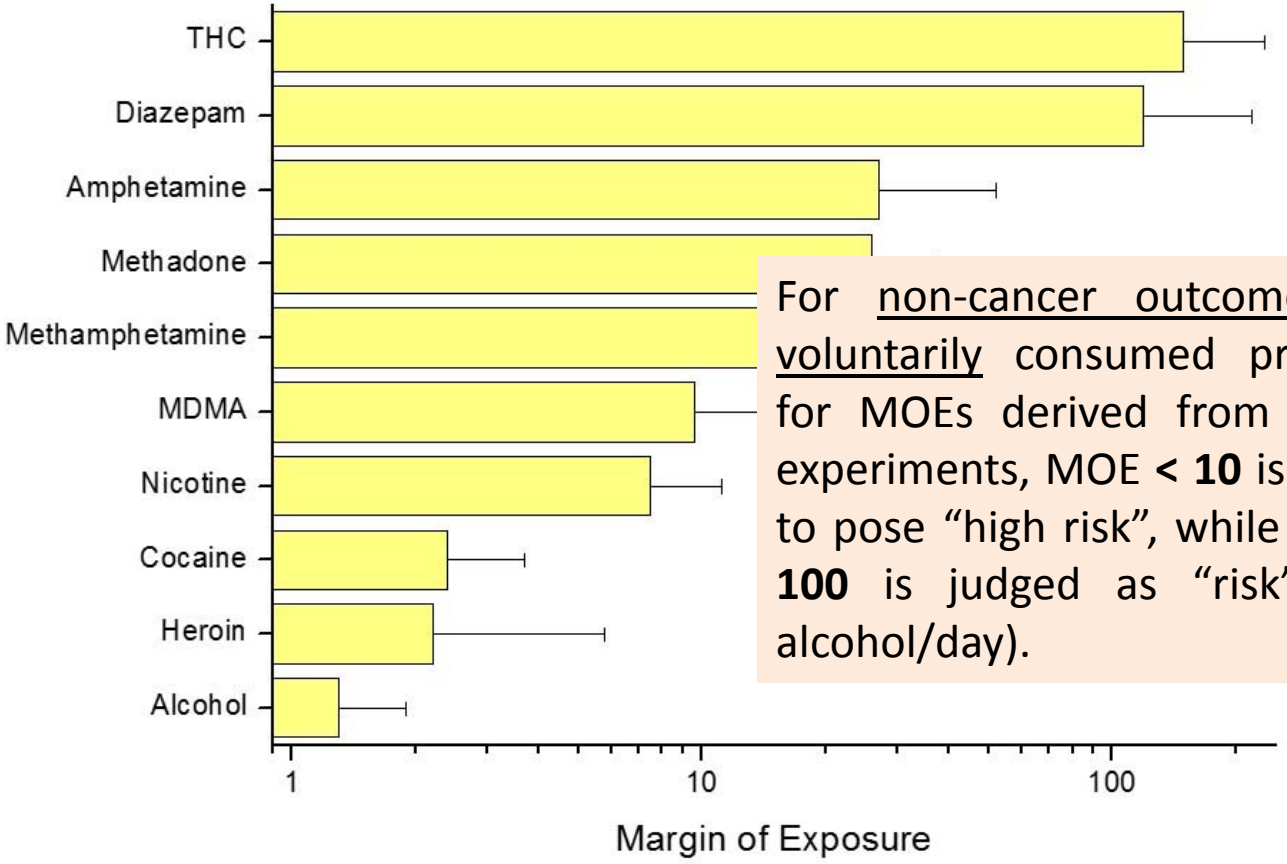
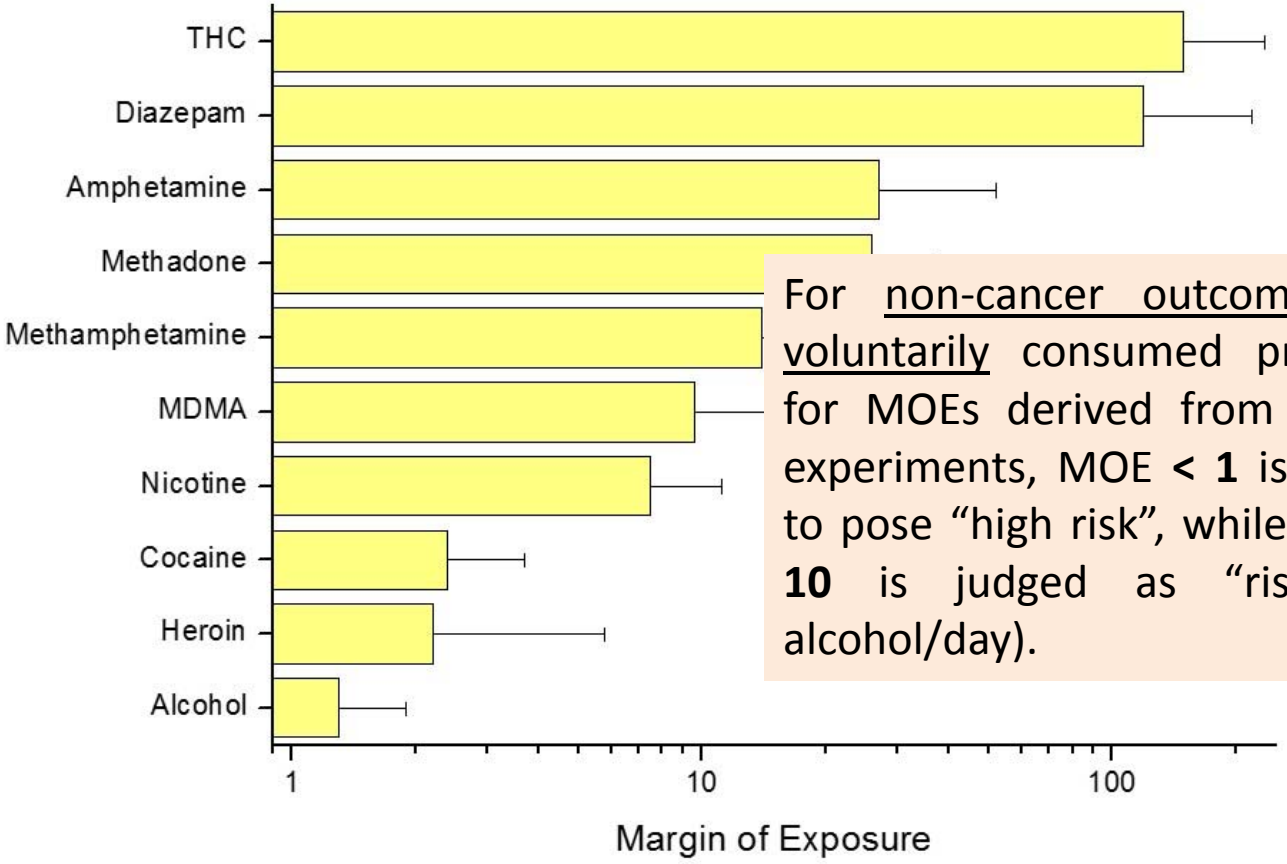


For <u>non-cancer outcomes</u>, for <u>voluntarily</u> consumed products, for MOEs derived from **<u>animal</u>** experiments, MOE **< 10** is judged to pose “high risk”, while MOE **< 100** is judged as “risk” (0.3g alcohol/day).

MOE: daily exposure European adults



For <u>non-cancer outcomes</u>, for <u>voluntarily</u> consumed products, for MOEs derived from **<u>human</u>** experiments, MOE **< 1** is judged to pose “high risk”, while MOE **< 10** is judged as “risk” (3g alcohol/day).

All drug policy should ensure that MOE for daily drug use is no less than 10.

Going from >30 grams of alcohol per day (European average) to 3 grams a day is problematic – however:

We can reduce toxic (benchmark) dose through less alcohol in the bottle, assuming inelastic response to ‘price’ increase.

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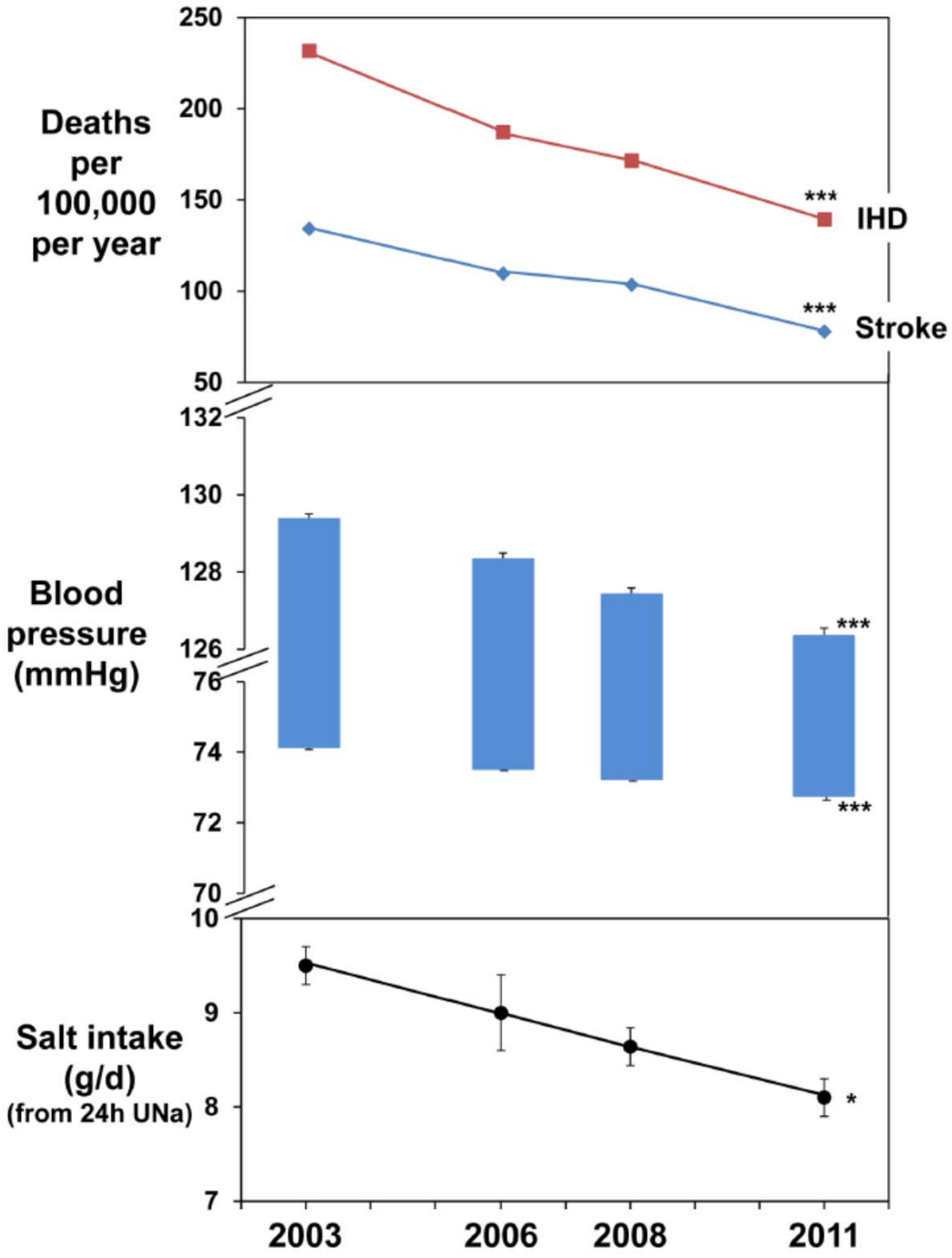
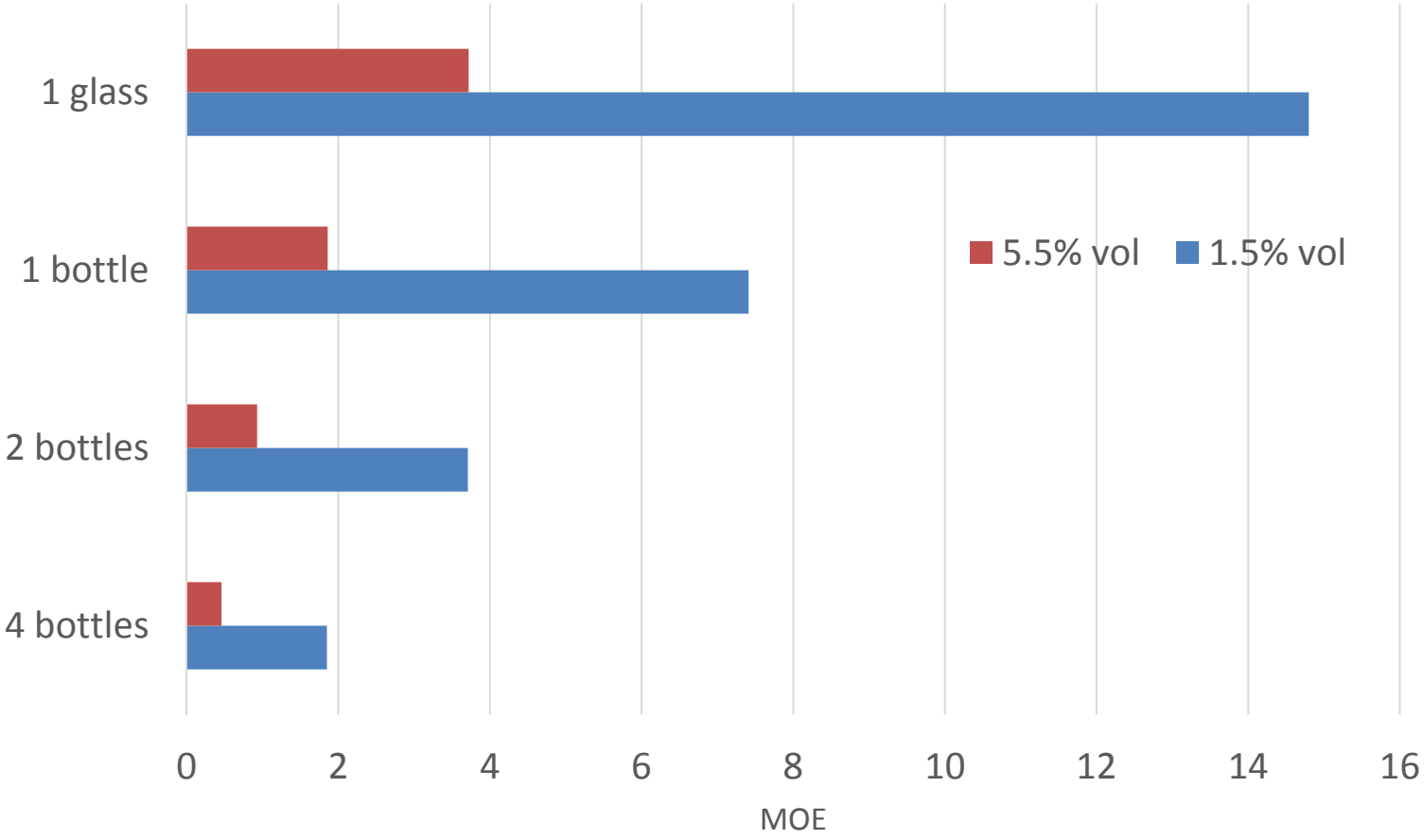
Remember, it is the amount of alcohol consumed, not the product, that drives harm:

Amongst Scottish heavy drinkers, the MOE for cider drinkers (0.29) is the same as that for vodka drinkers (0.31)


Deaths per 100,000 per year
250
200
150
100
50
***
IHD
***
Stroke
Blood pressure (mmHg)
132
130
128
126
76
74
72
70
***
***
Salt intake (g/d)
(from 24h UNa)
10
9
8
7
*
2003
2006
2008
2011



MOE for 1.5% beer compared to 5.5% beer for different volumes (remember, higher MOE, less risk)
1 glass=250mL; 1 bottle=500mL

Reducing alcohol concentration in the same priced bottle is a price increase

Price in-elasticities imply any compensatory drinking offset by concentration reduction

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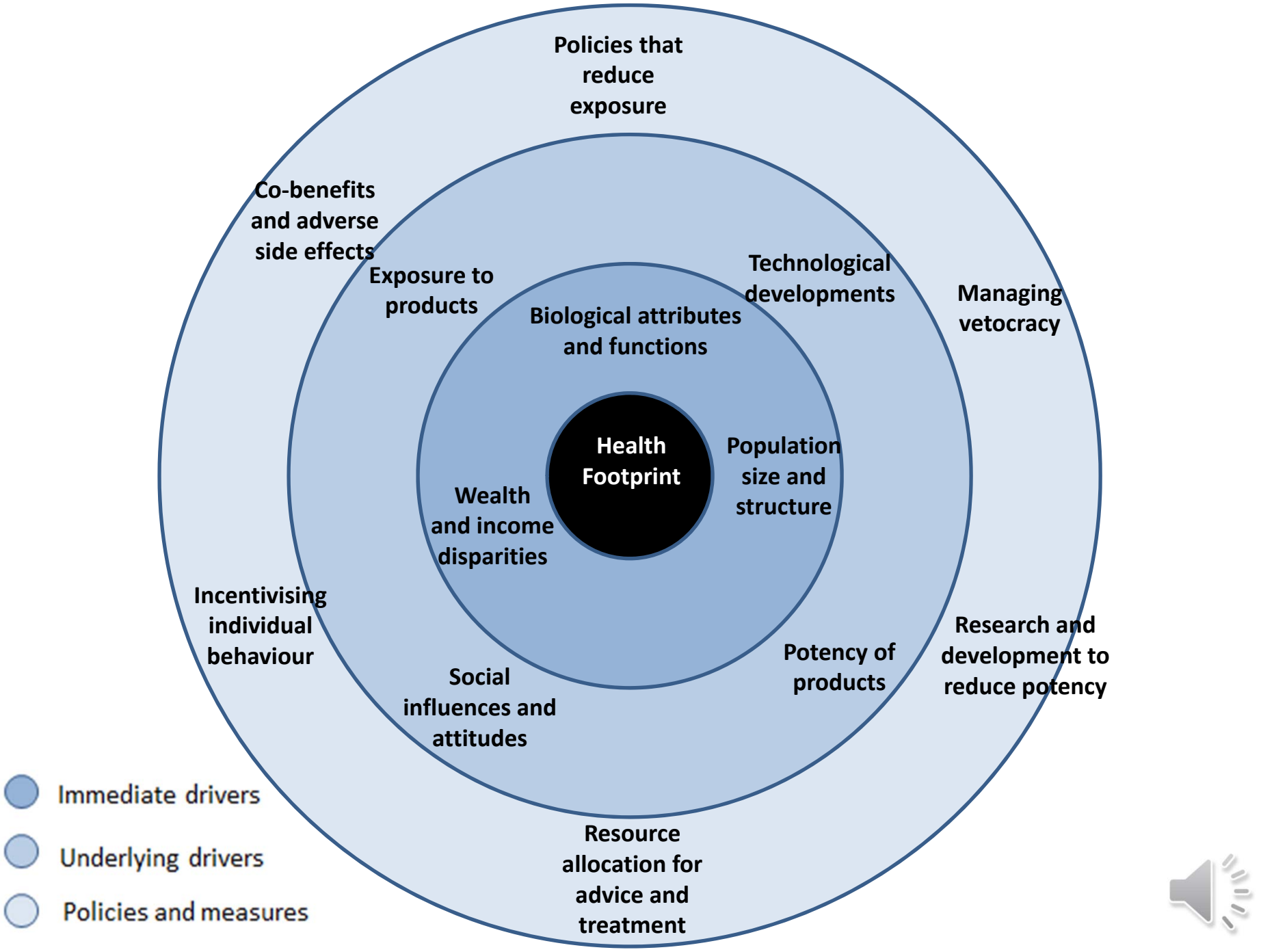
Policies that reduce exposure
Co-benefits and adverse side effects
Exposure to products
Technological developments
Managing vetocracy
Biological attributes and functions
Health Footprint
Population size and structure
Wealth and income disparities
Incentivising individual behaviour
Social influences and attitudes
Potency of products
Research and development to reduce potency
Resource allocation for advice and treatment
Immediate drivers
Underlying drivers
Policies and measures

Alcohol-related health footprint should be apportioned by main drivers, as well as governments, policies, sectors and producers

The health footprint should be the accountability and monitoring tool to drive change

Governments and Producers should report their health footprint in their annual reports and indicate measures to be adopted to reduce it

Conclusions:

1. Margin of Exposure should be the driver and monitor of European alcohol policy, which should ensure a MOE no lower than 10 (3 grams alcohol per day on average)

Conclusions:

2. Toxicity of the product should be reduced through an alcohol reduction initiative, similar to salt and sugar reduction initiatives, leading to at least a 10% reduction in the harmful use of alcohol by 2025.

Conclusions:

3. Alcohol-related health footprint should be the accountability tool to drive change in public and private sectors

Thank you for your attention

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