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www.hscic.gov.uk
enquiries@hscic.gov.uk

Author: Lifestyle Statistics, Health and Social Care Information Centre

Responsible statistician: Paul Eastwood, Section Head

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## Contents

### Executive Summary
1

### 1 Introduction
4

### 2 Drinking behaviour among adults and children
6

#### 2.1 Introduction
7
#### 2.2 Alcohol consumption
8
#### 2.3 Purchases, availability and affordability of alcohol
10
#### 2.4 Alcohol consumption and socio-economic variables
12
#### 2.5 Drinking and pregnancy
12
#### 2.6 Geographic patterns of alcohol consumption
13
#### 2.7 Drinking among children
13

### References
16

### 3 Knowledge and attitudes to alcohol
17

#### 3.1 Introduction
17
#### 3.2 Adults knowledge and Attitudes to Alcohol
17
#### 3.3 Knowledge of drinking limits
18
#### 3.4 Children’s attitudes to drinking alcohol
20

### References
21

### 4 Drinking-related costs, ill health and mortality
22

#### 4.1 Introduction
22
#### 4.2 Hazardous, harmful and dependent drinking
22
#### 4.3 Discussion of drinking with health professionals and specialist treatment
23
#### 4.4 Alcohol-related hospital admissions
23
#### 4.5 Prescribing
28
#### 4.6 Deaths related to alcohol consumption
30
#### 4.7 Cost to the NHS
31

### References
32

### Appendix A: Key sources
33

### References
42

### Appendix B: Cross-departmental policies
44

### References
48
Executive Summary

Main findings

In England (unless otherwise specified):

Drinking behaviour among adults and children
- Between 2005 and 2012 the proportion of men who drank alcohol in the week before being interviewed fell from 72% to 64%, and the proportion of women fell from 57% to 52% in Great Britain.
- Among adults who had drunk alcohol in the last week, 55% of men and 53% of women drank more than the recommended daily amounts, including 31% of men and 24% of women who drank more than twice the recommended amounts in 2012.
- In real terms, between 2009 and 2012 household spending on alcoholic drinks in the UK increased by 1.3%, whilst that bought for consumption outside the home fell by 9.8%.
- In 2012, 43% of school pupils (aged 11-15) said that they had drunk alcohol at least once. This continues the downward trend since 2003, when 61% of pupils had drunk alcohol.

Drinking related costs, ill health and mortality

The report used a revised methodology for estimating alcohol-related hospital admissions following a review by Public Health England, the Department of Health and the Health and Social Care Information Centre. Consequently estimates of alcohol-related hospital admissions for 2012-13, reported in this publication, are not comparable to estimates in earlier years’ publications. A time series of estimates of alcohol-related hospital admissions, calculated using the revised methodology, for the years 2003-04 to 2011-12 were made available as additional tables on the 1st October 2014. They provide a comparable 10 year time series from 2003-04 to 2012-13.
- In 2012/13, there were an estimated 1,008,850 admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis. Of the estimated 1,008,850 alcohol related admissions:
  - 65% (651,010) were due to conditions which were categorised as partly attributable chronic conditions
  - 6% (60,830) were for conditions categorised as partly attributable acute conditions
  - males were more likely to be admitted to hospital with alcohol related diseases, injuries and conditions than females, with 65% of the overall admissions being male patients
  - however amongst under 16s, the opposite is true where females were more likely to be admitted to hospital with alcohol related diseases, injuries and conditions than males, with females accounting for 55% of all admissions
- there were 1,890 alcohol-related hospital admissions per 100,000 population in England
- the rate of alcohol-related admissions varied regionally from an estimated 2,500 per 100,000 population in North East Region to 1,500 admissions per 100,000 population in South East Region. All rates, to allow meaningful comparisons, are age and gender standardised

- In 2012/13, there were an estimated 325,870 admissions where the primary diagnosis or external causes recorded in secondary diagnosis fields were attributable to the consumption of alcohol.

- In 2013, 183,810 items were prescribed (in a primary care setting or NHS hospital) for the treatment of alcohol dependency and dispensed in the community. The Net Ingredient Cost (NIC) of these prescription items in 2013 was £3.13 million, which is an increase of £0.2 million since 2012 and just over double the NIC in 2004 of £1.51 million.

- In 2012, there were 6,490 alcohol-related deaths. This is a 19% increase from 2001 (5,476) but a 4% decrease from 2011 (6,771).
1 Introduction

This statistical report acts as a reference point for health issues relating to alcohol use and misuse, providing information obtained from a number of sources in a user-friendly format. It covers topics such as drinking habits and behaviours among adults (aged 16 and over) and school children (aged 11 to 15), drinking-related ill health and mortality, affordability of alcohol, alcohol related admissions to hospital and alcohol-related costs. The report contains previously published information and also includes additional new analyses.

The data within this report relate to England where possible. Where figures for England are not available, figures for England and Wales, Great Britain or the United Kingdom are provided.

Chapter 2 reports on alcohol consumption among adults and children, looking at how much and how often people drink, drinking patterns among different groups, the type of alcohol consumed and the affordability of alcohol.

Chapter 3 reports on adults’ knowledge of alcohol and children’s attitudes towards drinking, including their knowledge of measuring alcohol in units and awareness of the health risks of drinking.

Chapter 4 looks at the health risks associated with alcohol misuse including the number of admissions to hospital related to alcohol and the number of deaths that are linked to alcohol. Information on prescription drugs used for the treatment of alcohol dependency is also included and the cost of alcohol misuse to the NHS is considered.

A brief explanation and a short review of the quality of each of the sets of statistics used in this publication have been included in Appendix A.
2 Drinking behaviour among adults and children

2.1 Introduction

The information presented in this chapter relates to the drinking patterns of adults (aged 16 and over) and children (aged 11 to 15). A number of sources are used to describe drinking patterns, drinking among different groups in society, geographical patterns in the prevalence of drinking among adults and children, and expenditure on and affordability of alcohol.

In 2012, the survey vehicle for collecting drinking data changed from the General Lifestyle Survey (GLF) to the Opinions and Lifestyle Survey (OPN) published by the Office for National Statistics (ONS). The OPN uses the same initial approach to sampling as the GLF. That is, a random sample of addresses is drawn from the Postcode Address File (PAF). Initially, a sample of postcode sectors is drawn, and from within those, a list of addresses is chosen. GLF analysis was based on four waves of longitudinal data, weighted to produce cross-sectional estimates. The OPN only produces cross-sectional estimates. Both the OPN and GLF surveys use Computer Aided Personal Interviewing (CAPI) and the response rates to both surveys are around 60% of sampled addresses.

The latest data from the OPN is presented in the Drinking Habits Amongst Adults 2012 report. As with last year’s report, the Health and Social Care Information Centre (HSCIC) have been unable to produce any England level analysis for this report as the full dataset was not available in time. Instead Great Britain level analysis has been presented.

Average weekly alcohol consumption and maximum alcohol consumption estimates are presented in the Health Survey for England (HSE) 2012.

Data on purchased quantities of alcohol are taken from the Living Costs and Food Survey (LCFS). Alcohol price and retail price indices data are taken from the ONS publication Focus on Consumer Price Indices, while households’ disposable income data are taken from the ONS publication Household sector: Secondary Distribution of Income Account.

International comparisons on alcohol consumption are included in the report using data from the Health at a Glance 2013 published by the Organisation for Economic Co-operation and Development (OECD).

The Smoking, drinking and drug use among young people in England in 2012 (SDD12) report published by the HSCIC is the main source of data for drinking prevalence among children.

The NHS advises that men should not regularly drink more than three to four units of alcohol per day, and women should not regularly drink more than two to three units of alcohol per day. The current NHS guidelines for sensible drinking are further described in Section 6.1.2 of the HSE 2012 report and some information on guidelines and indicators used to measure consumption are described in Appendix B.
2.2 Alcohol consumption

2.2.1 Drinking in the last week

Respondents to the OPN were asked questions about their drinking in the week prior to interview.

In Great Britain:

- Between 2005 and 2012 the proportion of men who drank alcohol in the week before being interviewed fell from 72% to 64%, and the proportion of women fell from 57% to 52%.

- Between 2005 and 2012 there was a fall from 22% to 14% in the proportion of men who were frequent drinkers (those who drank alcohol on at least five days in the week before being interviewed), and from 13% to 9% in the proportion of women. In 2012 people aged 65 and over were most likely to have drunk frequently, both for men (23%) and women (14%).

- Young people (those aged 16 to 24) were more likely to have drunk very heavily (more than 12 units for men and 9 units for women) at least once during the week (27%), with similar proportions for men (26%) and women (28%). Only 3% of those aged 65 and over were very heavy drinkers.

For further information see OPN, Drinking Habits among adults 2012, Table 3.

Figure 2.1 shows how the proportion of adults who reported drinking in the last week varied by age and gender. Adults aged 45 to 64 were more likely to report drinking during the previous week than the other age groups with men aged 45 to 64 drinking more than women aged 45 to 64 (71% and 59% respectively).

Figure 2.1 - Proportion of adults in Great Britain who drank in the last week, by age group and gender, 2012
OPN, Drinking Habits among adults 2012\textsuperscript{2}, Table 3 also shows that those aged 65 and over were more likely than any other age group to have drunk on 5 or more days in the previous week (23% of men and 14% of women) compared to 5% and 2% of men and women (respectively) aged 16 to 24.

### 2.2.2 Maximum daily consumption in the last week

HSE 2012\textsuperscript{3}, Chapter 6, Tables 6.5 to 6.10 show findings for maximum daily consumption of alcohol in the last week for England.

HSE 2012, Table 6.5 shows:

- 67% of men had drunk alcohol in the last week; this included 30% of men who did not exceed 4 units on any day that they drank, 17% who drank between 4 and 8 units, and 21% who drank more than 8 units on at least one day in the last week.
- 53% of women had drunk alcohol in the last week, including 25% who drank 3 units or less on the day drank most, 16% who had drunk between 3 and 6 units and 13% who had drunk more than 6 units on at least one day.
- More than a quarter of 16 to 24 year old men (27%) drank more than twice the recommended daily amount (more than 8 units). This proportion was slightly lower (between 22% and 24%) among men aged 25 to 64. Smaller proportions of older men drank at this level; 11% of those aged 65 to 74, and 2% of those aged 75 and over. Similarly, the proportion of women who drank more than 6 units declined broadly with age from 19% of 16 to 24 year olds to 1% of those aged 75 and over.

HSE 2012, Table 6.6 shows:

- Among adults who had drunk alcohol in the last week, 55% of men and 53% of women drank more than the recommended daily amounts, including 31% of men and 24% of women who drank more than twice the recommended amounts.

HSE 2012, Table 6.8 shows similar information broken down by equivalised household income and Table 6.9 by Index of Multiple Deprivation. Table 6.10 shows the types of drinks consumed on the day of maximum alcohol consumption.

### 2.2.3 Types of alcohol consumed

HSE 2012, Chapter 6, Table 6.10 shows the types of drinks consumed on the day of maximum alcohol consumption in the last week. The key findings were as follows:

- The types of drink consumed on the day that men and women drank the most in the last week varied with age and sex. The majority of men had drunk normal strength beer, lager, cider or shandy (62%); a third had drunk wine (33%), and just over a fifth had drunk spirits (22%). In contrast, the majority of women had drunk wine (64%); a quarter had drunk spirits (26%), and a fifth (19%) had drunk normal strength beer, lager, cider or shandy.
- The proportions of men and women who had drunk normal strength beer, lager, cider and shandy declined with age. Among men and women, drinking spirits was most likely among those aged between 16 and 34 (particularly those in the youngest age group), and among men aged 75 and over. The proportion of men who drank wine increased with age.
- The proportions of women who drank wine also increased with age, levelling out at those aged 55 to 74, and decreasing in the oldest age group. The proportions who
drank fortified wines and alcopops were each very small, but consumption of these was concentrated in particular age groups. 1% of men and 4% of women had drunk fortified wine, but this included 7% of men and 20% of women aged 75 and over. 2% of both men and women had drunk alcopops, but these were most likely to be aged 16 to 24 (14% of young men, 10% of young women).

### 2.2.4 Estimated weekly alcohol consumption

HSE 2012, Chapter 6, Tables 6.11 to 6.15 show findings for estimated weekly alcohol consumption.

HSE 2012, Table 6.11 shows:

- 62% of men usually drank up to 21 units a week and 61% of women usually drank up to 14 units a week (the level of drinking defined as lower risk). The likelihood of drinking at this level did not vary significantly by sex or age.

- Almost a quarter of men (24%) drank more than 21 units a week, including 5% who drank more than 50 units (a level considered to be higher risk). Among women, 18% usually drank more than 14 units a week, including 4% who drank more than 35 units, and were therefore at higher risk from their drinking.

HSE 2012, Table 6.12 shows:

- Men were more likely than women to drink at the level defined as higher risk (5% and 4% respectively). For men, higher risk drinking was most likely between the ages of 55 and 64 (7%); among women there was little variation in the proportion who drank at this level between the ages of 16 and 64 (4% or 5% in each age group).

Table 6.13 shows similar information by region, Table 6.14 by equivalised household income and Table 6.15 by Index of Multiple Deprivation.

### 2.3 Purchases, availability and affordability of alcohol

#### 2.3.1 Purchases

The purchase of alcoholic drinks bought for consumption within the home in the United Kingdom (UK), as reported by the LCFS, have increased overall since 1992 from 527 millilitres (ml) per person per week, peaking in 2003/04 at 792 ml per person per week. In 2012, this figure was 700 ml per person per week, a 33.0% increase since 1992 (see Table 2.1). Yorkshire and the Humber had the highest purchases of alcohol at 874 ml per person per week, 400 ml per person higher than the lowest level in London.

Some of the key findings of the LCFS 2012 covered in the *Family Food 2012* report also show that:

- In real terms, between 2009 and 2012 household spending on food and drink fell by 3.1% and eating out expenditure by 5.6%. Household spending on alcoholic drinks increased by 1.3% over the same period, whilst that bought for consumption outside the home fell by 9.8%.

- Alcohol intake fell 7.5% in 2012 to 9.4 grams per person per day. Since 2009 intake has been on a downward trend. Eating out purchases accounted for 23% of total alcohol intake in 2012. Eating out intakes of alcohol were 22% lower in 2012 than in 2009 and showing a significant downward trend.
2.3.2 Availability

Information on the volume of alcohol released for home consumption is collected by Her Majesty’s Revenue and Customs and relates to the United Kingdom as a whole. The data on alcohol released for home consumption excludes personal imports (both legal and illegal).10

2.3.3 Affordability

The Health and Social Care Information Centre (HSCIC) has routinely published a series of indices derived from ONS data in its Statistics on Alcohol: England reports. These include the alcohol price index (API), retail price index (RPI), relative alcohol price index (defined as API / RPI), real households’ disposal income (RHD) and the affordability of alcohol index (defined as RHD / relative price index).

For information on the methodology see Appendix A.

Figure 2.2 - Alcohol affordability index in the United Kingdom: 1980 to 2013

In the UK, prices of alcoholic drinks, as measured by the alcohol price index (see Table 2.2):

- have increased more than the retail price index since 1980 (an arbitrarily chosen base year).
- between 1980 to 2013 the price of alcohol increased by (nearly) 24% more than retail prices generally.
- real households’ disposal income per adult (adjusted) increased by 99% over the same period.
- alcohol in 2013 was nearly 61% more affordable than it was in 1980, highlighting the overall trend of increasing affordability over the period.
The alcohol price index used in the affordability index relates to a ‘basket of alcoholic drinks’ chosen by the ONS and provides an overall picture of the affordability of alcohol. It is not designed to measure the affordability of the cheapest alcohol, and neither is it designed to measure the affordability of pure alcohol. It is intended to be used as a national measure – its relevance at an individual level will depend on the extent to which an individual’s choice of drinks match the drinks included in the measure.

2.4 Alcohol consumption and socio-economic variables

2.4.1 Economic activity status

OPN, Drinking Habits in 2012\textsuperscript{9}, Table 7 shows variations in alcohol consumption by employment status in Great Britain:

- A higher proportion of working adults (65%) drank in the last week than those who were unemployed (not working but looking for work) (47%). This is in contrast to findings from the \textit{Opinions and Lifestyle Survey - Smoking Habits Amongst Adults, 2012} publication\textsuperscript{11}, which found that the level of smoking prevalence in 2012 was highest amongst those who were unemployed (not working but looking for work).

2.4.2 Other socio-economic variables

OPN, Drinking Habits in 2012 also show variations in alcohol consumption in Great Britain by:

- Relationship status (Table 8)
- Ethnicity (Table 9)
- Smoking status (Table 11)

2.5 Drinking and pregnancy

OPN, Drinking Habits in 2012, Table 12 shows that in Great Britain:

- Pregnant women aged 16 to 49 were far less likely than women who were not pregnant to have drunk in the last week. One in 10 pregnant women drank in the last week compared with five in 10 of all other women.

- None of the pregnant women interviewed were frequent drinkers, compared with 5% of all other women aged 16 to 49.

Information on drinking during pregnancy is collected as part of the Infant Feeding Survey (IFS), the latest survey being \textit{Infant Feeding Survey 2010}\textsuperscript{12}. The main focus of the survey is the prevalence of breast feeding, however the new mothers interviewed are also asked about their drinking behaviours before, during and after pregnancy.

Key findings from the IFS show that in 2010 in England, of the women who drank before pregnancy, 48% gave up (33% in 2005) while they were pregnant and 47% (62% in 2005) said they cut down on the amount drank while 2% reported no change/drank more (4% in 2005) to their drinking patterns.

Further details are provided within Chapter 11 of the IFS 2010 report.
2.6 Geographic patterns of alcohol consumption

2.6.1 International comparisons

The Organisation for Economic Co-operation and Development (OECD) report *Health at a Glance 2013* includes data on alcohol consumption among adults across different countries.

Figure 2.6.1 in the OECD report shows alcohol consumption for the population aged 15 and over in 2011 (or the nearest year) and change between 1990 and 2011.

Although average alcohol consumption has gradually fallen in many OECD countries over the past two decades, it has risen in several Northern European countries (Iceland, Sweden, Norway and Finland) as well as in Poland and Israel. There has been a degree of convergence in drinking habits across the OECD, with wine consumption increasing in many traditional beer-drinking countries and vice versa. The traditional wine-producing countries of Italy, Greece, Spain, Portugal and France, as well as the Slovak Republic, Switzerland and Hungary have seen per capita consumption fall by one fifth or more since 1990.

The OECD report also provides estimates for drunkenness which record the proportions of 15-year-old children saying they have been drunk twice or more in their lives in 2009-10.

Figure 2.1.2 in the report shows that drunkenness is reported to have been experienced at least twice by more than 40% of 15-year-olds in the Czech Republic, Denmark, Estonia, Finland, Hungary, Slovenia and the United Kingdom. Much lower rates (less than 20%) are reported in Iceland, Italy, Luxembourg, the Netherlands, and the United States. Across all surveyed OECD countries, boys are more likely than girls to report repeated drunkenness (32% vs. 28%). France, Hungary, and Slovenia have the biggest differences, with rates of alcohol abuse among boys at least 9 percentage points higher than those of girls. In four countries, Finland, Spain, Sweden and the United Kingdom, more girls than boys report repeated drunkenness (around 5-7 percentage points).

2.6.2 Alcohol consumption by region

Table 6.7 of the HSE 2012 report shows the maximum alcohol consumption on any day in the last week by region. Among adults who had drunk alcohol in the last week, the proportions who drank above recommendations on at least one day in the last week varied between regions:

- Among men who had drunk in the last week the proportion who had drunk more than 4 units in one day was lowest in the South West (49%) and highest in the North West (64%). Among women, the proportion who drank more than 3 units on at least one day varied between 45% in the South West and 66% in the North East.

- The proportions of men who drank more than twice the recommended amounts on a single day varied between 24% (London) and 45% (the North East). The proportions of women who drank more than twice the recommended amounts on a single day varied between 15% to 16% (the South West and London respectively) and 37% (the North East).

2.7 Drinking among children


The key findings for 2012 are:
- 43% of pupils said that they had drunk alcohol at least once. This continues the downward trend since 2003, when 61% of pupils had drunk alcohol.

- Boys and girls were equally likely to have drunk alcohol. The proportion of pupils who had drunk alcohol increased with age from 12% of 11 year olds to 74% of 15 year olds.

- 10% of pupils had drunk alcohol in the last week. The prevalence of recent drinking has reduced significantly since 2003, when 26% of pupils had drunk in the last week, and is lower than in 2011 (12%).

- Similar proportions of boys and girls had drunk alcohol in the last week. The proportion increased with age from 1% of 11 year olds to 25% of 15 year olds.

- Pupils who had drunk in the last week had drunk an average (mean) of 12.5 units. Median consumption – which gives a more representative indication of how much pupils drink – was lower (8.0 units).

- Most pupils who had drunk alcohol in the last week had consumed more than one type of drink. Compared with boys, girls were less likely to have drunk beer, lager or cider, and more likely to have drunk, spirits, alcopops or wine. Both boys and girls consumed the majority of their alcohol intake in the form of beer, lager or cider.

- 33% of pupils said that they had obtained alcohol in the last week. This continues the downward trend since 2004 when 49% said they had obtained alcohol in the last week. The most common ways of obtaining alcohol were to be given it by parents (19%), given it by friends (19%), to ask someone else to buy it (13%), or to take it from home (13%).

- Under half of pupils who drank alcohol (44%) said they bought it. Pupils who had bought alcohol had usually done so from friends (53%), someone other than family or friends (34%), off-licences (32%) or shops or supermarkets (24%).

- Pupils who drank alcohol were most likely to do so in their own home (54%), someone else’s home (48%), at parties with friends (47%), or somewhere outside (18%). Since 2006, there has been an increase in the proportions who usually drink at home or in other people’s homes or at parties with friends, and a reduction in the proportion drinking outside.

- Pupils were most likely to drink with friends of both sexes (57% of current drinkers), their parents (53%), brothers, sisters or other relatives (37%) or friends of the same sex (37%). Younger pupils were most likely to drink with family members, older pupils were most likely to drink with friends.

- Half (50%) of pupils who had drunk alcohol in the last four weeks said that they had been drunk at least once during that time. Although 61% said that they had deliberately tried to get drunk, 39% said they had not.

- Pupils are more likely to drink if they live with other people who drink alcohol. 83% who lived with no one who drank alcohol had never drunk alcohol, compared with 30% of pupils who lived with three or more drinkers.

### 2.7.1 Regional comparisons of drinking among children

The SDD12 report presents drinking estimates by the nine English regions in Chapter 6 based on 2011 and 2012 data combined.

SDD12, Table 6.3 shows the proportion of pupils who have ever drunk alcohol by region and sex. Table 6.4 shows the proportions of pupils who drank alcohol in the last week by region.
and Table 6.5 shows mean consumption of alcohol by pupils who drank in the last week, by region and sex.

- The proportion of pupils who drank alcohol was lower in London than anywhere else; 31% of pupils in London had ever drunk alcohol, and 7% had drunk in the last week.

- Outside London, the proportion of pupils who had ever drunk alcohol ranged from 36% in the West Midlands to 51% in the North East, and the same pattern was seen for drinking alcohol in the last week.

Similar regional variations were found in the analysis of data for the SDD2011 report\(^{13}\).
References

1. ONS Opinions and Lifestyles Survey


   http://www.defra.gov.uk/statistics/foodfarm/food/familyfood/datasets/


   http://www.oecd.org/els/health-systems/health-at-a-glance.htm

   http://www.hscic.gov.uk/pubs/sdd12


10. HM Revenue and Customs, Tax and Duty bulletins


    http://www.hscic.gov.uk/pubs/infantfeeding10final

    http://www.hscic.gov.uk/pubs/sdd11fullreport
3 Knowledge and attitudes to alcohol

3.1 Introduction

The information presented in this chapter relates to adults’ knowledge and awareness of alcohol and children’s attitudes to drinking.

There are three sources used, The Office for National Statistics (ONS) Omnibus Survey Report Drinking: adults’ behaviour and knowledge in 2009 which ran biannually but is now discontinued. The last report was published in 2009 using data collected from 2008/09. The survey report presented results from questions about drinking over several years, allowing comparisons to be made over time. The survey used a small sample size and asked respondents about knowledge and attitudes. The survey provided Great Britain level data.

The Heath Survey for England 2007 (HSE07) asked questions of people’s knowledge and attitudes towards alcohol. It used a larger sample size and different population sample to the Omnibus survey report. There have been more recent HSE reports, however these have not had the same focus on knowledge and attitudes so the 2007 data remains the most recent.

In general, the HSE07 estimates levels of knowledge to be slightly higher than the Omnibus survey report on drinking. As the two surveys are of different populations, ask slightly different questions and cover different geographies, it is expected that estimates are slightly different.

Smoking, drinking and drug use among young people in England in 2012 (SDD). The survey began in 1982 and since 1998 each survey has included a core section of questions on smoking, drinking and drug use and from 2000 there has been a focus on either smoking and drinking, or drug use. The emphasis of the 2012 survey was on smoking and drinking.

3.2 Adults knowledge and Attitudes to Alcohol

3.2.1 Knowledge of Units

Advice on the amount people should drink has to be provided in such a way that it applies to the wide range of different types of alcohol people may drink, which can have very different alcohol content. Advice on drinking is therefore given in terms of units, and for people to be able to monitor how much they drink, they need to understand what is meant by a unit of alcohol, and how many units different drinks contain. Drinking guidelines are available in Appendix B.

The 2009 Omnibus survey report on drinking asked respondents whether they had heard of measuring alcohol consumption in units

- 90% of respondents said that they had. This has steadily increased from 79% in 1997. Men and women were equally likely to have heard of alcohol units and the increase in knowledge since 1997 has occurred among both men and women.

- On the whole, the more people drank, the more likely they were to have heard of units: 95% of those with the highest average weekly consumption (22 units and over for men and 15 units and over for women) had heard of units, compared with only 71% of those who did not drink at all (see Table 3.1).

- Those aged 65 and over were less likely to have heard of alcohol units: 80% had done so, compared with 88% of the youngest age group (16 to 24).
Although average weekly alcohol consumption is not strongly related to socio-economic classification, there were marked differences in awareness of units between those in different occupations. Those in managerial and professional occupational groupings were the most likely to have heard of measuring alcohol in units (96%), and those in routine and manual occupations the least likely to have done so (87%) (see Tables 3.2 and 3.3).

In the HSE07 most adults (92% of men and 89% of women) had heard of units; this was most common among adults aged between 35 and 64.

### 3.2.2 Awareness of Units and Alcohol Content

It is especially important that people are aware of the alcohol content of drinks they themselves drink. Therefore, for each of the most common types of drink, the 2009 Omnibus survey asked respondents who had drunk that particular drink in the last year if they knew what a unit of that drink was.

Results found that those who frequently drink a particular type of alcohol at least once a week were aware of its alcohol content. Those who drank beer and those who drank wine at least once a week were much more likely to know how many units were in that drink than were those who seldom drank these drinks, but even so, about a third (31%) of frequent beer drinkers and a sixth (17%) of frequent wine drinkers were not aware of the number of units in what they were drinking. Differences according to frequency of consumption were much less marked for those who drank spirits and fortified wine (see Table 3.4).

Further information on respondents’ awareness of units for different types of alcohol can be found in the ONS Omnibus Survey Report Drinking: adults’ behaviour and knowledge in 2009, Chapter 4.

In the HSE07, results showed that accurate knowledge of the content of different drinks in units varied with age, being highest among 25 to 54 year olds.

It was also related to what people actually drank. Seventy seven per cent of men and 73% of women who had drunk wine on the day they drank most in the last week said correctly that a 125 ml glass of wine contained one or two units, compared with 65% of men and 60% of women who had not drunk wine on the day they drank most in the last week (though they may have drunk wine on other days).

A similar, though less marked pattern was seen for beer and spirits. Further information can be found in HSE07, Chapter 7.

### 3.3 Knowledge of drinking limits

#### 3.3.1 Alcohol consumption

The 2009 Omnibus survey report on drinking asked respondents whether or not they kept a check on the number of units they drank: 13% said that they did.

It should be noted however, given that not all respondents who drank each type of drink knew how many units were contained therein, the likelihood of them keeping an accurate check was, in some cases, low.

Although men were more likely than women to drink heavily (see Chapter 2 of this report for details), they were not more likely to keep a check in terms of units on how much they drank – overall,

- 12% of men and 14% of women who had heard of units did so.
Women who did keep a check on units were slightly more likely to do so on a weekly basis (6%) than on the daily basis (2%) suggested by the government’s current advice on sensible drinking. There was no difference among men.

The percentage of people who kept a daily or a weekly check on the number of units drunk has remained similar over the period covered by the surveys varying between 11% and 16% between 1997 and 2009.

Among men who had heard of units, those who drank less than 10 units a week were less likely than others to keep a daily or weekly check on the number of units drunk. Among women, those who drank less than 1 unit a week were least likely to keep a check (see Tables 3.5 and 3.6).

In the HSE07 results showed the majority of adults who drank in the last week exceeded recommendations on at least one day; 59% of men and 55% of women had done so. This was more likely in adults of working age than those aged 65 or over.

Among adults who drank in the last week, 35% of men and 27% of women had drunk more than twice the recommended levels on at least one day in the last week. This was most common among the youngest age group (56% of men and 52% of women aged between 16 and 24), and decreased with age to 6% of men and 3% of women aged 75 and over.

3.3.2 Daily drinking limits

The 2009 Omnibus survey report on drinking asked respondents if they had ever heard of the recommended maximum number of alcohol units that people should drink in a day.

There has been an increase from 54% in 1997 to 75% in 2009 in the percentage of people who had heard of daily drinking limits. Throughout the period, differences between men and women have been slight.

Male non-drinkers and those who drank very little were less likely to have heard of daily drinking limits than heavier drinkers.

The percentage of men who drank less than 1 unit a week who had heard of daily drinking limits increased significantly from 49% in 2007 to 65% in 2009.

Women, non-drinkers were the least likely to have heard of daily drinking limits and heavier drinkers the most likely. 70% of women who drank less than 1 unit a week had heard of daily consumption levels compared with 86% of those who drank 15 units or more a week (see Tables 3.7 and 3.8).

The HSE07 results showed:

- 35% of men and 47% of women had heard of units but said they didn’t know what the recommendations were for men
- 39% of men and 43% of women similarly knew about units but said they did not know the recommendations for women.

Those who attempted to define the recommendations were more likely to be wrong than right. General awareness of units was higher among men and women who had drunk alcohol in the last week but most adults who drank more than the recommended amounts either did not know what these limits were or could not identify them correctly. Information on government recommendations for consumption are contained in Appendix B.
3.4 Children’s attitudes to drinking alcohol

In *Smoking, drinking and drug use among young people in England in 2012* (SDD) pupils were asked about their attitudes to drinking alcohol, including their perceptions of parents views on drinking alcohol and being drunk.

The key findings are:

- About half (52%) of pupils thought their parents didn’t like them drinking, slightly more than the proportion who said their parents didn’t mind as long as they didn’t drink too much (47%). Few pupils (1%) said their parents let them drink as much as they liked. There was a strong relationship between pupils’ drinking behaviour and their parents’ attitudes to their drinking. 87% of pupils who felt their parents would disapprove of their drinking had never drunk alcohol, compared with 28% who thought their parents wouldn’t mind as long as they didn’t drink too much.

- There has been a fall in recent years in the proportion of pupils who think that drinking is acceptable for someone of their age. In 2012, 28% thought it was OK for someone of their age to drink once a week compared with 46% in 2003.

- Pupils were most likely to think that people of their age drink to look cool in front of their friends (77%), because it gives them a rush or buzz (68%), to be more sociable with friends (66%) or because their friends pressure them into it (61%). Pupils’ beliefs about why people of their age drink alcohol vary according to whether or not they have drunk alcohol themselves. Pupils who had never drunk alcohol were more likely than those who had to think that people of their age drink because of social pressures: to look cool in front of their friends or because their friends pressure them into it. Pupils who have drunk alcohol are more likely than non-drinkers to believe that people their age drink to be sociable with friends or because it gives them a rush or buzz.

In the HSE07 children aged 13 to 15 were asked about their perceptions of their parents’ views on drinking alcohol. Those who stated that they ever drank alcohol were asked whether their parents knew about it, and if so what their parents thought about them drinking alcohol. Very few who drank thought that their parents were unaware of this (5% of boys and 3% of girls). Among the rest, a minority said that their parents did not like them drinking (21% of boys and 17% of girls), while a slightly greater percentage said that their parents did not mind (38% and 35% respectively), or that their parents’ views on their drinking varied (26% and 33% respectively).
References

   http://www.ons.gov.uk/ons/release-calendar/index.html?pagetype=calendar-entry&pageSize=50&newquery=drinking+behaviour&sortBy=releaseDate&sortDirection=DESCENDING&releaseDateRangeType=allDates

   http://www.hscic.gov.uk/pubs/hse07healthylifestyles

   www.hscic.gov.uk/pubs/sdd12
4 Drinking-related costs, ill health and mortality

4.1 Introduction

Alcohol misuse can cause serious harm to a person’s health. This chapter presents information on:

- the prevalence of hazardous, harmful and dependent drinking
- the proportion of drinkers who had discussed drinking with a health professional
- the estimated number of alcohol-related hospital admissions
- drugs prescribed for the treatment of alcohol dependence
- the number of deaths from causes directly related to alcohol consumption
- the estimated cost to the NHS of alcohol misuse

4.2 Hazardous, harmful and dependent drinking

Chapter 9 of the report *Adult Psychiatric Morbidity in England - 2007, Results of a household survey* (APMS2007) presents prevalence estimates of hazardous and harmful drinking, and of alcohol dependence in the adult general population. Findings from this survey are summarised below. It should be noted that a survey of the household population such as this is likely to under-represent dependent adults, who are more likely to be homeless or in an institutional setting. Moreover, problem drinkers who do live in private households may, like problem drug users, be less available, able or willing to participate in surveys.

Hazardous drinking is a pattern of alcohol consumption carrying risks of physical and psychological harm to the individual. Harmful drinking denotes the most hazardous use of alcohol, at which damage to health is likely. One possible outcome of harmful drinking is alcohol dependence, a cluster of behavioural, cognitive, and physiological phenomena that typically include a strong desire to consume alcohol, and difficulties in controlling drinking.

Hazardous and harmful drinking was measured using the AUDIT (Alcohol Use Disorders Identification Test). Alcohol dependence was assessed using the SADQC (Severity of Alcohol Dependence Questionnaire, community version).

- The prevalence of hazardous drinking identified by APMS 2007 was 24.2% (33.2% of men, 15.7% of women). This included 3.8% of adults (5.8% of men, 1.9% of women) whose drinking could be categorised as harmful. In men, the highest prevalence of both hazardous and harmful drinking was in 25 to 34 year olds, in women in 16 to 24 year olds.
- The prevalence of alcohol dependence was 5.9% (8.7% of men, 3.3% of women). For men, the highest levels of dependence were identified in those between the ages of 25 and 34 (16.8%), for women in those between the ages of 16 and 24 (9.8%). Most recorded dependence was categorised as mild (5.4%), with relatively few adults reporting symptoms of moderate or severe dependence (0.4% and 0.1% respectively).
- The prevalence of alcohol dependence was lower for men in 2007 than in 2000, whereas it remained at a similar level in women.
- Alcohol dependence was more common in white men and women than in those from minority ethnic groups. There were no significant variations in the prevalence of
dependence by region or income. However, the likelihood of being a hazardous drinker did vary between regions.

- 14% of alcohol dependent adults were currently receiving treatment for a mental or emotional problem. Dependent women (26%) were more likely than dependent men (9%) to be in receipt of such treatment.

Full details and further breakdowns are available in chapter 9 of the report *Adult Psychiatric Morbidity in England - 2007, Results of a household survey* (APMS2007)

### 4.3 Discussion of drinking with health professionals and specialist treatment

#### 4.3.1 Discussion of drinking with health professionals

The ONS Omnibus Survey 2009\(^2\) is still the most-up-to-date source of information on discussion of drinking with health professionals.

Respondents to the Omnibus Survey 2009 (the last year that this survey covered alcohol), carried out by the ONS, were asked if, in the last year, they had had any discussions about drinking with their General Practitioner (GP), someone else at the surgery, another doctor or any other medical professional.

In Omnibus Survey 2009, Tables 4.17 to 4.19, one in ten male drinkers and a slightly lower proportion of female drinkers (7%) had such discussions in the last year, the majority of these with their GP. There has been little change since 2000, when this question was first asked, in the proportions having such discussions.

#### 4.3.2 Specialist alcohol treatment

From April 2008, the National Treatment Agency for Substance Misuse started collecting and monitoring data on specialist alcohol treatment, requiring providers of specialist treatment for alcohol misuse to submit data to the National Drug Treatment Monitoring System (NDTMS), which has been in existence since 2004. The NDTMS provides an on-going published dataset on specialist alcohol and drug treatment in England. The NDTMS is now managed by Public Health England and a copy of the 2012/13 Alcohol Treatment in England report can be found on the Public Health England website\(^3\).

### 4.4 Alcohol-related hospital admissions

This section presents information on Finished Admission Episodes (referred to here as hospital admissions) with diseases, injuries and conditions that can be attributed to alcohol consumption. Estimates of the number of alcohol-related hospital admissions are presented. These have been calculated by applying alcohol-attributable fractions (AAFs) to the number of hospital admissions. AAFs take account of patient age, sex and diagnosis to estimate the number of admissions attributable to alcohol consumption.

Work in this area was carried out by the North West Public Health Observatory (now part of Public Health England (PHE)) on commission by the Department of Health using Hospital Episode Statistics\(^4\) (HES) data from the HSCIC. This is used to determine the proportions of a wide range of diseases and injuries that can be partially attributed to alcohol as well as those that are, by definition, wholly attributable to alcohol.

PHE also publish local level information on alcohol related admissions in the Local Alcohol Profiles for England (LAPE)\(^6\).
Hospital admissions data on diagnoses are based on the tenth revision of the International Classification of Diseases (ICD-10). The list of the ICD-10 codes for diseases, injuries and conditions found to be wholly or partly attributable to alcohol can be found in the tables (these have been amended following the public consultation). For the purpose of this report, the diseases, injuries and conditions have been split into those which are wholly attributable to alcohol (‘alcohol-specific’) such as alcoholic liver disease or mental and behavioural disorders due to the use of alcohol, and those which are partly attributable to alcohol such as some cancers, accidents and injuries.

Estimates of the number of alcohol-related admissions to hospital are calculated using information on patients’ characteristics and diagnoses from the HES databank, together with estimates for the proportion of cases of a particular disease or injury that are caused by alcohol consumption, known as alcohol-attributable fractions (AAFs). AAFs were calculated where a causal relationship with alcohol consumption has been established using a method devised by North West Public Health Observatory. For some conditions, all cases are caused by alcohol consumption and so all admissions for these conditions are included (e.g. alcoholic liver diseases), whereas other conditions are partially attributable to alcohol, meaning that only a fraction of these cases can be attributable to alcohol consumption (e.g. cancer of the oesophagus).

For each episode of care in hospital, clinicians record the primary diagnosis and up to 19 secondary diagnoses. The primary diagnosis is defined in the NHS Data Dictionary as “the main condition treated or investigated during the relevant episode of healthcare”.

A review of the methodology used to estimate alcohol related admissions took place in the form of a public consultation led by the North West Public Health Observatory working with the Department of Health and the Health and Social Care Information Centre (HSCIC). The consultation was launched on 31 May 2012 and ran for 12 weeks. The responses to the consultation were considered and summarised and are available on the LAPE website.

As a result of this consultation the following changes have been made to this publication:

1. Revised alcohol attributable fractions will be used to estimate the number of alcohol-related hospital admissions.
2. The alcohol-related diagnoses reported on have been revised.
3. The previous measure based on primary diagnosis only has been revised to use alcohol-related primary diagnoses or alcohol-related external causes recorded in secondary diagnosis fields.

Within this publication, two main measures of alcohol related admissions are presented:

- **broad measure** - derived by summing the alcohol attributable fraction associated with each admission based on the diagnosis most strongly associated with alcohol out of all diagnoses (both primary and secondary)
- **narrow measure** - is constructed in a similar way but counts only the fraction associated with the diagnosis in the primary position or alcohol-related external causes recorded in secondary diagnosis fields.

Within each of these measures, the data can be broken down into admissions that are wholly and partially attributable to alcohol, according to the required purpose.

The report used a revised methodology for estimating alcohol-related hospital admissions following a review by Public Health England, the Department of Health and the Health and Social Care Information Centre. Consequently estimates of alcohol-related hospital
admissions for 2012-13, reported in this publication, are not comparable to estimates in earlier years’ publications. A time series of estimates of alcohol-related hospital admissions, calculated using the revised methodology, for the years 2003-04 to 2011-12 were made available as additional tables on the 1st October 2014. They provide a comparable 10 year time series from 2003-04 to 2012-13.

In a number of cases, the epidemiological studies on which the AAFs were based estimated the increased risks of morbidity in the general population, rather than among those admitted to hospital. Where this is the case, applying these AAFs to admissions involves making the assumption that the AAFs for admitted patients are the same as those for the general population.

In some of the cases where an admission episode contains an alcohol-related condition in a secondary diagnosis field but not the primary diagnosis field, the condition may not have been a causal factor leading to the admission. Rather, it may be a complicating factor and affect the care that is given to the patient, potentially making treatment more costly. The estimates calculated based on the broad measure are felt to give a better estimate of the number of admissions to hospital caused or affected by alcohol consumption at a particular time or place and hence the pressure put on the health system, rather than a measure of admissions directly caused by alcohol.

Information based on the narrow measure provides a less complicated picture of trends in alcohol-related admissions over time, although it gives an incomplete picture of admissions resulting from or affected by alcohol consumption. This is because in some cases, the secondary diagnoses will have been a contributing factor to the admission to hospital. This is particularly true of external causes of admission such as accidents and violence, which are never recorded as a primary diagnosis, but some of which can be attributed to alcohol.

The number of admissions per 100,000 population have been standardised to the England population. These figures will differ from those in the Local Alcohol Profiles for England (LAPE) published by Public Health England where the European Standard population was used to standardise the number of admissions per 100,000 population.

The Department of Health have developed an alcohol-related admissions indicator for inclusion in the Public Health Outcomes Framework. Currently the preferred option is for an indicator which estimates alcohol related admissions based on the narrow measure (primary diagnoses or alcohol-related external causes recorded in secondary diagnosis fields). The Public Health Outcomes Framework states that this is in order to “minimise the risk of perverse consequences from any changes in coding practice so the indicator rewards local areas for good performance”.

### 4.4.1 Alcohol-related admissions based on the broad measure (primary and secondary diagnoses) - admissions relating to wholly and partially attributable conditions combined

In 2012/13, there were an estimated 1,008,850 admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis (broad measure).

Of the estimated 1,008,850 alcohol related admissions (broad measure) in 2012/13:

- 65% (651,010) were due to conditions which were categorised as partly attributable chronic conditions
- 6% (60,830) were for conditions categorised as partly attributable acute conditions
- 20% (198,600) were for mental and behavioural disorders due to alcohol (Table 4.1)
• males were more likely to be admitted to hospital with alcohol related diseases, injuries and conditions than females, with 65% of the overall admissions being male patients

• however amongst under 16s, the opposite is true where females were more likely to be admitted to hospital with alcohol related diseases, injuries and conditions than males, with females accounting for 55% of all admissions (Table 4.2)

• there were 1,890 alcohol-related hospital admissions per 100,000 population in England

• the rate of alcohol-related admissions varied regionally from an estimated 2,500 per 100,000 population in North East Region to 1,500 admissions per 100,000 population in South East Region. All rates, to allow meaningful comparisons, are age and gender standardised (Table 4.3)

The mid-2012 population estimates were used to derive age-group and gender specific rates for each area. The age and gender standardised rate is obtained as a weighted sum of the age group and gender specific rates, where the weights are the proportion of the England population in each age and gender group.

4.4.2 Alcohol-related admissions based on the broad measure - admissions relating to wholly attributable conditions only

Out of 1,008,850 alcohol-related admissions in 2012/13, roughly 297,010 of these were for diseases or injuries that were wholly attributable to alcohol consumption or ‘alcohol-specific’ (i.e. had an attributable fraction of 1).

Of this group,

• mental and behaviour disorders due to the use of alcohol (ICD-10 code F10) was the most common alcohol-related diagnosis, accounting for two-thirds of admissions (198,600)

• around 50,510 admissions were for alcoholic liver disease (ICD-10 code K70)

• 33,870 admissions were for the toxic effects of alcohol types which are common in alcoholic drinks (ICD-10 codes T51.0, T51.1 and T51.9) (Table 4.1)

Among different age groups, those aged 75 and over had the lowest number of admissions of all adults where the primary or secondary diagnosis was wholly attributable to alcohol. There was a peak in admissions among those aged 45 to 54 (Table 4.2 and Figure 4.1).
4.4.3 Alcohol-related admissions based on the broad measure - admissions relating to partially attributable conditions only

Of the 1,008,850 admissions in 2012/13,

- around 711,840 admissions were for reasons that are partly attributable to alcohol consumption (i.e. the attributable fraction associated with the diagnosis (either primary or secondary) most strongly associated with alcohol consumption was less than 1)
- over half (57%) of these partly attributable admissions were for hypertensive diseases (ICD-10 codes I10 – I15), accounting for approximately 404,650 admissions. Admissions with other partly attributable diseases, injuries or conditions were much lower in comparison
- second highest condition in this category was cancer (ICD-10 codes C00 – C15, C18 – C22, C32 and C50) with 83,510 admissions (Table 4.1).

4.4.4 Alcohol-related admissions based on the narrow measure (primary diagnosis plus external cause code in secondary diagnosis fields) - admissions relating to wholly and partially attributable conditions combined

In 2012/13, there were an estimated 325,870 admissions where the primary diagnosis or alcohol-related external causes recorded in secondary diagnosis fields were attributable to the consumption of alcohol (the narrow measure) (Table 4.4).

Of these,

- 42% (136,280) were due to conditions which were categorised as partly attributable chronic conditions
- 27% (86,420) were for conditions categorised as partly attributable acute conditions
- 32% (103,160) were for wholly attributable conditions (Table 4.4)
• more males than females were admitted to hospital with a primary diagnosis or external cause code of a condition attributable to alcohol (202,580 and 123,280 admissions respectively)

• however amongst under 16s, the opposite is true where females were more likely to be admitted to hospital with alcohol related diseases, injuries and conditions than males, with females accounting for 57% of all admissions (Table 4.5)

• there were 610 alcohol-related hospital admissions per 100,000 population in England

• the rate of alcohol-related admissions varied regionally from 820 per 100,000 population in North East Region to 490 admissions per 100,000 population in South East Region. All rates, to allow meaningful comparisons, are age and gender standardised (Table 4.6)

4.4.5 Alcohol-related admissions based on the narrow measure (primary diagnosis plus external cause code in secondary diagnosis fields) - admissions relating to wholly attributable conditions only

In 2012/13, there were around 103,160 admissions where the primary diagnosis or alcohol-related external causes recorded in secondary diagnosis fields were wholly attributable to alcohol consumption or ‘alcohol-specific’ (i.e. had an attributable fraction of 1).

Of this group,

• mental and behavioural disorders due to alcohol was the most common reason for hospitalisation with 44,300 admissions

• intentional self-poisoning by and exposure to alcohol and also alcoholic liver disease were the next two most common reasons for hospitalisation (around 30,460 and 16,200 admissions respectively) (Table 4.4)

4.4.6 Alcohol-related admissions based on the narrow measure (admissions relating to partially attributable conditions only)

Of the 325,870 admissions in 2012/13,

• around 222,700 admissions were for reasons that are partly attributable to alcohol consumption (i.e. the attributable fraction associated with the diagnosis (primary or alcohol-related external causes recorded in secondary diagnosis fields) most strongly associated with alcohol consumption was less than 1)

• 33% of these partly attributable admissions were for cancer, accounting for approximately 72,660 admissions

• 33% of these partly attributable admissions were for unintentional injuries, accounting for approximately 74,380 admissions (Table 4.4).

4.5 Prescribing

Information on prescription items for the treatment of alcohol dependence are presented from Prescription Services7, a division of the NHS Business Services Authority (NHS BSA) by the HSCIC.

The two main drugs prescribed for the treatment of alcohol dependence in primary care settings and in NHS hospitals in England are Acamprosate Calcium (Campral) and Disulfiram (Antabuse). In May 2013 a new drug Nalmefene (Selincro) was launched.
Nalmefene is the first medicine to be granted a licence for the reduction of alcohol consumption in people with alcohol dependence. It helps reduce the urge to drink in people accustomed to large amounts of alcohol, but does not prevent the intoxicating effects of alcohol. Whilst Acamprosate Calcium helps restore chemical balance in the brain and prevents the feelings of discomfort associated with not drinking, therefore reducing the desire or craving to consume alcohol. Disulfiram produces an acute sensitivity to alcohol resulting in a highly unpleasant reaction when the patient under treatment ingests even small amounts of alcohol.

Presented here are data on prescription items and Net Ingredient Cost (NIC) for drugs used to treat alcohol dependence. Prescription items give a measure of how often a prescriber has decided to write a prescription for the treatment of alcohol dependence. The number of items is not a good measure of the volume of drugs prescribed as different practices may use different durations of supply. The NIC is the basic cost of a drug as listed in the Drug Tariff or price lists; it does not include discounts, dispensing costs, prescription charges or fees.

183,810 items were prescribed (in a primary care setting or NHS hospital,) in 2013 for the treatment of alcohol dependency and dispensed in the community. The majority of these (95%) were prescribed in a primary care setting (e.g. GP surgery, pharmacist or clinic). Overall, there has been a steady increase (70%) in the number of items prescribed in the last 10 years. As expected the majority of items are prescribed in a primary care setting, this has remained at between 90% and 95% over the last 10 years.

The Net Ingredient Cost (NIC) of these prescription items in 2013 was £3.13 million, which is an increase of £0.2 million since 2012 and just over double the NIC in 2004 of £1.51 million. The introduction of Nalmefene in 2013 will have contributed slightly to the increased cost. However, the majority of the increase is attributable to the increase in the number of items being prescribed.

69% of the three main drugs prescribed for the treatment of alcohol dependency are for Acamprosate Calcium. This proportion has remained between 61% and 69% since 2004, although the number has risen considerably from 66,836 in 2004 to 126,558 in 2013. 79% of the additional prescription items since 2004 are for Acamprosate Calcium. Nalmefene which has only been available on prescription since May 2013 accounts for less than 1% of the items prescribed in 2013 (Table 4.7, Table 4.8 and Figure 4.2).
In April 2013, SHAs ceased to exist and were replaced by Area Teams which do not cover the same geographical areas as SHAs. Consequently there will be no breakdown of data by SHA for 2013 as there is only 3 months of data and no breakdown of data by Area Team for 2013 as there is only 9 months of data. When we have a full 12 months of data for 2014, we will breakdown the data by Area Team.

4.6 Deaths related to alcohol consumption

Alcohol misuse can be directly related to deaths from certain types of disease, such as cirrhosis of the liver, and in some cases, may be associated with other causes of death, such as strokes.

Table 4.9 shows the number alcohol-related deaths in England, by gender, 2001 to 2012 using the National Statistics definition. The National Statistics definition of alcohol-related deaths only includes those causes regarded as being most directly due to alcohol consumption. It does not include other diseases where alcohol has been shown to have some causal relationship, such as cancers of the mouth, oesophagus and liver. For further information see the ‘Definition’ section of Alcohol-related deaths in the United Kingdom, registered in 2012 by the Office for National Statistics (ONS).

In England, in 2012 there were 6,490 alcohol-related deaths. This is a 19% increase from 2001 (5,476) but a 4% decrease from 2011 (6,771).

The number of male deaths decreased from 4,498 in 2011 to 4,230 in 2012 and the number of female deaths decreased from 2,273 in 2011 to 2,260 in 2012.

The most common alcohol-related death was alcoholic liver disease which accounted for 63% (4,075) of all alcohol-related deaths in 2012. This proportion has remained stable throughout the time series (Figure 4.3).
The number of deaths from alcohol-related fibrosis and cirrhosis of the liver were also high accounting for 23% (1,479) of deaths in 2012.

**Figure 4.3 Alcohol-related deaths in England 2002 to 2012**

![Graph showing alcohol-related deaths in England from 2002 to 2012](chart.png)

Public Health England’s Knowledge and Intelligence Team North West (KIT(NW)) produce estimates of the number of alcohol-related deaths. These estimates are higher than the ONS figures since they include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls. The estimates use the same alcohol-attributable fractions methodology as that used to estimate the number of alcohol-related hospital admissions. Applying this methodology to mortality data they estimated that in 2012 there were 13,971 alcohol-related deaths amongst men and 7,514 alcohol-related deaths amongst women. Further data and resources are available on the *Local Alcohol Profiles for England* website.

### 4.7 Cost to the NHS


The estimated cost of alcohol harm to society is £21 billion per year. Information on estimated cost to the NHS of alcohol misuse shows that it costs £3.5 billion every year, which is equal to £120 for every taxpayer. These estimates are presented in the evidence paper to the House of Commons Health Select Committee on the Government’s Alcohol Strategy\(^\text{13}\). The cost of £3.5 billion is an updated figure to the one given in 2008 when the then government produced a report, *The cost of alcohol harm to the NHS in England*\(^\text{14}\) where it estimated that the cost of alcohol harm to the NHS in England was £2.7 billion (in 2006/07 prices). These updated estimates take into account increases in unit costs as well as more recent and accurate data on alcohol consumption and harm.
References

   http://www.hscic.gov.uk/pubs/psychiatricmorbidity07


   http://www.hscic.gov.uk/hes


   http://www.lape.org.uk/data.html

7. The prescription data included in this report are not routinely available. National prescription data may be available on request.
   http://www.hscic.gov.uk/primary-care

8. Nice 2014 – Evidence Summary
   http://publications.nice.org.uk/ensenm29-alcohol-dependence-nalmefene-ensenm29

   http://www.ons.gov.uk/ons/dcp171778_353201.pdf


    http://www.alcoholconcern.org.uk/assets/files/Publications/Alcohol%20strategy%20local%20implementation%20toolkit.pdf


    http://www.alcohollearningcentre.org.uk/Topics/Browse/Policy/?parent=4441&child=4652
Appendix A: Key sources

Alcohol attributable fractions
Affordability data
Health Survey for England
Hospital Episode Statistics
Infant Feeding Survey
International Classification of Diseases and related health problems (ICD)
Living Costs and Food Survey (LCFS)
Local Alcohol Profiles for England (LAPE)
Mortality statistics
Organisation for Economic Co-operation and Development (OECD), Health at a glance data
Opinions and Lifestyle Survey
Prescription data
Smoking, Drinking & Drug Use among Young People in England

Most of the sources referred to in this publication are National Statistics. National Statistics are produced to high professional standards set out in the Code of Practice for Official Statistics. Not all statistics in this publication are National Statistics some are Official Statistics, whilst others are neither. All are included to provide a fuller picture. Official Statistics should still conform to the Code of Practice for Official Statistics, although this is not a statutory requirement. Unless otherwise stated, all sources contained within this publication are considered robust. A short review of the quality of each of the sets of statistics used in this publication are provided below.

Alcohol attributable fractions (AAFs)

North West Public Health Observatory (NWPHO) (now Public Health England (PHE)) developed alcohol attributable fractions (AAFs) which take into account the level of risk all injuries and diseases attributable to alcohol consumption have on a patient being admitted to hospital. With commission from the Department of Health these AAFs have been applied to data from Hospital Episode Statistics (HES) and Office for National Statistics (ONS) to give an estimation of the number of hospital admissions attributable to alcohol. Within this publication, two main measures of alcohol related admissions are presented: a broad measure and a narrow measure. The broad measure is derived by summing the alcohol attributable fraction associated with each admission based on the diagnosis most strongly associated with alcohol out of all diagnoses (both primary and secondary). The narrow measure which is constructed in a similar way but counts only the fraction associated with the diagnosis in the primary position or alcohol-related external causes recorded in secondary diagnosis fields. Within each of these measures, the data can be broken down into admissions that are wholly and partially attributable to alcohol, according to the required purpose.
A review of the methodology used to estimate alcohol related admissions took place in the form of a public consultation led by the North West Public Health Observatory (NWPHO) working with the Department of Health and the Health and Social Care Information Centre (HSCIC). The consultation was launched on 31 May 2012 and ran for 12 weeks. The responses to the consultation were considered and summarised and are available on the LAPE website.

As a result of this consultation the following changes have been made:

4. Revised alcohol attributable fractions will be used to estimate the number of alcohol-related hospital admissions.

5. The alcohol-related diagnoses reported on have been revised.

6. The previous measure based on primary diagnosis only has been revised to use alcohol-related primary diagnoses or alcohol-related external causes recorded in secondary diagnosis fields.

Tables 4.1 to 4.3 show the number of admissions into hospital based on primary and secondary diagnoses attributable to the consumption of alcohol; Tables 4.4 to 4.6 show the number of admissions based on the primary diagnosis and external causes in secondary diagnoses fields.

The number of alcohol-related admissions is based on the methodology developed by the NWPHO, which uses indicators for alcohol-related illnesses, determining the proportion of a wide range of diseases and injuries that can be partly attributed to alcohol as well as those that are, by definition, wholly attributable to alcohol. Wholly attributable conditions are alcohol-specific by definition and so have an attributable fraction of one, whereas partially attributable conditions are those where some, but not all cases can be ascribed to alcohol consumption so have an attributable fraction of less than one. Where there is more than one alcohol-related condition among the diagnostic codes the condition with the largest fraction is used. Where there are two or more codes with equally high AAFs the one which appears earliest in the diagnostic fields is selected. The estimate of the overall number of alcohol-related admissions is then derived by summing up the number of episodes counted against each alcohol-related condition.

To construct alcohol related admission estimates, the AAFs are applied to the data on admitted patients (inpatients) collected in the HSCIC HES databank. HES is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.

In order to estimate the number of admissions attributable to alcohol, a methodology is used which involves assigning an AAF to each hospital episode that contains at least one of the conditions known to be associated with alcohol consumption in either the primary or one of the 19 secondary diagnosis positions. Where an episode involves more than one alcohol related diagnosis, the AAF associated with the diagnosis most strongly related to alcohol (the one with the highest AAF) is assigned. Where there are two or more codes with equally high AAFs the one which appears earliest in the diagnostic fields is selected. The estimate of the overall number of alcohol related admissions is then derived by summing the AAFs across all episodes.
The number of admissions per 100,000 have been standardised to the England population. These figures will differ from those in the Local Alcohol Profiles for England (LAPE) published by Public Health England where the European Standard population was used to standardise the number of admissions per 100,000.

The following age bands have been used for standardising:
Under 16  16 to 24  25 to 34  35 to 44  45 to 54  55 to 64  65 to 74  75+
as these are the same groups as used for calculating the AAFs.

**Affordability data**

An important adjustment was introduced for the first time in *Statistics on Alcohol: England, 2011* so that the revised Real Households' Disposable Income (RHDI) index tracks, exclusively, changes in real disposable income per capita.

Previously, the RHDI index tracked changes in the total disposable income of all households and was not on a per capita basis. This meant that changes in the RHDI index over time were, in part, due to changes in the size of the population and not exclusively due to changes in real disposable income per capita. The RHDI index feeds into the affordability of alcohol index therefore this was also affected.

The adjustment was carried out using ONS mid-year population estimates of the adult population aged 18 and over, and was applied to all years in the index (1980 onwards). The adjusted RHDI index was then carried forward to produce an adjusted affordability of alcohol index.

The retail prices index (RPI) shows how much the prices of all items have changed compared with the base price (1980).

The relative alcohol price index is calculated by dividing the alcohol price index by the retail prices index and multiplying by 100.

\[
\text{relative alcohol price index} = \left( \frac{\text{alcohol price index}}{\text{retail prices index}} \right) \times 100
\]

This shows how the average price of alcohol has changed since the base (1980) compared with prices of all other items. A value greater than 100 shows that the price of alcohol has increased by more than inflation during that period, for example between January 1980 and 2012, the price of alcohol increased by 349.4%. After considering inflation at 263.1%, alcohol prices increased by 23.8% over the period, as shown by the relative index of 123.8.

Adjusted real households’ disposable income is an index of total households’ income, minus payments of income tax and other taxes, social contributions and other current transfers, converted to real terms (i.e. after dividing by a general price index to remove the effect of inflation) which tracks, exclusively, changes in real disposable income per capita.

The adjusted real households’ disposable income index is obtained by carrying out the following 2 steps;

1. Calculate real households’ disposable income index / total number of UK adults aged 18 and over
2. Rebase the resulting series so that 1980 = 100%.
Affordability of alcohol gives a measure of the relative affordability of alcohol, by comparing the relative changes in the price of alcohol, with changes in households’ disposable income per capita over the same period (with both allowing for inflation).

The alcohol affordability index is calculated by dividing the adjusted real households’ disposable income index by the relative alcohol price index and multiplying by 100.

\[
\text{alcohol affordability index} = \left( \frac{\text{adjusted real households' disposable income index}}{\text{relative alcohol price index}} \right) \times 100
\]

If the affordability index is above 100, then alcohol is relatively more affordable than in the base year, 1980. For example, in 2012 alcohol prices were 349.4% higher than in 1980 but, after taking inflation and households’ disposable income per capita into account, alcohol was 60.9% more affordable, as shown by the affordability index of 160.9.

Publications used to produce these figures include *Price Indices and Inflation*[^2], *Economic and Labour Market Review*[^3] and the *Mid-Year Population Estimates*[^4].

Both the unadjusted RHDI index and the unadjusted affordability of alcohol index (as used in *Statistics on Alcohol: England 2010* and prior publications) are presented alongside the revised indices for comparability purposes in *Statistics on Alcohol: England 2011.*

### Health at a Glance, Organisation for Economic Co-operation and Development (OECD)

Released during November 2013, *Health at a Glance 2013*[^5] offers the most comprehensive source of comparable statistics on health and health systems across OECD countries. It is an essential tool for health researchers and policy advisors in governments, the private sector and the academic community, to carry out comparative analyses and draw lessons from international comparisons of diverse health care systems. Data from this report can be found in Chapter 2 on Drinking behaviour in Adults and Children.

### Health Survey for England

The *Health Survey for England (HSE)*[^6] is an annual survey, monitoring the health of the population which is currently commissioned by the Health and Social Care Information Centre (HSCIC), and before April 2005 was commissioned by the Department of Health. The HSE has been designed and carried out since 1994 by the Joint Health Surveys Unit of the National Centre for Social Research (NatCen) and the Department of Epidemiology and Public Health at University College London Medical School (UCL). All surveys have covered the adult population aged 16 and over living in private households in England. Since 1995, the surveys have also covered children aged two to 15 living in households selected for the survey, and since 2001 infants aged under two have been included as well as older children. Trend tables are also published each year updating key trends on a number of health areas.

Each survey in the series includes core questions and measurements such as blood pressure, anthropometric measurements and analysis of saliva and urine samples, as well as modules of questions on specific issues that vary from year to year. In recent years, the core sample has also been augmented by an additional boosted sample from a specific population subgroup, such as minority ethnic groups, older people or, as in 2006 and 2007, children.

The Health Survey for England is a National Statistic.
Hospital Episode Statistics

Hospital Episode Statistics (HES) is a data warehouse containing details of all admissions to NHS hospitals in England. NHS hospital admissions in England have been recorded using the HES system since April 1987. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contains details of all NHS outpatient appointments in England as well as detailed records of attendances at major A&E departments, single specialty A&E departments, minor injury units and walk-in centres in England. HES data is available from 1989-90 onwards. There have been a number of changes to the classifications used within HES records. Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed)

HES data are classified using International Classification of Diseases (ICD) A finished admission episode (FAE) is the first period of inpatient care under one consultant within one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Please note that admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

The primary diagnosis is the first of up to 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was admitted to hospital. As well as the primary diagnosis, there are up to 19 (13 from 2002-03 to 2006-07 and 6 prior to 2002-03) secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.

Infant Feeding Survey

The Infant Feeding Survey (IFS) covers the population of new mothers in the United Kingdom, and is carried out every 5 years, the first was in 1975. The main aim of the survey is to provide figures on the incidence, prevalence and duration of breastfeeding and other feeding practises. The survey also collects information on the smoking and drinking behaviours of women before, during and after pregnancy.

The Infant Feeding Survey is a National Statistic.

International Classification of Diseases and related health problems (ICD)

The Tenth Revision of the ICD codes (ICD-10) is the latest in a series of classifications started in 1993, and incorporates a major reorganisation of the structure and groupings used in the ninth revision (ICD-9). An alphanumeric coding scheme replaced the numeric one, e.g. alcohol dependence syndrome changed from 303 in ICD 9 to F10.2 in ICD 10. The regrouping of classifications means that classifications may not map precisely between the two revisions - the nearest equivalent to ICD 9 571.1 (acute alcoholic hepatitis), is the ICD 10 code K70.1 (alcoholic hepatitis) and ICD 10 code K70.9 (alcoholic liver disease, unspecified).

Deaths in England and Wales were classified using ICD 9 to 2000 and by ICD 10 for 1999, and 2001 onwards. Hospital Episode Statistics (HES) have been classified using ICD 10 for 1995/96 onwards.
Living Costs and Food Survey

In 2008 the Expenditure and Food Survey (EFS) was renamed as the Living Costs and Food Survey (LCFS)\(^9,10\) when it became part of the Integrated Household Survey (IHS) run by the Office for National Statistics (ONS). The Expenditure and Food Survey (EFS) was formed by bringing together the Family Expenditure Survey and the National Food Survey (FES and NFS). The LCFS provides data on food purchases and expenditure. Historical estimates based on NFS are available from 1940 to 2000.

Historical estimates of household purchases between 1974 and 2000 have been adjusted to align with the level of estimates from the Family Expenditure Survey in 2000. These estimates of household purchases are broadly comparable with estimates of household purchases from the LCFS and EFS which commenced in April 2001.

The aligned estimates are generally higher than the original ones and indicate that the scaling has partially corrected for under-reporting in the NFS. Under-reporting is likely to be lower in the LCSF because it does not focus on diet but on expenditure across the board and is largely based on till receipts. However it is necessary to be aware that there is a change in methodology which makes the estimate of the year on year change unreliable between 2000 and 2001/02. The largest adjustments were for confectionery, alcoholic drinks, beverages and sugar and preserves. Details of the adjustments to the NFS estimates can be found in Family Food 2002/03.

The Living Costs and Food Survey is a National Statistic.

Local Alcohol Profiles for England (LAPE)\(^11\)

The LAPE tool presents data for 26 alcohol-related indicators in an interactive tool, which helps local areas assess alcohol-related harm and monitor the progress of efforts to reduce this. A review of the methodology used to estimate alcohol related admissions took place in the form of a public consultation led by the North West Public Health Observatory (NWPHO) working with the Department of Health and the Health and Social Care Information Centre (HSCIC). The consultation was launched on 31 May 2012 and ran for 12 weeks. The responses to the consultation were considered and summarised and are available on the LAPE website.

As a result of this consultation the following changes were made:

1. Revised alcohol attributable fractions will be used to estimate the number of alcohol-related hospital admissions.
2. The alcohol-related diagnoses reported on have been revised.
3. The previous measure based on primary diagnosis only has been revised to use alcohol-related primary diagnoses or alcohol-related external causes recorded in secondary diagnosis fields.

Mortality statistics

The Office for National Statistics (ONS) produces annual statistics on numbers of deaths by cause in England and Wales.\(^12\) Registered deaths in England and Wales are classified using ICD 9 to 2000 and by ICD 10 for both 1999, and from 2001 onwards. The majority of
information published using ONS mortality data on drinking relate to England and Wales, and therefore differ from those shown in this report, which covers England only. This information is presented in Chapter 4 of this report – Drinking-related costs, ill-health and mortality, and has been obtained from the ONS mortality statistics data set.

In 2006, ONS revised their definition of alcohol-related deaths to include a number of extra diseases that are wholly attributable to alcohol consumption. They do not currently consider deaths from causes that can be partly attributable to alcohol, however the North West Public Health Observatory (NWPHO) report, Alcohol-attributable fractions for England, does include analysis of deaths that can be attributed to alcohol consumption based on the same methodology as that for alcohol-related hospital admissions (see above).


Mortality Statistics produced by ONS are National Statistics.

Omnibus Survey, Drinking: Adults’ behaviour and knowledge report

Results from questions on drinking behaviour and knowledge, included in the Office for National Statistics Omnibus surveys and includes text, data and tables on alcohol consumption, knowledge of units of alcohol and daily benchmarks and where people buy alcohol.

Opinions and Lifestyle Survey

In 2012, the survey vehicle for collecting drinking data changed from the General Lifestyle Survey (GLF) to the Opinions and Lifestyle Survey (OPN). The OPN uses the same initial approach to sampling as the GLF. That is, a random sample of addresses is drawn from the Postcode Address File (PAF). Initially, a sample of postcode sectors is drawn, and from within those, a list of addresses is chosen. The design means that every address and every person in Great Britain has an equal chance of selection. The PAF is ordered by region and other socio-demographic indicators provided by the census. Ordering the PAF helps to ensure the sample represents the general population of Great Britain.

Prescription data

Information on prescription items prescribed in primary care settings in England are obtained from the Prescribing Analysis and Cost Tool (PACT) system. The PACT system covers prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Prescriptions written in England but dispensed outside England are included. Prescriptions written in hospitals/clinics that are dispensed in the community are also included but prescriptions dispensed in hospitals and private prescriptions are not.

Each single item is counted as a prescription item. Net Ingredient Cost (NIC) is the basic cost of a drug. It does not take account of discounts, dispensing costs, fees or prescription charges income.

NHS Prescription Services have stated that due to the complex and manual processes involved there may be inaccuracies in capturing prescription information which are then reflected in the data. Internal quality assurance processes exist and currently the prescription
processing activity is internally audited to 97.5 per cent accuracy (i.e. at least 97.5 per cent of prescriptions are recorded accurately).

Preparations where the number of items dispensed is small are more likely to be significantly affected by any processing errors.

**Smoking, Drinking and Drug use among Young People in England**

Between 1982 and 2003, surveys of secondary school children in England were carried out for the Department of Health. This was done by the Office of Population Census and Surveys (OPCS) between 1982 and 1994, by the Office for National Statistics (ONS) between 1994 and 1999 and by the National Centre for Social Research (NatCen) and the National Foundation for Educational Research (NFER) between 2000 and 2003. Since 2004, the survey has been run by NatCen and NFER on behalf of the Health and Social Care Information Centre.

In 1988, questions on alcohol consumption were added and have been included in the survey ever since. The core of the questionnaire comprises of questions about the prevalence of drug use, smoking and drinking, since 2000, the remainder of the questionnaire focuses, in alternate years, on either smoking and drinking or drug taking. The most recent survey in the series, Smoking, Drinking and Drug Use among Young People in England in 2010 (SDD10) focused on smoking and drinking.

The target population for the survey is secondary school children in England, in years 7 to 11, from almost all types of school (comprehensive, secondary modern, grammar and other secondary schools), both state and public. Only special schools and hospital schools are excluded from the survey.

The survey uses a stratified design in which every eligible child has an equal chance of inclusion in the study. The survey is conducted using a confidential questionnaire, which the pupils fill in individually.

**Changes to questions on alcohol**

The questionnaire development for the 2002 survey included cognitive testing of questions about alcohol consumption in the last week. This cognitive development work focused on children’s comprehension of the categories of drink asked about in the survey and the language used in the questionnaire.

The cognitive work on alcohol consumption found that:

- ‘Alcopops’ was a widely used and commonly understood term among young people, but ‘pre-mixed alcoholic drinks’ was not;
- There was some confusion about how strong shandy should be before it counted as a proper alcoholic drink; and
- There were some brands and types of drink, such as champagne, that young people have difficulty classifying.

As a result of these findings a number of changes were made in 2002 to the questions asking about alcohol consumption in the last week.

These changes are likely to have only a very minor effect on comparability and estimates of alcohol consumption in the last week for the following reasons.
• Where new questions were introduced, these were placed at the end of a section to minimise any effect on how preceding questions were answered.

• Analysis of the quantities of other alcoholic drinks that were reported suggested that the ‘other types of alcohol’ questions were not completed very reliably. Therefore answers from this additional set of questions have not been included in survey estimates of amount of alcohol drunk, and comparability with how these estimates were derived in surveys before 2002 has been retained.

• The questions measuring drinking in the last week are regularly updated to reflect changes in the drinks market: ‘alcopops’ was introduced as a new category of drink in 1996 and the list of example brands is updated annually. Therefore estimates have not been strictly comparable year-on-year.
References


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8. International Classification of Diseases (ICD), from The World Health Organization (WHO).
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9. The Living Costs and Food Survey (LCFS).

   http://www.defra.gov.uk/statistics/foodfarm/food/familyfood/datasets/

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http://www.ons.gov.uk/ons/release-calendar/index.html?pageType=calendar-entry&pageSize=50&newQuery=drinking+behaviour&sortBy=releaseDate&sortDirection=DESCENDING&releaseDateRangeType=allDates


15. The prescription data included in this report are not routinely available. National prescription data may be available on request. 
http://www.hscic.gov.uk/primary-care

www.hscic.gov.uk/pubs/sdd12
Appendix B: Cross-departmental policies

The NHS advises that¹:

- adult women should not regularly drink more than 2 to 3 units of alcohol a day;
- adult men should not regularly drink more than 3 to 4 units of alcohol a day; and
- pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to minimise the risk to the baby they should not drink more than 1-2 units of alcohol once or twice a week and should not get drunk.
- after an episode of heavy drinking, it is advisable to refrain from drinking for 48 hours to allow tissues to recover

The Government’s Alcohol Strategy

The Alcohol Strategy² is targeted at harmful drinkers, problem pubs and irresponsible shops. It addresses both health and social harms describing coordinated actions across Government, including a strong package of health measures. The Strategy sets ambitions to reduce the number of people (i) drinking above the NHS guidelines (ii) ‘binge drinking’ and (iii) the number of alcohol related deaths as well as other ambitions, such as to see a change in behaviour where people think it is not acceptable to drink in ways that could cause harm to themselves or others.

Public Health Responsibility Deal

The Public Health Responsibility Deal was formally launched in March 2011. It challenges businesses and other organisations to play their role in creating an environment that supports people to make informed, balanced, healthier choices.

Around 125 companies are signed up to alcohol pledges that support the overall commitment to help people drink within the guidelines.

Industry has already taken action, making pledges in a range of areas.

This includes a pledge to give consumers a wider choice of lower strength products to help take one billion units out of the market by 2015, over 30 companies are signed up; and a pledge that 80% of bottles and cans will have health and alcohol unit information clearly labelled by the end of 2013 - with 92 companies signed up.

The focus going forward will be to deliver the existing pledges; however, we will strengthen these while focusing on areas that will make the biggest difference such as the industry’s pledge to remove one billion units of alcohol from the market by 2015. This would be a drop of around 2% of units of alcohol sold. It is estimated that in a decade, this will result in many hundreds fewer alcohol-related deaths; many thousands fewer hospital admissions and alcohol-related crimes, as well as substantial savings to health services and crime costs each year.

Improving Information

Clear and easily understood information is central to ensuring that everyone is aware of the lower-risk guidelines and the risks of drinking above the guidelines, as many people who drink do not realise how much they are drinking.
The Government asked Dame Sally Davies, the Chief Medical Officer, to oversee a review of the alcohol guidelines, to ensure these are founded on the best science and so that the guidelines help people at all stages of life to make informed choices about their drinking.

This is now underway and we expect to be able to consult on new guidelines by the end of the year.

A voluntary labelling agreement to provide unit and health information, including a pregnancy warning, on 80% of bottles and cans is one of the collective pledges under the Public Health Responsibility Deal. A large number (91) of major producers and retailers have signed up to this pledge and supporting guidance has been produced by the Portman Group.

Not everything that has to be done, is best done by Government. Drinkaware is an alcohol education charity, funded by cash donations and in-kind support from the alcohol industry. Five board members from the industry, five with a health or other professional interest in alcohol and three, who have no professional interest in alcohol, including the chair, govern it. Drinkaware has become a well-known brand, recognised by over two-thirds of its target audience and there are more than 5 million visits a year to their website.

An Audit of Drinkaware was recommended in the 2009 addendum to the Memorandum of Understanding between Drinkaware, government and the alcohol industry. The Drinkaware trustees asked Sir Hugh Taylor to chair an Independent Review Panel to commission, oversee and publish the Audit to ensure that it was rigorous, independent and transparent. The report is available on the Panel’s website at www.independentreview.org.uk. The Audit will provide invaluable guidance as Drinkaware shapes its strategy and plans for the organisation in the coming years.

**Licensing**

The Government has legislated via the Police Reform and Social Responsibility Act 2014 to overhaul the Licensing Act 2003 and to rebalance it in favour of local communities. These reforms give the police and licensing authorities more local powers to shape their night-time economies and to tackle irresponsible premises, particularly those selling alcohol to children. Local health bodies are now Responsible Authorities under the Licensing Act and allow them to make a fuller contribution to reducing acute harms from alcohol.

Evidence suggests that increased outlet density is linked to alcohol-related harms. As part of a consultation by the Home Office in 2012/13, the Government sought views on the introduction of a new density power that would enable licensing authorities to consider local health harms specifically when introducing Cumulative Impact Policies. This would be framed under a limited licensing objective ‘protecting and improving public health’.

The Government remains interested in this policy in principle, as there is good international evidence that this can reduce a range of health and crime harms from alcohol. However, the response received to the public consultation made clear more work is required at a local level to put in place processes to underpin it. This will form a key part of the Local Alcohol Action Areas work, which was launched in February this year.

**Pricing**

The Government sought views on a number of measures set out in the Alcohol Strategy, including proposals to tackle the availability of cheap alcohol, in a consultation published by the Home Office in 2012/13.

A wide range of evidence was provided on Minimum Unit Price (MUP) throughout the consultation, and this was considered alongside updated modelling by the University of Sheffield.
In particular, a number of issues were raised highlighting concerns about unintended consequences from introducing MUP, including the potential impact on the cost of living and the economic impact of the policy and increases in illicit alcohol sales.

The Government acknowledges the need to give careful consideration to any possible unintended consequences of MUP and, for these reasons, has decided that the introduction of MUP for alcohol will remain a policy under consideration, while additional evidence becomes available, but will not be taken forward at present in England and Wales.

Following our consultation on the Government’s Alcohol Strategy, we will now:

- Take targeted national action, ending sales of the cheapest alcohol by introducing a ban on selling alcohol below the price of duty and VAT, and strengthening the ban on irresponsible promotions in pubs and clubs.
- Challenge industry to increase its efforts, building on what has already been achieved through the Public Health Responsibility Deal. This includes improving education to promote safer drinking; tackling high strength products; and promoting alcohol responsibly in shops.
- Support local action on alcohol-related harm, identifying a number of high harm local alcohol action areas and take action with them to strengthen local partnerships; improve enforcement; and share good practice based on what works locally.
- Make the licensing system more targeted, proportionate and flexible by freeing businesses and communities from unnecessary red tape. In particular, by introducing a simpler authorisation process for community groups.

**Alcohol Interventions**

The Department of Health is supporting the NHS to put in place high quality services to prevent, mitigate and treat effectively alcohol-related health harm. The relevant services range from identification and brief advice to specialist services to treat dependent drinkers.

From April 2013, the Department of Health has funded the inclusion of an alcohol risk assessment in the NHS Health Check, so that people will be given brief advice to help them cut down if they need to. The support given will depend on the individuals’ needs and might involve some brief advice or a referral to specialist alcohol service(s), if needed.

**Local action**

Public Health England (PHE) is the Executive Agency of the Department of Health with the role of supporting local authorities responsible for public health. PHE provides data, evidence and support to local authorities and NHS partners to enable them to reduce the harmful impact from alcohol in local communities.

PHE also encourages greater use of effective interventions, such as brief interventions, alcohol interventions in secondary NHS care and the treatment of dependent drinkers.

As part of the Public Health framework, local government has been given the responsibility, backed by ring-fenced budgets, to improve people’s health – this includes responsibility for tackling problem drinking. This is led locally by the Director of Public Health.

From April 2013, upper tier and unitary local authorities have received a ring-fenced public health grant. This includes funding for alcohol misuse prevention and treatment.

Health and Wellbeing Boards will bring together councils, the NHS and local communities to understand local needs and priorities expressed in the Joint Strategic Needs Assessment (JSNA). In addition, they develop a joint Health and Wellbeing strategy, which sets out how
they will work together to meet these needs. The boards promote integration of health and social care services with health-related services like criminal justice services, education or housing. This helps join up services around individual’s needs and improve health and wellbeing outcomes for the local population.
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