ALCOHOL AND HEALTH INEQUALITIES

'Inequalities are a matter of life and death, of health and sickness, of well-being and misery' – The Marmot Review

- **Health inequalities are systematic differences in health between different social groups within a society.**
- **Lower socioeconomic status (SES) is associated with higher mortality for alcohol-attributable causes and higher alcohol-related hospital admissions, despite lower socioeconomic groups often reporting lower levels of consumption (the 'harm paradox').**
- **Alcohol can be seen as a contributing factor for over 200 health conditions. Among those aged 15 to 49 in England, alcohol is now the leading risk factor for ill-health, early mortality and disability.**
- **More working years of life are lost in England because of alcohol-related deaths than from the ten most prevalent cancers combined.**
- **The North East has the highest rate of alcohol-related hospital admissions in England, totalling over 71,800 in 2017/18, with costs to the NHS estimated to be in excess of £200m.**
- **Alcohol-related health inequalities are a huge issue in the North East - people from the lowest socio-economic group are 45% more likely to suffer an alcohol-related death than those from the highest.**
- **Addressing alcohol-related harm could be a key route to improving public health and reducing general health inequalities and we would recommend:**
    - **Population level action on alcohol price and availability, with the introduction of evidence-based interventions, such as Minimum Unit Price (MUP) particularly effective at reducing health inequalities.**
    - **More targeted measures to support more vulnerable groups of the population, such as a substantial increase in the availability across the population of alcohol treatment services, increased access to alcohol interventions in primary care etc.**

Introduction

Throughout the ongoing COVID-19 pandemic, commentators have spoken about the impact of health inequalities upon the virus, noting that people from poorer socioeconomic groups are likely to suffer from worse health outcomes, than those from more affluent sectors of society. It is a theme that public health professionals are extremely familiar with and one which promises to remain an important issue over the coming months. The purpose of this paper is to highlight the role of alcohol in terms of fuelling health inequalities and to ensure that opportunities are identified to address alcohol-related harms – and thereby reduce health inequalities - in the future.

In the UK, the term 'health inequality' is usually used to refer to systematic differences in health which exist between socio-economic classes or geographical area. The moral and ethical dimensions of health inequalities are often emphasized. For example, Whitehead defines health inequalities as ***'systematic differences in health between different socio-economic groups within a society' which are 'socially produced' and, therefore, 'potentially avoidable and widely considered unacceptable in a civilised society'***.[1]

[1] Whitehead, M. (2007). 'A typology of actions to tackle social inequalities in health.' Journal of Epidemiology and Community Health, 61, 473-78

Health inequalities often manifest themselves in terms of life expectancy - for example, a baby boy born into the most deprived communities in Gateshead, can expect to live on average to the age of 73.2 years, compared to a baby boy born in the least deprived communities of an English borough with the highest average life expectancy of 88.3 years; a **difference of over 15 years[2].**

Cultural-behavioural factors such as **alcohol consumption**, smoking, exercise and diet are known to fuel health inequalities. The North East suffers poor outcomes across a range of issues due to health and social inequality and alcohol harms are particularly pronounced in the region. For instance:

- Rates of alcohol consumption are among the highest in England.
- Rates of alcohol-related hospital admissions are the highest in England.
- Deaths as a result of alcohol are the highest in England.
- Only 1 in 5 people who require treatment for harmful alcohol use are currently accessing it.

This paper will further explore and outline the links between alcohol and health inequalities in the North East and provide a rationale for tackling alcohol-related harms and narrowing the gap between the most and least affluent sectors of our society.

Alcohol and health inequalities

- **Although less affluent groups report lower average levels of alcohol consumption, they suffer from higher rates of alcohol-related health harms.**
- **The alcohol-specific death rate for the most deprived quintile of local authorities in England is 5.5 times the rate of the least deprived.**
- **People from the poorest socio-economic groups are also over five times more likely to end up in hospital due to alcohol, than those from the most affluent.**

There is a strong body of research identifying the link between alcohol and health inequalities; however interestingly, alcohol-related health inequalities are more complicated than those linked to other substances, such as tobacco. At the heart of this sits the **'alcohol harm paradox'** – which shows that although lower socioeconomic groups often report lower average levels of alcohol consumption than more affluent groups, **lower socioeconomic status (SES) is associated with higher mortality for alcohol attributable causes and higher rates of alcohol-related hospital admissions.[3]**

For example, one study found the most deprived quintile of local authorities in England to have alcohol specific mortality rates 5.5 times the rate of the least deprived[4].

[2] Gateshead DPH annual report 2017 'It never rains but it pours' https://www.newcastlegatesheadccg.nhs.uk/wp-content/uploads/2017/11/Gateshead-DPH-Annual-Report-2017-18.pdf

[3] Probst. C., Roerecke. M., Behrendt. Rehm. J., (2014) 'socioeconomic differences in alcohol-attributable mortality compared with all-cause mortality: a systematic review and meta-analysis.' Int. J. Epidemiology. Oxford University Press.

[4] Department of Health (May 2012) Written evidence from the Department of Health for the Health Select Committee.

Among men in 2017, there were 30.1 deaths per 100,000 males in the most deprived regions compared with 7.0 deaths per 100,000 males in the least deprived regions[5].

Alcohol is involved in a wide range of health and social concerns, from dangerous driving to crime and domestic abuse, cancer, heart and liver disease, to accidents at work. Given this, and the fact that the most deprived communities are disproportionately affected by these issues[6], tackling problems associated with alcohol can be seen as central to efforts to reduce health inequalities across society, whilst tackling the 'upstream' social, economic and environmental determinants of health inequalities is likely to support efforts to reduce alcohol-related harms[7].

Minimum Unit Price and health inequalities

- **MUP would be extremely effective in terms of reducing health inequalities.**
- **A 50p MUP would reduce consumption among low income heavy drinkers by 7.6% and low income moderate drinkers by 2.9%.**
- **A 50p MUP would reduce alcohol-related deaths among the lowest socioeconomic group by 7.8%.**

Research has shown that the introduction of a Minimum Unit Price (MUP) for alcohol would be an extremely effective mechanism for reducing health inequalities and cutting consumption among low income heavy drinkers. Although more affluent groups of the population tend to drink at higher levels, the people in our most deprived communities suffer from the worst alcohol-related harms - harmful drinkers on the lowest incomes spend on average almost £2700 a year on alcohol, with 41% of the alcohol they consume purchased for less than 45 pence per unit.

Using the well-known Alcohol Policy Model, the Sheffield Alcohol Research Group was able to estimate the impact of economic policies on alcohol consumption and health. Their findings showed that a MUP of 50p was estimated to reduce consumption among low income heavy drinkers by 7.6% (equating to nearly 300 units per year per drinker) and low income moderate drinkers by 2.9%. In terms of reducing mortality among the heaviest drinkers and reducing alcohol-related health inequalities, the research team found that MUP had the greatest impact on consumption among heavy drinkers on low incomes who are at greatest risk of harm from their alcohol use.

Among heavy drinkers in the lowest socioeconomic group, it was estimated that the introduction of MUP would reduce alcohol-related deaths by 7.8%, compared to a decrease of 2.9% if a value-based taxation system was introduced. These low income harmful drinkers were also projected to accrue 87·1% of gains in terms of quality-adjusted life-years. As a result of the targeted effects, the Sheffield Alcohol Research Group also concluded that the introduction of MUP would be most

[5] Office for National Statistics (2018) Table 2: Alcohol-specific age-standardised rates of death per 100,000 population by deprivation quintile, deaths registered in England, 2011 to 2017 in Alcohol-specific deaths in the UK: liver diseases and the impact of deprivation in Alcohol-specific deaths in the UK: registered in 2017. Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2017.

[6] Impinen. A., Mäkelä. P., Karjalainen. K., Haukka. J., Lintonen. T., Lillsunde. P., Rahkonen. O., Ostamo. A. (2011) 'The Association between Social Determinants and Drunken Driving: A 15-Year Register-based Study of 81,125 Suspects.' Alcohol and Alcoholism

[7] Marmot, M (2010). 'Fair Society, Healthy Lives, the Marmot Review.' UCL Institute of Health Equity.

effective in terms of reducing the gap in alcohol-related deaths rates between the lowest and highest socioeconomic groups.

The study concluded: "The alcohol-related mortality rate was 108% higher in lower socioeconomic groups before introducing any policy, but this gap was estimated to reduce to 79% higher under a 50p minimum unit price[8]."

Outlet density and health inequalities

- **There is a link between alcohol outlet density and alcohol-related harms and outlet density – off trade in particular – tends to be higher in less affluent neighbourhoods.**
- **The greater the outlet density, the higher the rates of alcohol-related hospital admissions and alcohol-related deaths.**
- **The link is particularly strong with the off-trade, where cheap, strong alcohol is playing a growing role in unhealthy levels of consumption.**

One factor that may influence alcohol consumption and alcohol-related harms, is the density of alcohol retail outlets. Research has shown that neighbourhood availability of alcohol retailing may influence local consumption patterns and health outcomes in a number of ways. For example, greater local availability of alcohol retailers, and increased visibility of their advertising and promotions, can increase the physical availability of alcohol, reduce the prices of alcohol products due to retailer competition, and shape and reinforce local attitudes and norms around drinking behaviours and drunkenness.[9]

This can lead to increased consumption and several studies indicate that population-wide consumption of alcohol may be higher in neighbourhoods with higher alcohol outlet densities.[10] Local alcohol outlet densities have also been linked to acute alcohol-related health problems, such as assault and vehicle collision injuries.[11] Chronic alcohol-related health problems have received less attention, although recent work in America and Australia indicates that chronic consequences such as cirrhosis and mental disorders are more prevalent in neighbourhoods with higher densities of retail outlets licensed to sell alcohol for consumption off the premises[12].

In a UK context, recent research carried out in Glasgow examined the links between alcohol outlet availability (on-trade and off-trade) and alcohol-related health outcomes in Scotland. It found that alcohol-related hospital admissions and deaths were significantly higher in neighbourhoods with higher outlet densities, and that off-sales outlets were more important than on-sales outlets[13].

The relationships held for most age groups, including those under the legal minimum drinking age, although were not significant for the youngest legal drinkers (18–25 years). From the perspective of

[8] 'Estimated effects of different alcohol taxation and price policies on health inequalities: A mathematical modelling study' was published in PLOS Medicine.

[9] Livingston et al., 2007; Pasch et al., 2009, 2007

[10] Ayuka et al., 2014; Bryden et al., 2012

[11] Gruenewald et al., 2006; LaScala et al., 2001; Livingston, 2008b; Treno et al., 2007

[12] Pereira et al., 2013; Theall et al., 2009

[13] Is local alcohol outlet density related to alcohol-related morbidity and mortality in Scottish cities? https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4415114/

health inequalities, the research concluded that alcohol-related deaths and hospital admissions were higher in less affluent neighbourhoods, and the gradient in deaths (but not hospital admissions) was larger in neighbourhoods with higher off-sales outlet densities. Efforts to reduce alcohol-related harm and associated health inequalities, should therefore consider the potentially important role of the alcohol retail environment.

Alcohol, violence, anti-social behaviour and health inequalities

- **People from the most deprived groups experience 14 times as many alcohol-related incidents every year, compared with the least deprived.**
- **People from the most deprived groups were seven times more likely to experience alcohol-related violence from someone they know.**
- **They were also most likely to be victims of 'high frequency' alcohol-related anti-social behaviour.**

A recently released report by the Institute of Alcohol Studies (IAS), 'Inequalities in victimisation: alcohol, violence and anti-social behaviour' looked at several types of alcohol-related violence. It found that for domestic violence, the most deprived groups experience **14 times as many alcohol-related incidents every year**, compared with the least deprived. This has taken on new urgency in recent weeks, as reports of domestic violence incidents have risen dramatically under the Covid-19 restrictions.[14]

The report also revealed most deprived groups were **seven times more likely to experience alcohol-related violence** from someone they know and were most likely to be on the receiving end of '**high frequency' alcohol-related anti-social behaviour** in the last year. Of those who experienced alcohol-related anti-social behaviour in the lowest socio-economic groups, as many as half were victims of this on a weekly basis.

Conclusions and Recommendations

Alcohol affects all sectors of society, but as we have seen throughout this paper, it fuels health inequalities. People from the poorest socio-economic groups are significantly more likely to suffer from a raft of alcohol-related harms, although higher socio-economic groups drink more. Evidence also shows that alcohol dependence is high amongst vulnerable groups, including rough sleepers, offenders and care leavers. The causes of alcohol-related harms are complex, with no one resolution. However, population level action on alcohol price and availability has already been demonstrated to reduce alcohol harms, with evidence-based interventions, such as Minimum Unit Price (MUP) particularly effective at reducing health inequalities.

Population level measures must be coupled with a substantial increase in the availability across the population of alcohol treatment services, increased access to alcohol interventions in primary care and emergency services settings and a range of targeted interventions. These measures together, might disproportionately benefit those from economically disadvantaged groups.

Specifically, we would encourage local partners to consider the following:

14 https://www.bbc.co.uk/news/uk-52433520

1. Rolling out 'Blue Light' training for non-alcohol specialist frontline staff – e.g. health, social care, housing, homelessness services and the criminal justice system – to embed harm reduction approaches, for people resistant to receiving alcohol treatment – for more information, please see: https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project-in-detail

2. Introduce evidence-based, clinician-led Alcohol Care Teams in every district general hospital, with a 7-day Alcohol Specialist Nurse Service and an Assertive Outreach Alcohol Service. Modelling shows that this would save the UK economy at least £393 million every year – for more information, please see: https://www.bsg.org.uk/resource/alcohol-related-disease-meeting-the-challenge-of-improved-quality-of-care-and-better-use-of-resources.html

3. Encourage the Government to update guidance within the Mental Capacity Act to ensure that definitions can be applied to heavy / alcohol dependent drinkers where appropriate – for more information, please see: https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

4. Target excluded communities with tailored / specialist support – for example, consulting and working with communities to appoint "dedicated health visitors [working with the community] to encourage them to register with and visit a GP, drug and alcohol services or attend hospital appointments" – for an example of good practice, please see: https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Drinking-problems-and-interventions-in-BME-communities-Final-Report.pdf?mtime=20190726160248

5. Work with Balance to advocate for the introduction of a Minimum Unit Price (MUP) for alcohol in England, which would disproportionately target harmful drinkers on low incomes, who tend to purchase more alcohol at less than the 50p MUP threshold compared with other groups. Research carried out by the University of Sheffield MUP shows that 8 in 10 of the lives saved by the introduction of MUP would come from routine and manual worker groups. In the absence of a national approach to MUP local councils may wish to consider a local/regional bid for MUP using the Sustainable Communities Act

6. Work with Balance to encourage the Government to reinstate the alcohol 'duty escalator' in the short term. Alcohol duty has been cut or frozen for six out of the last seven years. In real terms, beer duty is now 18% lower than in 2012, cider and spirits duty are 10% lower and wine duty is 2% lower. Research has shown that alcohol duty cuts since 2013-14 will cost the Treasury a total of £9.1 billion by 2023.[15] An increase of 2% above inflation would go a small way to redress the balance, raising about £150-200 million. In the longer term, utilize the Government's planned review of the alcohol duty system to call for a new approach which is based on the alcohol strength of the product

7. Implement proactive local licensing policies, based upon analysis of 'live' data, which identify 'hotspot' neighbourhoods and introduce measures which limit further expansion of outlet density within these communities (e.g. via the designation of 'Cumulative Impact Zones').

[15] Institute of Alcohol Studies (2018), Budget 2018 analysis