Improving Health and Social Care

The Institute of Alcohol Studies is concerned with the prevention of problems associated with the use of alcohol products, and it is from this perspective that we approach the Consultation Document[i].

1 The General Picture

1.1 In developed countries such as the UK, alcohol is one of the ten leading causes of death and injury, and is responsible for 9.2 per cent of the disease burden. This is less than the disease burden caused by tobacco (12.2%) but more than that caused by overweight (7.4%) and by illegal drugs (1.8%)[ii]

1.2 In the UK, alcohol-related mortality has increased markedly over recent years, especially in younger age groups. Over the last 30 years, deaths from liver disease, of which the main cause is alcohol, have increased 7-fold in men, 8-fold in women. Liver cirrhosis now kills more men than Parkinson's Disease, more women than cancer of the cervix.[iii]

2 The Consultation Document

2.1 The Document raises three issues bearing specifically on alcohol questions:

I. Health inequalities: addressing these is the top priority stated in the Consultation Document which recognises that health inequalities can be exacerbated by the abuse of illegal drugs and the excessive consumption of alcohol, as well as by smoking.
II. The Document raises the possibility of `health agreements', ie. some form of patient agreement to tackle aspects of their lifestyle causing or likely to cause ill health.
III. The general question of the basis and limitations of state intervention into health lifestyles, including drinking habits.

Our brief comments on these three questions are in reverse order.

3 State Intervention

3.1 In some respects, this is the most important question involved in public policy regarding lifestyle issues, including of course, alcohol consumption, and it is one that will arise at various points in relation to the National Alcohol Harm Reduction Strategy. In summary, it has been suggested[iv] that there are three kinds of justification for state intervention in the alcohol and illegal drugs markets:

I. Externalities – some people's drinking has detrimental effects on other people's welfare.
II. Imperfect rationality – people may not always act in their own best interests.
III. Perverse effects – individual's free choices may sometimes produce sub-optimal outcomes for all.

3.2 These considerations, we would argue, justify the state intervening in the market for alcohol, as in the markets for other potentially harmful and addictive substances, in order to protect and promote public health and public safety.

3.3 We would place particular emphasis on the first of these considerations. One of the features that most obviously distinguish alcohol harm from harm caused by tobacco is that very often the victim is someone other than the consumer, as in many road traffic accidents where the victim is someone other than the drinking driver. We also know, for example, that there are large numbers of children being brought up in problem drinking families, and there is the blight inflicted on our main urban centres by alcohol-fuelled crime, disorder and anti-social behaviour associated with the night-time economy.

3.4 While a fuller examination of these issues will have to wait for another occasion, it is worth noting here that it is clear that Government action to reduce levels of alcohol-related harm would meet the approval of the great majority of the British public. The NOP Solutions poll commissioned by IAS, for example, found that 79 per cent of adults agreed with the statement "The Government should do more to reduce the level of alcohol abuse in society".[v]

4 Health Agreements

4.1 Clarifying mutual expectations and agreeing goals for the future are useful and indeed routine elements of the doctor-patient relationship, including in relation to `addiction' problems. These, however, are agreements that arise spontaneously between an individual doctor and an individual patient, with the best interests of that particular patient in mind.

4.2 The Consultation Document floats the idea of another kind of agreement, one in which a third party, the state, would impose obligations on the other two, and one in relation to which it is less clear whose interests would be regarded as paramount. The details of what is being proposed are vague. At one point it is stated that the patient's duty to the health service is to be put on a statutory footing, while later it is stated that the agreement would not be legally binding.

4.3 This vagueness notwithstanding, we cannot support the concept of health agreements as proposed in the Consultation Document.

4.4 These could, we believe, seriously compromise doctor-patient relationships, and so lead to less rather than more efficient use of health service resources. One obvious danger, for example, is that health agreements could deter people from seeking medical advice until forced to do so by the severity of their condition. Another is that patients may become unwilling to tell the doctor the truth about their condition. In addition, and despite the protestations to the contrary, there is a clear implication that failure to abide by an agreement would result in treatment being denied to some, but by no means all patients whose actual or risk of illness or injury could be described as in some sense self-inflicted. Health agreements are clearly intended to apply in cases of smoking, overeating and excessive drinking: there is no suggestion that they would also apply to sportspeople, despite lots of costly injuries, or the promiscuous, despite lots of expensive treatment for sexually transmitted diseases. The policy would thus be inherently discriminatory.

4.5 While we fully support the notion that users of the health service have responsibilities as well as rights, and while we have been long-standing advocates of the need to prevent alcohol-related ill health as well as treating it, we do not believe that health agreements are the way to achieve these ends. What is required is a coherent set of policies designed to reduce the harm associated with alcohol products, paying particular attention to the environmental factors that generate alcohol problems rather than an approach that, whatever is intended, inevitably looks like an exercise in blaming the individual victim.

5 Health Inequalities

5.1 It has been believed for a long time that poverty and alcohol abuse are linked. In the Victorian era, much of the concern about the alcohol question arose from awareness of the impact of alcohol on the urban poor, and there was vigorous debate as to whether drunkenness was a cause or a consequence of poverty.[vi] This did not prevent alcohol problems being seen subsequently also as diseases of affluence.

5.2 Modern research has found evidence that social class is a risk factor for alcohol-related mortality, with men in manual occupations being significantly more likely than professional men to die of alcohol-related causes. It is suggested therefore that alcohol appears to be similar to other psychoactive substances in that problem use is linked to social structural factors such as poverty, disadvantage and social class.[vii]

5.3 However, the picture is not a simple one. The impact of class on alcohol-related mortality is mediated by age and gender. In men, the magnitude of the difference in alcohol-related mortality between unskilled manual and professional is greatest in the 25-39 age group, declining thereafter, although a raised risk of alcohol-related mortality is still evident in older men. However, in women, for those in paid employment there is no consistent class gradient: in the young, those in manual occupations have raised mortality, but in older women it is the professionals who have the highest risk of dying from alcohol-related causes.[vii]

5.4 There is little evidence of strong class differences in relation to average consumption of alcohol or the prevalence of hazardous drinking, though there is a somewhat raised risk of hazardous consumption in manual occupations compared with non-manual. Being on benefit appears to reduce the risk of hazardous consumption.[viii]

5.5 In regard to alcohol dependence, although again the picture is not wholly consistent, the risk of dependence does appear to be raised in both men and women of social class v.[ix]

5.6 In regard to this question our interpretation is that while there are indeed links between alcohol problems and social deprivation, and that therefore policies to mitigate the one may also help to mitigate the other, these links should not be over-emphasised or be allowed to mask the wider picture that alcohol problems are endemic in all socio-economic strata and that alcohol-related morbidity and mortality is rising in the population as a whole.

6 Conclusion

6.1 There is compelling evidence of consistent, positive relationships between population levels of alcohol consumption and levels of alcohol-related morbidity and mortality, and hence on the overall mortality rate. On average, a 1 litre change up or down in per capita

alcohol consumption is accompanied by a corresponding 1.3 per cent change in overall mortality.[x] In the UK, unlike many other European countries, alcohol consumption is rising and will probably continue to do so, encouraged in part by Government policies. At the time of writing, we do not know what will be included in the national alcohol harm reduction strategy, but we do know that licensing reform to facilitate 24 hour drinking will soon be coming into effect. As suggested above, there is some reason to think that the increased morbidity and mortality that will accompany increasing consumption will exacerbate health inequalities.

Andrew McNeill July 2003

Sources:

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iv Ole-Jorgen Skog: Alcohol policy: why and roughly how? Nordic Studies on Alcohol and Drugs [English supplement]: 16, 1999, p21-34

v NOP Solutions. Alcohol, January 2000

vi Harrison B, Drink and the Victorians: the temperance question in England 1815 - 1872. 1971. Faber and Faber: London. 510p

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viii Coulthard M, Farrell M, Singleton N and Meltzer H, Tobacco, alcohol and drug use and mental health. Office for National Statistics, 2002

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