



UK Chief Medical Officer's Low Risk Drinking Guidelines

IARD Statement

Washington, D.C., U.S. – August 25, 2016 – Released on 25 August 2016, the [UK Chief Medical Officer's Low Risk Drinking Guidelines](#) clarify that the intention is “not to prevent those who want to drink alcohol from doing so,”^[1] but to provide people with information to help navigate potential risks and make decisions about their consumption. The guidelines also acknowledge that for many people, “alcohol is part of their social lives.” ^[1]

However, the guidelines would have been strengthened by a more balanced representation of the available scientific evidence. In failing to present the scientific evidence in a balanced way, the recommendations run the risk of confusing rather than accurately informing the public.

The guidelines represent a departure from those issued in [other countries around the world](#). ^[2]

1. The UK is only one of 6 countries that recommend the same levels of intake for both men and women. [\(See Infographic\)](#)

According to the new guidelines, a weekly limit of 14 standard units (the equivalent of 112 grams of alcohol) applies to both. [\(See Infographic\)](#)

This is inconsistent with scientific evidence about alcohol metabolism in men and women, and the relationship with risk of developing certain diseases.

The limits recommended for men in the UK are lower than those set by most (82%) governments around the world. [\(See Infographic\)](#)

The recommendations for men are also lower than those in other developed countries. [\(See Infographic\)](#)

2. While the majority of [countries that issue guidelines](#) offer recommendations on daily drinking levels (85%), the UK is one of only 6 countries that offer advice exclusively in terms of weekly limits.^[3] [\(See Infographic\)](#)

There is concern that weekly guidance alone:

- Does not clearly describe the relationship between drinking patterns and outcomes; for example, the possible risks related to heavy episodic drinking compared with potential health benefits of regular moderate consumption;
- May be more difficult to monitor and abide by; and
- May confuse the general public instead of providing helpful guidance to those choosing to drink.

3. The “low-risk” approach that was used in developing the UK guidelines is in contrast to that adopted in countries like the United States and Canada.

While the UK guidelines focus on risk of individual diseases, other national recommendations on drinking are based on a net assessment of risk and the weighing of potential benefits against harms.

4. Assessment of risk should take into account the balance of evidence on all-cause mortality. This shows that the risk of death from all causes is increased with heavier levels of consumption, but decreases at low-to-moderate drinking levels, when compared with mortality associated with no drinking at all.

These findings are supported by robust large-scale research studies that show that the reduction in risk of certain diseases in the presence of moderate drinking may outweigh any increases in risk for other diseases.

According to a 2016 review of findings from the U.S. Nurses' Health Study,^[4] potential increases in risk of cancer associated with moderate drinking are more than offset by reductions in risk of cardiovascular diseases, the largest contributor to mortality.

5. The depiction of the relationship between drinking and outcomes reflected in the guidelines does not reflect well-established evidence on the beneficial effects of moderate drinking.

The large body of established research into potential health benefits of moderate drinking has been discounted on methodological grounds, reflecting a particular perspective and not the full evidence base.

The guidelines downplay the established protective effects of low-to-moderate levels of drinking for a range of populations. ^[5]

The J-shaped relationship with reduced risk of [cardiovascular disease](#), [Type II diabetes](#), and death from all causes (all-cause mortality) has been well documented and is supported by large and robust studies that are widely used to inform other areas of health. ^[4]

6. Heavier drinking has been associated with increased risk of certain types of cancers. However, in the absence of proper context, the statement that "there is no level of regular drinking that can be considered as completely safe in relation to some cancers" ^[1] may confuse and unnecessarily alarm consumers.

Alcohol is one of a number of [lifestyle factors associated with cancer risk](#); others include smoking, obesity, reproductive history, exposure to sunlight, and diet.

It is the interaction among these factors, and their interaction with other risks, such as environmental exposure or genetic predisposition and family history, that ultimately determines the degree of known cancer risk for the individual.

Cancer risk rises with increasing levels of alcohol consumption, but more significant increases are observed starting at levels around 30 grams per day,^[6] which is in excess of the daily equivalent of the CMO guidelines. ([See Infographic](#))

To put the relationship between various risk factors into perspective, the following associations have been reported for breast cancer risk: ([See Infographic](#))

- 4% increase with "light" drinking (defined as <12.5 g/day);^[7]
- 16% increase with physical inactivity;^[8]

- 25% increase with current tobacco smoking;[\[9\]](#)
- 27% increase with older age at first childbirth;[\[10\]](#)
- 36% increase following 30 years of shift work;[\[11\]](#)
- 39% increase with a BMI of 30 or more (for post-menopausal women);[\[12\]](#)
- 42% increase with 8+ years of oral contraceptive use;[\[13\]](#)
- 61% increase with heavier levels of drinking (>50 g/day). [\[7\]](#)

All cancers for which alcohol is a risk factor also occur in the absence of drinking. Risk of disease and death is associated with many lifestyle factors, not only alcohol consumption, and must be considered within this broader context.

7. For the best and most appropriate advice around their alcohol consumption, adults who choose to drink are encouraged to consult with health care professionals who can provide advice based not only on government recommendations, but also take into account individual lifestyle factors and medical history.

The response of The Portman Group can be viewed [here](#).

The response of The British Beer & Pub Association can be viewed [here](#).

###

For editors:

What is IARD?

IARD is a not-for-profit organization, dedicated to addressing the global public health issue of harmful drinking and promoting responsible drinking. As a contributing risk factor for three major non-communicable diseases (NCDs), reducing harmful drinking is a priority for the world's governments, as set out in the WHO Global Action Plan on NCDs and the UN Political Declaration on the Prevention and Control of NCDs. IARD supports implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol and the constructive role Member States have identified for producers.

As a global public health NGO, we partner with public, civil society, and private stakeholders to advance our mission of contributing to the reduction of harmful drinking and promoting responsible drinking worldwide. IARD supports implementation of the global target set by the world's governments of "at least 10% relative reduction in the harmful use of alcohol" by 2025. IARD is supported by its Member Companies from all sectors of the alcohol industry – beer, wine, and spirits – in their common purpose of being part of the solution to the harmful use of alcohol.

The 12 signatories of the Commitments are: Anheuser-Busch InBev; Asahi Group Holdings; Bacardi; Beam Suntory; Brown-Forman Corporation; Carlsberg; Diageo; Heineken; Kirin Holdings Company; Molson Coors; Pernod Ricard; and SABMiller.

1225 19th Street NW, Suite 500 • Washington, D.C. 20036 USA
Tel: +1.202.986.1159 • Fax: +1.202.986.2080 • www.iard.org

For inquiries about IARD, please contact:

Isabella Platon, Senior Vice President of Strategy and Communications
 IPlaton@IARD.org / +32 471 611 373 (Europe) / +1 202 556 6970 (USA)

References:

- [1] UK Department of Health (2016). UK Chief Medical Officers' Low Risk Drinking Guidelines. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf
- [2] International Alliance for Responsible Drinking (IARD). IARD Policy Review: National Drinking Guidelines. <http://www.iard.org/wp-content/uploads/2016/04/Policy-Review-National-Drinking-Guidelines.pdf>
- [3] International Alliance for Responsible Drinking (IARD). Drinking Guidelines: General Population. <http://www.iard.org/policy-tables/drinking-guidelines-general-population/>
- [4] Mostofsky, E. et al. (2016). Key findings on alcohol consumption and a variety of health outcomes from the Nurses' Health Study. *American Journal of Public Health*, Published early online 26 July 2016.
- [5] See Appendix of key references.
- [6] Chen, W.Y. et al. (2011). Moderate alcohol consumption during adult life, drinking patterns, and breast cancer risk. *Journal of American Medical Association*, 306(17): 1884-1890.
- [7] Bagnardi, V. et al. (2015). Alcohol consumption and site-specific cancer risk: a comprehensive dose-response meta-analysis. *British Journal of Cancer*, 112: 580-593.
- [8] Harris, H. R. et al. (2016). Adherence to the World Cancer Research Fund/American Institute for Cancer Research recommendations and breast cancer risk. *International Journal of Cancer*, 138(11): 2657-64.
- [9] Gaudet, M.M. et al. (2013). Active smoking and breast cancer risk: original cohort data and meta-analysis. *Journal of National Cancer Institute*, 105(8):515-25.
- [10] Ma, H. et al. (2006). Reproductive factors and breast cancer risk according to joint estrogen and progesterone receptor status: A meta-analysis of epidemiological studies. *Breast Cancer Research and Treatment*, 8(4), R43.
- [11] Schernhammer, E.S. et al. (2001). Rotating night shifts and risk of breast cancer in women participating in the Nurses' Health Study. *Journal of the National Cancer Institute*, 17(9): 1563-1568.
- [12] Munsell, M. et al. (2014). Body mass index and breast cancer risk according to postmenopausal estrogen-progestin use and hormone receptor status. *Epidemiology Review*, 36(1): 114-136.
- [13] Hunter, D. et al. (2010). Oral contraceptive use and breast cancer: A prospective study of young women. *Cancer Epidemiology Biomarkers and Prevention*, 19(10): 2496-2505.