Guest editorial

Alcohol and public health: heavy drinking is a heavy price to pay for populations

Alcohol consumption contributes to over 60 diseases and is responsible for 2.74 million deaths annually (4% of the worldwide total), as well as being the fifth leading risk factor for the global disease.\(^1\) In the UK alone, alcohol-related hospital admissions increased by 41% between 2003 and 2013\(^2\) and this increased impact on health systems is mirrored in other countries across the world.\(^3\) In addition to acute and chronic physical health problems, excessive drinking is linked to poor mental health, crime and disorder, domestic violence, unprotected sex and unintended pregnancy.\(^4\) Given this wide array of harm, the total cost to the UK economy has been estimated to be £25.1 ($40.2) billion each year.\(^5\)

When considering global or national disease profiles, it is easy to overlook the impact of alcohol-related risk or harm on specific groups within populations. Jayasekara et al.\(^6\) investigated alcohol-attributable morbidity and mortality between 2000 and 2010, and found that morbidity increased significantly over this timeframe whilst mortality remained relatively stable. Increased rates of alcohol-related morbidity were found in females, those aged 25–64 and metropolitan males aged 45+. Data such as these are a timely reminder that excessive drinking is not just the preserve of the young, and that public health interventions need to reach across the entire population and include middle aged drinkers, women and those living in conurbations where alcohol outlet density is often greatest.

Nevertheless, alcohol does present a specific risk for young people since they are more vulnerable to its effects than adults. This impact is due to: a typically lower body mass and less-efficient metabolism of alcohol; psychoactive effects of alcohol affecting motor control and coordination, which increases the likelihood of accidents and trauma; a typically low-frequency, high-intensity drinking pattern that leads to intoxication and risk-taking behaviour; and the fact that young people generally have less experience at dealing with alcohol and/or other drug use. Thus despite the positive intention of socially sanctioned celebratory events, it is important for teachers and other organizers to be aware that these occasions can actually lead to increased health risk.

In addition to external events, advertising and other promotional activity is associated with the initiation of drinking and regular use of alcohol in young people, as well as the development of pro-drinking attitudes.\(^11\)–\(^13\) Furthermore, mid-adolescents in the UK and The Netherlands are known to be significantly more exposed to alcohol advertisements per viewing hour than adults.\(^14\) The papers by Lyons and Pitts represent a welcome addition to this evidence base.\(^15\),\(^16\) Both papers explore the frequency of alcohol content in UK media; Lyons et al. focused on broadcast media (terrestrial television) whereas Pitts et al. examined print media (monthly women’s magazines). Whilst not specifically measuring young people’s exposure per se, both studies support the conclusion that young people are increasingly growing up in an ‘intoxigenic environment which normalises alcohol via far-reaching and frequent presentation in daily life’.\(^17\) Lyons et al. found that alcohol imagery was a dominant part of UK television, occurring in over 40% of broadcasts, particularly soap operas, feature films, sport and comedies, all of which appeal to young people. Similar work conducted by Graham and Adams\(^18\) found that visual alcohol references in televised top-class English football matches were common, with viewers exposed to an average of nearly two per minute. Pitts et al. found that alcohol marketing messages were much more likely than food advertisements to relate to matters of ‘taste’, ‘location’, ‘fun’ or ‘quality’. Content such as this reinforces the idea that positive social status can be derived from drinking.\(^19\)

Indeed, recent work in the UK has found that young people aged 14–17 have already clustered into distinct groups which are differentially responsive to different aspects of the alcohol marketing mix (price, promotion, product and place).\(^20\)

It is increasingly accepted that a fully joined-up public health response to tackle alcohol problems needs to include policy-focused interventions as well as individual-level input from health and social care practitioners.\(^21\) Policy-level interventions have been slow to be implemented due to political pressures which can lead some national governments to
employ less-effective strategies at the expense of more effective approaches, such as tackling affordability or availability. Nevertheless, some power to influence the social determinants of heavy drinking does lie within the control of local government. Martineau et al. reviewed the challenge of achieving health gains through local alcohol control policies in England and Wales and specifically by considering licensing and planning policies that affect the number and distribution of outlets that can sell alcohol. Addressing alcohol-related health harm was seen to be constrained by a lack of a specific health licensing objective. Local health leads were ‘responsible authorities’ with a recognized role in commenting on licensing applications — but the evidence they needed to present had to be framed in terms of non-health objectives. Moreover, local decisions can often be subjected to legal challenges and appeals which stretch the limited resources of local authorities. Nevertheless, this review reported some innovative work in particular local authorities that could blaze a trail for others to follow.

In addition to policy-focused interventions, there is a key role for practitioners in helping individuals recognize when they are drinking too much and in encouraging health promoting behaviour-change. A large and robust evidence-base supports the effectiveness of screening and brief alcohol intervention to help reduce excess drinking, particularly (although not exclusively) in primary care. To date, there have been over 56 controlled trials of brief alcohol interventions that have reported primarily positive outcomes on weekly drinking and a range of alcohol-related problems. Nevertheless, brief interventions are not routinely delivered in health settings due to a well-recognized ‘implementation gap’ where evidence is not translated into practice. Barriers to screening and brief interventions reported by practitioners include: lack of time, training and resources; a belief that patients will not heed advice or be offended by it; and a lack of financial incentives to support this work.

Studies by Assanangkornchai et al. and Hamilton et al. have taken up the implementation challenge and investigated strategies that might be used to promote increased delivery of screening and brief intervention in routine primary care. The former Thailand-based study widened its lens from alcohol consumption to include smoking and other substances, and used staff training and interactive workshops to encourage wide-scale screening and brief intervention delivery in patient aged 18–65. Over a 1 year period, 2.5% of eligible patients were screened as they attended primary care. Although this percentage seems low, the actual number of patients was 5931. Moreover, 1960 (33%) patients were identified as requiring brief intervention and 1627 (83%) received this input. Given the numbers of patients presenting to primary care each year, it is clear that a systematic and supported programme of screening and brief intervention activity has the potential to promote well-being in a large number of patients. Since the majority of screening and brief intervention studies have been based in developed countries, it is heartening to see work emerging in differing cultural and health contexts.

Finally, Hamilton et al. assessed the impact of a local pay for performance on delivery of screening and brief alcohol intervention in UK primary care. The pay for performance scheme was an enhanced version of the Quality and Outcomes Framework and it provided specific additional payments for screening in patients with cardiovascular conditions and mental health problems. In retrospective longitudinal work with 30 practices in north-west London from 2008 to 2011, they were able to interrogate routinely recorded data relating to over 20,000 registered patients aged over 16 years. The financial incentive scheme was associated with a large increase in screening in patients with recognized cardiovascular disease and mental health problems (from ~4.8–65.7%). However, screening rates for patients with mental health conditions were lower than for those with cardiovascular disease. In addition, younger patients were less likely to be screened than older patients, Black and south Asian patients were more likely to be screened than white patients and individuals from more deprived areas were more likely to be screened than those in affluent areas. These findings contradict what we know about the prevalence of heavy drinking based on age, ethnicity and social class and suggest that factors other than screening outcome may have been at play, as has been reported before.

The wide range of high-quality work presented in this special section reflects a rapidly growing research, clinical and political interest in alcohol and its related problems. Hitherto, alcohol has often been overlooked in comparison with other major public health issues such as smoking and obesity. However, with such wide-ranging health and social effects that impact on parts of society, a multifaceted, multi-level response is clearly needed to tackle national and global alcohol problems. The papers published in this section represent a key contribution to the evidence-base that is needed to inform such a response.

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References


