Public Health England

Enclosure PHE/14/08

Title of meeting	PHE Board
Date	11 March 2014
Sponsor	Kevin Fenton
Title of paper	Alcohol: a pressing priority

1. Purpose of the paper

This paper and appendix outlines: the harmful impact of the alcohol consumption, the evidence base of effective policy and interventions, latest policy context and PHE's proposed approach to prevention and reducing alcohol related harm.

2. Recommendation

The Board is asked to **COMMENT** on**:**

a) Future PHE stance on Minimum Unit Price and availability controls.
b) PHE approach to preventing and reducing alcohol related harm through local delivery of interventions and treatment.

3. Background

Alcohol serves many purposes for individuals and society. It is an important economic commodity with a complex supply chain. There are economic benefits to its production and sale but this comes with an enormous cost caused by the harm to individuals and society. The double-edged nature of this product needs to be taken into account when planning public health policy.

Alcohol is the 3rd biggest risk factor for ill health and death in the UK after tobacco and high blood pressure. Its harmful impact is widespread and far-reaching both to drinkers, others and compounds health inequalities. Much of this harm is preventable.

Price and availability are identified as key drivers of increased consumption.

World Health Organisation (WHO) has reviewed the evidence for alcohol harm reduction policy and interventions. The following were identified as those interventions with the strongest evidence:

- Pricing
- Availability controls
- Marketing controls
- Drink driving laws
- Screening and Advice
- Treatment

The appendix (on page 4) further outlines the harmful impact of alcohol and WHO recommendations in further detail.

4. Government Alcohol Strategy

In 2011, the Government published its Alcohol Strategy which identified its ambition as radically reshaping the approach to alcohol and reducing the numbers of people drinking to excess. Action was proposed to reduce the availability of cheap alcohol, including the introduction of a minimum unit price (MUP) for alcohol, along with powers to enable local areas to tackle local problems such as reducing alcohol-fuelled violent crimes and tackling health inequalities through an extensive range of tools and powers.

Following consultation, the Government decided not to pursue MUP at this time - although the Government did not question the benefits of MUP on alcohol related health harms. A number of issues were raised including the potential impact of MUP on the cost of living, the economic impact of the policy and increases in illicit alcohol sales. Since the Government response, Sheffield University has published further research showing that moderate drinkers would experience only small impacts from MUP policies, in terms of both economic costs and health benefits. Somewhat larger impacts would be experienced by hazardous drinkers (those who regularly drink above recommended guideline limits) and the main substantial effects would be experienced amongst harmful drinkers. PHE's stance has been that the evidence for MUP is strong and that there is a strong case for its introduction to reduce alcohol related harm.

Currently the main focus for reducing alcohol related harm is on delivery of interventions at a local level. PHE has been making the case for local action between Local Government, NHS and Police & Crime Commissioners in the following areas:

- Effective use of local powers to restrict the irresponsible sale of alcohol
- Effective use of health data and information within the licensing act
- Targeting those at risk and providing advice
- Reducing harm in those already experiencing harm from alcohol

5. Our commitments

Given the significant harmful impact of alcohol, it is proposed that Alcohol is given greater prominence within PHE's business planning for 2014/15. Our approach, in line with the WHO framework, will focus on promoting and developing the evidence, supported by the implementation of PHEs Health & Wellbeing Framework, which we expect to include national and local action to support:

MUP	**National** Work with Sheffield University and gather emerging evidence from other countries on the impact of MUP and present the case to Government

Effective use of Licensing advice	**National**
	• Identify and disseminate emerging local practice in:
	  ○ licensing,
	  ○ local restrictions,
	  ○ responsibility agreements and
	  ○ A&E data sharing
	• Develop and disseminate guidance to increase effectiveness of health as a responsible authority within the licensing act
	
	Regional/Centre/Partners
	• Support Local Alcohol Action Areas (LAAAs)
	• Support local areas to implement licensing guidance

	• Support local areas to implement local initiatives and policies
Identification of those at risk and providing advice	**National** • Implement data collection systems within NHS Health Check to confirm delivery of the alcohol risk assessment • Participate in development of Directed Enhanced Service (DES) guidance by NHSE to influence future delivery arrangements • Advise and contribute to NICE QOF committee on inclusion of alcohol within appropriate QOF indicators • Run at least one regional pilot to explore the most effective approaches to delivering alcohol behaviour change. • Maintain and improve existing products and materials that help people cut down including those under the Change4Life brand, Drink Line and DHs digital challenge. **Regional/Centre/Partners** • Support local areas to implement the alcohol risk assessment in their NHS Health Check programme • Support local areas to implement the Directed Enhanced Service (DES) for alcohol • Encourage and support wider roll-out of interventions, i.e. the inclusion of alcohol risk assessment in Making Every Contact Count (MECC)
Reducing harm in those experiencing harm	• Promote the implementation of PHE Alcohol Care Teams guidance • Develop a consensus supported pro-forma service specification • Develop a consensus supported minimum dataset for secondary care alcohol services • Undertake a survey of Alcohol Care Teams and the interventions delivered **Regional/Centre/Partners** • Support the local investment and establishment of Alcohol Care Teams in appropriate NHS hospitals • Disseminate and support the implementation of PHE Alcohol Care Teams guidance
Improving access to and the quality of specialist alcohol treatment	**National** • Promote PHE service improvement tools that support implementation of NICE guidance • Develop a package of support to improve psychosocial interventions in line with NICE guidance **Regional/Centre/Partners** • Support local service improvement and implementation of NICE guidance • Support local areas to improve treatment access and successful treatment completions

Appendix

The harmful effects of alcohol are wide ranging.

Over nine million people (22% of the population) drink at levels that pose a risk to their health, of these 2.2m with the highest consumption are at significant risk of health harm. Although the heavier drinkers may be most at risk of harm, alcohol has a long term health consequence for a large group of regular drinkers. Regularly drinking above the Chief Medical Officer's lower-risk guidelines (3-4 units a day for men; 2-3 units a day for women) increases risk of ill health significantly.

Table 1: Increased risks of ill health to harmful drinkers

Condition	Men (increased risk)	Women (increased risk)
Hypertension (high blood pressure)	Four times	Double
Stroke	Double	Four times
Coronary heart disease (CHD)	1.7 times	1.3 times
Pancreatitis (inflammation of the pancreas)	Triple	Double
Liver disease	13 times	13 times

Source: Anderson P. (2007) *The scale of alcohol-related harm.* (Unpublished) Department of Health.

Alcohol-related hospital admissions provide a proxy measure of the level of alcohol related health harm in a population. In 2010-11 there were 1.2 million alcohol related hospital admissions in England accounting for 7% of all admissions and up 11 % from 2009-10, Alcohol costs the NHS £3.5bn per year.

Alcohol-related deaths in England have risen in recent years, from 5,476 in 2001 to 6,923 in 2011. Men are more likely than women to die from an alcohol-related cause. Alcohol-related mortality disproportionately affects men and women in the more disadvantaged classes – in England and Wales in 2001-2003, the alcohol-related mortality rate for men in the routine class was 3.5 times that of men in higher and managerial occupations; the corresponding increase for women in the routine class was 5.7 times that of women in higher and managerial class. [1] 15,479 people died from alcohol related causes in 2010. [2]

Liver cirrhosis, mostly caused by alcohol misuse, is the fifth most common cause of death in England and the only one of the top five killer diseases showing rising rates.

Harms are not restricted to the individual drinker they extend to children, families, and communities.

- Between 1.3 million and 2.5 million children in the UK live with parents who have alcohol problems; alcohol is a factor in 27% of social services serious case reviews.
- There were almost one million alcohol related crimes in 2010-11 costing £11 billion a year in England and Wales.
- 17 million working days per year are lost through alcohol use due to absenteeism, accidents and early retirement through ill health.

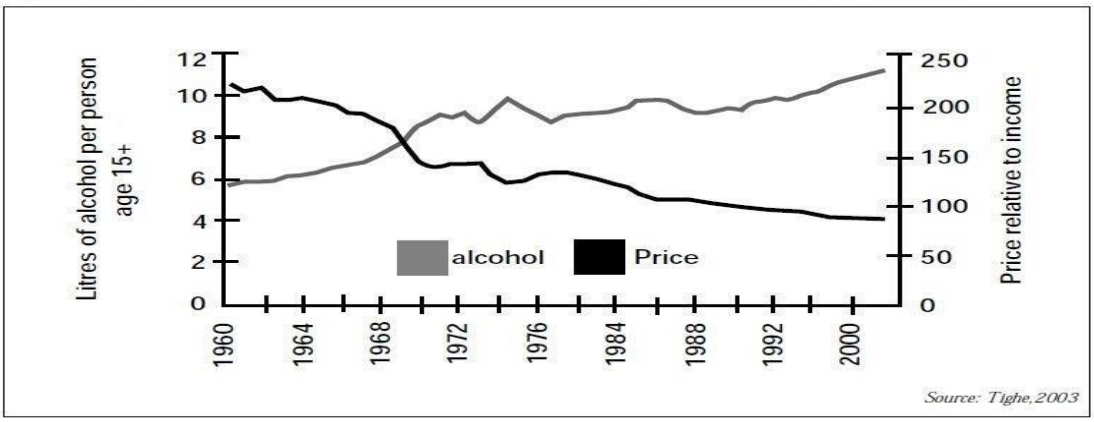
[1] Health and Social Care Information Centre, Health Survey for England 2012, published in December 2013)
[2] Jones L, Bellis M A, Dedman D, Sumnall H, Tocque K. 2008. Alcohol-attributable fractions for England. Alcohol-attributable mortality and hospital admissions. North West Public Health Observatory, Centre for Public Health, Liverpool John Moores University. ISBN: 978-1-906591-34-2

The total cost of alcohol related harm to society is an estimated £21bn a year, this include annual costs to NHS in England (£3.5bn), crime and disorder (£11bn) and UK economy (£7.3bn a year in lost productivity).

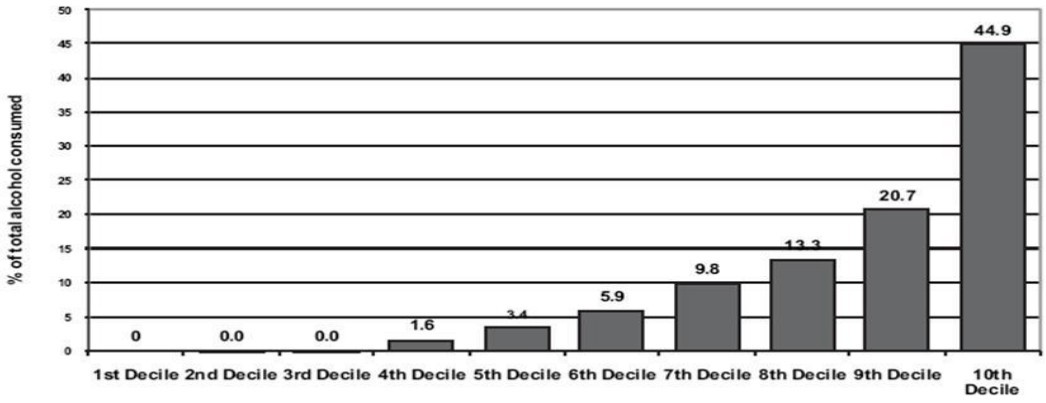
Alcohol consumption per head more than doubled between the mid-1950s and the early 2000s. Consumption has declined since 2005 but alcohol related harms remain historically high. Alcohol is currently more affordable and readily available than ever in recent history.

There is a relationship between consumption and affordability the following graph shows the inverse relationship showing consumption increasing as alcohol has become more affordable.

Figure 5 - *Consumption of alcohol in the UK (per person aged 15+) relative to its price: 1960-2002*



More than 40% of alcohol consumption is concentrated in 10% of the population



Evidence on effective policy

Much of the harm from alcohol is preventable. Alcohol is a complex issue that needs a multi-layered national and local response. Prevention policy and interventions following the World Health Organisation framework (Babor 2010) would be best served to focus on two key areas:

- **Population level:** aimed at affordability, physical availability and marketing
- **Targeting those at risk:** drink driving, early intervention and treatment

The WHO framework identifies the policies and interventions with the strongest evidence in reducing consumption or alcohol related harm.