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TECHNICAL REPORT

Reducing alcohol harm

International benchmark

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Prepared for the UK National Audit Office

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Executive summary

The National Audit Office (NAO) is undertaking a value for money (VfM) study to examine alcohol-harm prevention and treatment services that are supported by the Department of Health and the NHS in England, focusing specifically on NHS services for alcohol misusers. To supplement the evidence from England, the NAO has commissioned an international benchmark with the aim of identifying areas of good policy and practice which may be transferrable to England. Five countries, broadly comparable to England in terms of alcohol trends and other socioeconomic indicators, have been examined for this project: Australia, Canada, Germany, the Netherlands and the United States.

This report describes alcohol prevention and treatment interventions in the US, Canada, the Netherlands, Germany and Australia, placing them in the context of each country's healthcare system. The report does not consider the provision of alcohol harm prevention and treatment services in England itself, although it does compare some relevant statistics for England and the UK as a whole against the countries named above.

This executive summary presents the main findings of the study.

Alcohol harm is a significant public health issue in all countries examined in this report

All of the countries studied in this report incur significant social and economic costs due to heavy and problematic use of alcohol in the general population. All of these countries have significant rates of heavy drinkers, binge drinking and alcohol dependency. Chapter 2 gives an overview of the comparative consumption of alcohol and associated alcohol harm between countries. Alcohol use in all countries is a leading cause of mortality and morbidity, both in terms of primary and secondary diagnosis. In general terms, men and young people misuse alcohol more than women and older age groups respectively. Consumers from higher socioeconomic status tend to use more alcohol than those from a lower socioeconomic class, though lower-income groups tend to drink more in one sitting. The UK tends to have higher rates of alcohol misuse (heavy and binge-drinking) than the European Union and World Health Organization averages.¹

¹ We could not always disaggregate data for England, Scotland, Wales and Northern Ireland. Most international studies produce data for the whole of the United Kingdom.

Healthcare systems in the countries examined use a similar set of interventions to tackle alcohol harms, but have different funding and delivery structures and systems

We studied health and non-health interventions to tackle alcohol harms in five countries which differ considerably in the institutional set up of their health services. Some are tax financed and offer universal coverage, like the National Health Service (NHS) in England, others rely heavily on private funding and do not cover sizeable proportions of the population, as in the US. However, these countries use similar interventions to tackle alcohol problems and harms. These include awareness campaigns to prevent alcohol misuse, and treatment for the alcohol dependent as well non-health measures such as drink-driving limits. Nonetheless, there are considerable differences in the combinations of policies used and in the funding and provision of services. The ways in which different delivery and funding structures alter the effectiveness of alcohol policies is unclear from existing research.

Decentralized funding and provision of services makes assessments of cost-effectiveness difficult

The decentralized funding and provision of interventions to tackle alcohol harms does not allow for comparison of expenditure levels on alcohol-related interventions and of cost-effectiveness between countries. In most countries, services are provided at the regional or local level and funding is integrated into general healthcare expenditure. Central governments are often only responsible for coordination, research and national awareness campaigns. We only found limited information on the costs of, and spending on, services to reduce the impacts of alcohol harm. This information is provided in Chapter 3.

Screening and brief interventions for alcohol misuse are effective but not widely used in healthcare settings

Screening tests developed and used in the US and elsewhere have demonstrated acceptable levels of reliability in the identification of people with alcohol problems. Similarly, brief interventions² in primary care settings have been shown to have positive outcomes in reducing alcohol consumption and its attendant harms. Screening and brief interventions (SBI) have become an increasingly important tool in the prevention and treatment of alcohol problems, as they target people whose alcohol consumption is not diagnosable as abuse or dependence, but whose drinking pattern is or can be hazardous and result in harms. International evidence has also shown them to be cost-effective. However, evidence suggests that SBI are not widely used in healthcare settings. Barriers to their dissemination and use amongst healthcare professionals include lack of knowledge and skills to use the interventions, limited time with patients, and lack of financial incentives. The lack of governance structures to incentivize healthcare professionals to use SBI is common to all the countries examined in this report.

² Brief interventions are short interventions undertaken by a health professional to establish whether the patient has an alcohol problem and to give the patients some advice on how to address issues associated with alcohol consumption.

Specialist treatments for alcohol problems are not prominent elements of national alcohol strategies

Despite their central role in treating alcohol problems, specialist treatments do not feature prominently in the alcohol strategies of the countries studied here. Alcohol treatment within the healthcare system is considered a medical rather than a public health concern. This is compounded by the fact that, given the limited availability of treatment facilities and the significant proportion of problem drinkers who do not seek treatment, specialist treatment is unlikely to have an impact on aggregate mortality and morbidity at the national and even local levels. In the light of this evidence, one may make the case that closer coordination between specialist services and other services to reduce alcohol harm within the health system is desirable.

Many population-wide, non-health policies to reduce alcohol harms are effective if given adequate enforcement

Many population-wide, non-health policies have been shown to be effective in reducing alcohol harms. Pricing and taxation, for example, have consistently shown effectiveness in reducing alcohol harms. However, real prices of alcohol have decreased in the countries examined here, partly as a result of alcohol taxation not keeping up with inflation rates. Taxation is not normally used as a public health policy to reduce alcohol harm, with very few exceptions (such as the tax on alcopops in Germany). In general, taxation levels tend to be too low to have a substantial impact on alcohol consumption. However, there is strong evidence of the effectiveness of other policies, particularly restrictions on the availability of alcohol; drink-driving counter-measures; and minimum legal drinking ages (MLDA). There are significant differences in how these are implemented and enforced in the countries studied in this report. For example, the MLDA varies from 16 to 21 in the five countries included here, although research shows that raising the MLDA reduces alcohol harms. There is some indication of a trend towards more stringent drink-driving policies in most of the countries examined, particularly through decreases in legal limits for blood-alcohol concentration in drivers, and zero tolerance measures for new drivers. In some of the countries, there are increasing calls to raise the MLDA.

A comprehensive strategy is required to reduce alcohol harms but there is no research about the optimal policy mix

Many public health writers conclude that an effective policy mix – combining taxation, restrictions in alcohol availability, drink-driving counter-measures, and serious investment in prevention and treatment within healthcare settings – is necessary to reduce alcohol harms. However there has been little research into what the optimal mix of policies and resources would need to be to achieve the greatest reductions in alcohol harms. While extensive research has been conducted on the effectiveness of individual policies (or, at most, combinations of a small set of them such as MLDA and zero tolerance laws for under-age drivers), there is extremely limited understanding of how different interventions affect each other, and how to optimize their mix to obtain improved outcomes.

There is a need for continued investment in the improvement of alcohol prevention and treatment services within healthcare settings

The evidence in this report clearly indicates that screening and brief interventions (SBI) and specialist treatments provide services that are necessary for many people and

unavailable in many places. In view of the strong evidence of their efficacy, resources should be devoted to the effective promotion of the use of SBI in medical settings. Moreover, given not only the risk of relapse by existing patients but also the reluctance of many problem drinkers to seek treatment, it is crucial that continued resources are devoted to improving the design, delivery and accessibility of specialist treatments. While as discrete measures, SBI and specialist treatment only have a limited impact on overall alcohol harms, their contribution to a wider, comprehensive alcohol strategy is fundamental to ensuring that the social and economic harms from alcohol misuse are minimized.