

Hitting the bottle

Minimising the harms from alcohol misuse

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Executive Summary

Alcohol misuse is one of the growing public health epidemics of the 21st century. The scale of the problem is huge: 7.6 million people in England are drinking at hazardous levels; 2.9 million are showing evidence of harm to their own health, including 1.1 million people who have a level of alcohol addiction.¹ Between 2001 and 2007, the direct costs to NHS from alcohol misuse nearly doubled, increasing from £1.47 to £2.7 billion. This includes £1.46 billion on hospital treatment; £645 million on visits to accident & emergency; £372 million on ambulance services and £102 million on visits to the GP.²

OECD data shows that over the last 15 years alcohol consumption in the UK has increased significantly, while that for the majority of our European neighbours has been decreasing. From 1985 - 2005, alcohol consumption per person has fallen in Italy by 37%; in France by 27% and Germany by 29%. In the UK it increased by 22%. Not only does the UK now have higher alcohol consumption than that of the EU15 average, but also higher death rates from liver disease and cirrhosis - a marker of chronic alcohol misuse. From 1985 - 2005, the standard mortality measure for liver disease and cirrhosis has fallen in Italy by 58%; in France by 50% and Germany by 28%. In the UK it increased by 136%.³

Set against this background of increases in chronic disease, acute admissions to hospital for alcohol intoxication have doubled in a decade⁴ and there is concern is that this dramatic rise will translate into future increases in complex and costly NHS treatments. Our analysis shows that Bank Holiday weekends are a particular drain on NHS resources and we estimate that alcohol excess this Spring Bank Holiday weekend will cost the NHS a total of £25 million. In order to reverse these trends we recommend:

- There should be a fundamental review and restructuring of the alcohol duty regime in order to promote the production, and consumption, of lower alcohol products. Duty should be cut on beer and cider where the alcoholic strength is less than, or equal to, 2 units per pint whereas duty should be raised for beer and cider where the alcoholic strength exceeds 2.5 units per pint. For example:

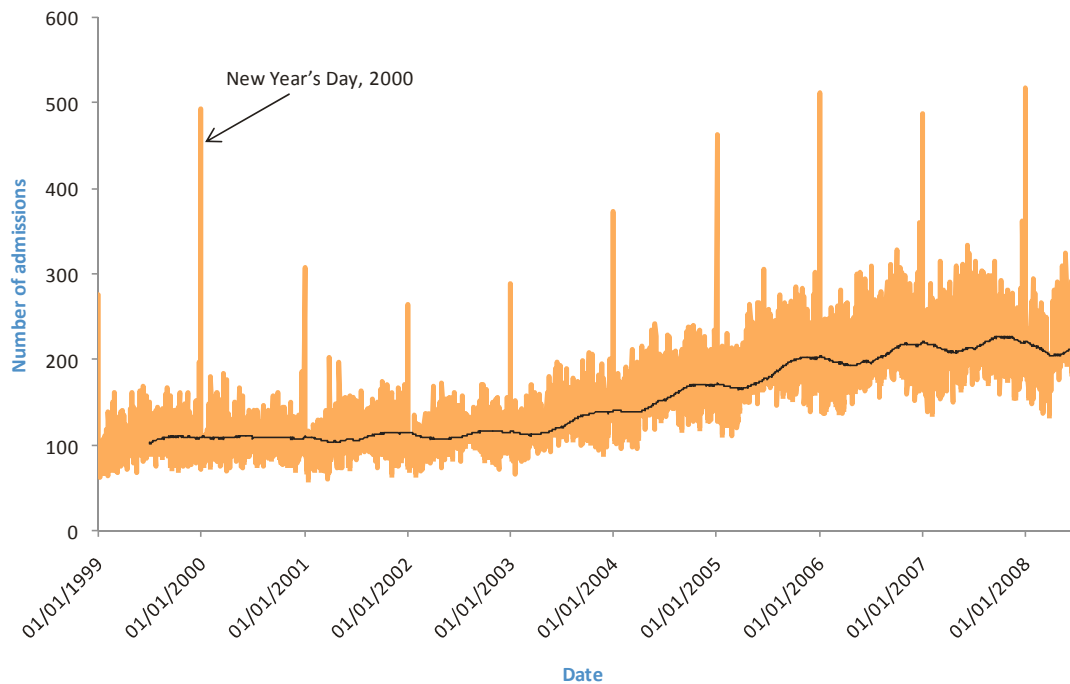
Beer strength (% abv) ⁵	Number of units per pint	Typical price per pint (£)	
		Current	Proposed
Above 2.6 to 3.5 e.g. Brakspear Bitter (3.4%)	≤ 2	£2.53	£2.30
Above 4.4 to 5.2 e.g. Kronenbourg (5.0%)	≤ 3	£2.72	£2.83
Above 6.2 to 7.0 e.g. Leffe Blonde (6.6%)	≤ 4	£2.91	£3.36

- The UK should press the EU to allow flexibility for Member States to set appropriate alcohol duty rates. We believe that a duty regime which recognises that people buy, and consume, alcohol in standard measures of drinks – pints and cans, bottles and glasses - and not by counting units displayed on packaging or calculated on a website, can help in reducing overall alcohol consumption, and therefore alcohol-related harm. An ideal duty system would allow variation in duty rates based on the number of units in a typical serving.
- In the interim, and since EU law does not fully permit duty on other alcoholic products to be applied in relation to their alcoholic strength - as is proposed above for beer and cider – some general price increases are necessary. This means the cost of a typical strength bottle of wine would increase by one price point from £3.99 to £4.49; however, low alcohol wines of less than 8.5% abv would reduce by one price point from £3.99 to £3.49. These duty changes should be arranged so that there is an element of return to the wine industry, so that investment could be made into the production of lower alcohol wines. The cost of a bottle of whisky would increase from £13.40 to £14.70.
- A public health duty escalator should be introduced where future alcohol duty rates are set in excess of the Retail Price Index with a specific aim of reducing the number of harmful drinkers in the population.
- The costs of being admitted to hospital to sleep off alcoholic excess should not be covered by the NHS, but should be borne by the relevant individuals themselves. Patients admitted to hospital for less than 24 hours with acute alcohol intoxication should be charged the NHS tariff cost for their admission of £532. This amount would be reduced for those paying the costs of their own ‘brief intervention’ alcohol education and awareness course. Such ‘brief interventions’ are proven to reduce both alcohol consumption and future healthcare costs.
- There should be a greater focus on policing public drunkenness and the use of Penalty Notices for Disorder (PNDs), so that more people are fined for being drunk. Our analysis shows that more people suffering with alcohol excess are now admitted to hospital than are dealt with by the police. The increased use of PNDs and police cautions should be accompanied by a national roll out of Alcohol Diversion Schemes - moving those issued with PNDs into ‘brief intervention’ alcohol education and awareness courses, as currently happens with speeding tickets.
- The ‘protection of public health’ should be inserted into the Licensing Act 2003. The licensing process is subject to judicial review, so decisions to refuse or modify licenses would be both reasonable and proportionate, although making the ‘protection of public health’ a licensing condition would not cede powers to local authorities to control the price or strength of alcoholic drinks in their area as this would breach competition law.
- Government education campaigns on alcohol should promote ‘dry days’, including a focus on weekend abstinence. The effectiveness these of campaigns should be monitored through hospital admission data for alcohol related conditions.
- A further indicator should be introduced into Public Service Agreement 25 – “the identification and effective treatment of problem drinkers”. Health related alcohol indicators in PSA 25 should become a higher priority for Primary Care Trusts.
- The Alcohol Education and Research Council (AERC) should be merged into the National Treatment Agency for Substance Misuse (NTA) and given a renewed focus on spreading best practice and promoting evidence-based interventions to reduce alcohol-related harm. For example; NHS alcohol screening can be delivered in local pharmacies to ensure large population coverage at relatively low cost.

Introduction

Today, in the UK about 90% of adults consume alcohol. By historical standards current levels of consumption are not exceptional, although they have more than doubled since the 1930s when they were at their lowest. At a population level, the consequence of rising alcohol consumption is that it translates into increased harm in the form of alcohol-related mortality, hospital admissions, crime, absence from work, school exclusions, sexually transmitted diseases, teenage pregnancy and road traffic accidents.

Number of daily emergency hospital admissions for alcoholic intoxication (January 1999 - June 2008)



Source: ICD-10 Codes F10.0, F10.1, T51.0, Y90. 4, Y90.5, Y90.6, Y90.7, Y90.8, Y90.9, Y91.2 & Y91.3, NHS Hospital Episode Statistics. Data courtesy of CHKS Ltd.

There is no doubt that too much alcohol is bad for you. The faculty of public health call it a “potentially addictive psychoactive substance”⁶ and it has similar properties to cannabis, LSD and ecstasy. The Government’s chief adviser on drugs rates alcohol as more dangerous than all three of those illegal substances.⁷ The statistics speak for themselves: alcohol-related hospital admissions have doubled in a decade and cases of alcoholic liver disease in intensive care have tripled over the same period.⁸ About 15,000 people die each year from alcohol misuse - over 3% of all deaths.⁹

But alcohol is part of our society and used responsibly by the majority of people. There is some evidence to suggest possible benefits for cardiovascular health at low levels of consumption. Yet, increases in alcohol strength and glass size makes it difficult to have one or two drinks and stay within the recommended guidelines of 3-4 units per day for men and 2-3 units per day for women.¹⁰

Surveys of public opinion¹¹ suggest alcohol misuse is a problem we should be doing something about: 70% of people think the UK would be a ‘healthier and better place to live’ if the amount of alcohol consumed was reduced; and 80% think more should be done to tackle the level of alcohol abuse in society. So the key

question is how we reconcile liberalisation of the licensing regime – which, in theory, has given more control to local communities - with the protection of public health?

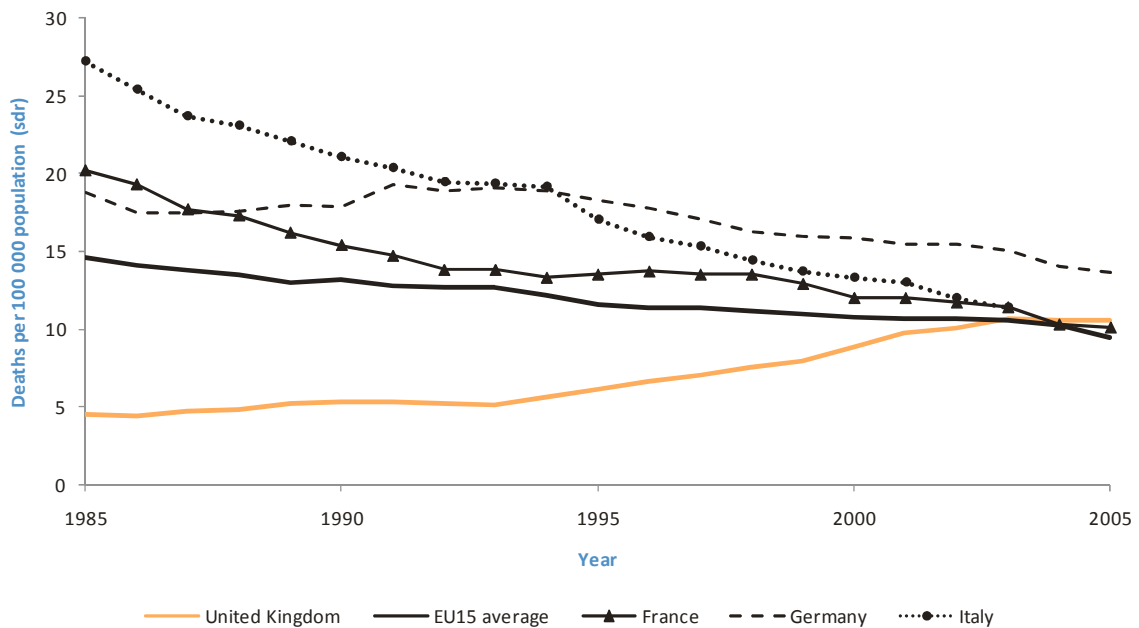
Protecting public health

Alcohol misuse is one of the growing public health epidemics of the 21st century. The scale of the problem is huge: 7.6 million people in England are drinking at hazardous levels; 2.9 million are showing evidence of harm to their own health, including 1.1 million people who have a level of alcohol addiction. The direct costs to NHS are £2.7 billion per year and the total costs to the economy are up to £25.1 billion.¹²

The Department of Health classifies levels of drinking: moderate drinkers consume within accepted 'safe' limits of 21 units for men and 14 for women, per week; 'hazardous' drinking is drinking regularly between 22–50 units for men and 15–35 for women, per week; harmful drinking is drinking regularly more than 50 units for men and 35 for women, per week.

A comparative measure of alcohol related harm among different populations is the mortality from cirrhosis of the liver. This shows that while the average mortality for liver cirrhosis across Europe as a whole is declining, the rate in the UK has continued to increase.¹³

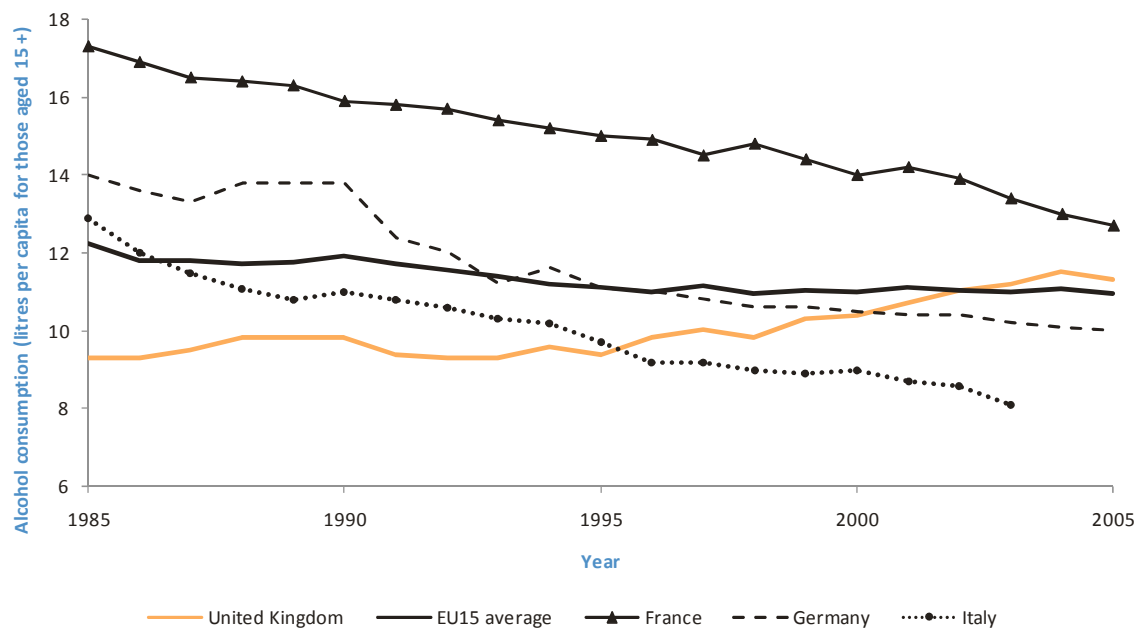
Deaths from liver disease and cirrhosis



Source: OECD Health Data 2008. December 2008

The concern is that the dramatic rise in acute alcohol-related hospital admissions over the last decade will translate into future increases in mortality from chronic disease since there is a time-lag of 5-15 years¹⁴ between hazardous drinking patterns developing into serious ill health. Whereas smoking kills many more people than alcohol misuse, the total numbers of years of life lost are similar since alcohol causes many deaths at a young age (accidents and violence) compared to smoking where the burden of mortality occurs at a much older age.¹⁵

Change in alcohol consumption habits



Source: OECD Health Data 2008. December 2008

Public health as a licensing objective

In the last 20 years, public health has been an increasing area of focus for successive governments. A number of reports¹⁶ have highlighted the need for preventative healthcare, because of the substantial cost savings to be gained from avoiding future complex treatments. There is a considerable body of evidence which shows that the most effective alcohol policies are those that combine measures addressed at the whole population – in particular increasing price and decreasing availability – as well as targeting groups where the risk of harm may be greatest.¹⁷ However, the approach to tackling alcohol misuse in England in the last decade has been contrary to the accepted evidence; instead we have seen a liberalisation of the licensing regime coupled with static increases in duty. There have been targeted interventions for problem drinkers but these have been substantially under resourced.^{18 19} The Licensing Act 2003 was the biggest reform in English licensing law for 40 years. It allows for 24 hour drinking and has amalgamated a number of separate licensing regimes (alcohol, public entertainment, theatre, cinema and night cafe) into a single piece of legislation. In doing so it has transferred the regulation of the sale of alcohol from magistrates' courts to licensing authorities. In virtually all cases these licensing authorities are local authorities and this move, in theory, establishes a more democratically accountable system, in which local communities have a greater say in licensing decisions.

The Licensing Act put four objectives at the centre of all licensing decisions: public safety; the prevention of crime and disorder; the prevention of public nuisance; and the protection of children from harm. Inconsistency with a licensing objective is one of the grounds for a licensing committee to refuse an application for a premises licence. However, despite the increase in the harmful effects of alcohol, the 2003 Act contains no requirement for public health to be considered when licences are granted or reviewed. Although during the Bill's passage through Parliament an amendment introducing the protection public health as a licensing objective was tabled at Commons Committee stage, it was not discussed.²⁰ But making public health a licensing condition would not cede powers to local authorities to control the price or strength of alcoholic drinks in their area as this would breach competition law.²¹

Following the implementation of the Licensing Act in November 2005, and in response to growing concerns that the Act had contributed to rise in binge drinking and alcohol related crime and disorder, the Department for Culture, Media and Sport undertook an evaluation of the Act. The report found a “mixed picture” with crime and consumption reduced but disorder higher in some areas. However, whereas overall consumption has decreased, harmful consumption has not: in the year following the Act’s implementation alcohol related hospital admissions were up 7% overall, with the number of acute intoxications up 6%.²²

The approach in Scotland - where there is greater harm from alcohol misuse - has been different. The Licensing (Scotland) Act 2005 contains an additional licensing objective: protecting and improving public health. The provisions of the Scottish Act will take effect on 1 September 2009 - there is, currently, a transitional period which started on 1 February 2008.

In England, the licensing process involves representations being made by a number of statutory consultees. These include the police, the fire service, social services (for the protection of children), local authority environmental health departments, and the local planning authority. Absent from the list is the local Primary Care Trust and even if it were to submit a representation, only those concerning the promotion of the existing licensing objectives are valid. Currently, a local authority with among the highest levels of alcohol-related hospital admissions and mortality cannot refuse or amend a premises license because of concerns about deteriorating levels of public health. Instead, local authorities and their Primary Care Trust (PCT) partners are left with Public Service Agreements to counter the rise in alcohol misuse.

Recommendation: the ‘protection of public health’ should be inserted into the Licensing Act 2003.

[Public Service Agreements Delivery Agreement 25 on alcohol and illegal drugs](#)

Public Service Agreements (PSAs), first introduced in 1998, set out the Government’s priority outcomes for public services. Despite evidence of growing harms it was not until 2008 that alcohol misuse featured as part of a cross-departmental PSA. The PSA Delivery Agreement 25 on alcohol and illegal drugs has five indicators, only two of which relate to alcohol: ‘reducing the increase in alcohol-related hospital admissions with 2006 as the baseline year’; and a ‘reduction in the percentage of the public who perceive drunk or rowdy behaviour to be a problem in their area’.²³ The other three indicators relate to tackling illegal drugs despite the wider costs to society from drug misuse being less than those from alcohol.²⁴

Public Service Agreement 25 is delivered by PCTs²⁵ and each of the five indicators are tiered according whether compliance is considered mandatory (e.g. reducing healthcare acquired infections); a national priority for local delivery (e.g. reducing smoking rates); or optional, which is currently the case for ‘reducing the increase in alcohol-related hospital admissions’.

Because of concerns that PCTs are not reversing the trend in alcohol-related hospital admissions and using available tools to assess the level of alcohol harm,²⁶ there have been calls for this indicator to become mandatory. However such a shift, coupled with the introduction of public health as a licensing objective, could result in some licensing authorities restricting the number of alcohol licenses in order to achieve compliance. But simply reducing supply would be a crude method of tackling alcohol related harm and impact disproportionately on responsible drinkers.

An alternative option would be to create an additional measure in PSA 25 for the ‘identification and effective treatment of hazardous and harmful drinkers’. This would be similar to another indicator in PSA 25 - ‘the

number of drug users recorded as being in effective treatment’. Both health related alcohol indicators should be made Tier 2 indicators – national priorities but for local delivery. This would strongly encourage, but not mandate, PCTs to introduce screening and brief interventions to problem drinkers as has been used imaginatively in Wirral PCT (see case study on page 18). Brief Interventions are short, easily administered and cost-effective methods for reducing future healthcare costs²⁷ and alcohol consumption by up to 20%²⁸.

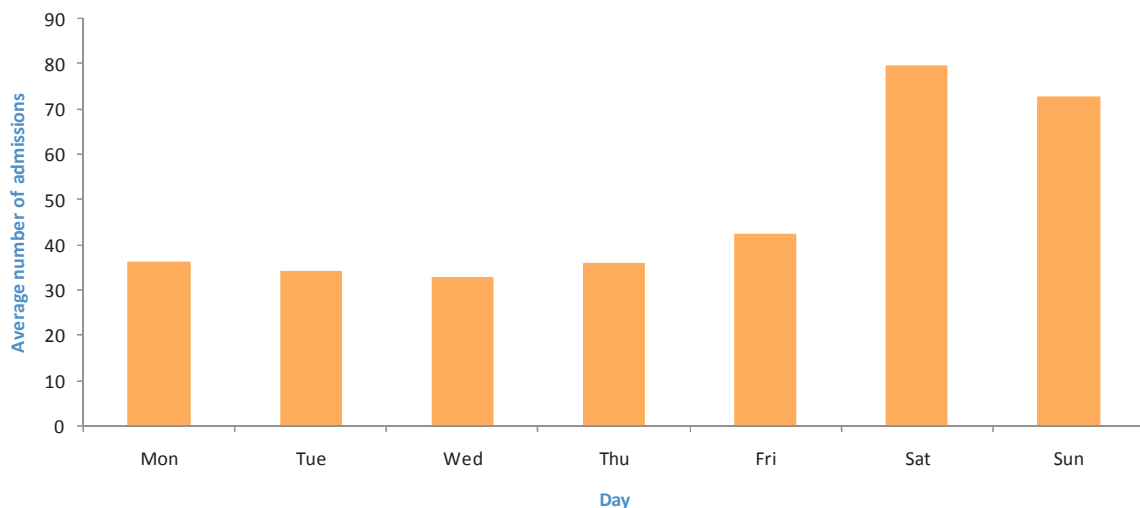
Recommendation: Introduce another alcohol indicator into PSA 25 – “the identification and effective treatment of problem drinkers”. Both health related alcohol indicators in PSA 25 should become Tier 2 Vital Signs performance measures – National Priorities for Local Delivery.

Promotion of ‘dry days’

Since 2006, the Department of Health has been funding educational campaigns aimed at increasing public understanding about alcohol units and the health risks associated with exceeding recommended daily drinking guidelines. The ‘Know Your Limits’ campaign costs £10 million per year, but it has no measurable goals beyond tracking consumer awareness of units.²⁹

In addition to recommended daily drinking guidelines, the Chief Medical Officer also advises that if people drink more than the recommended amount in one session they should abstain from drinking for 2 days afterwards, yet this advice has not been included as part of recent campaigns. Indeed, recent research has found that increases in UK liver deaths are a result of daily or near-daily heavy drinking, not episodic or binge drinking, and this regular drinking pattern is often discernable at an early age.³⁰ This research concluded that the importance of alcohol-free days each week should receive more prominence.

Emergency admissions for less than 24 hours for acute intoxication



Source: ICD-10 Codes F10.0 & F10.1, NHS Hospital Episode Statistics. Data courtesy of CHKS Ltd.

The majority of drinking now takes place in the home where the amount of alcohol consumed is underestimated because the quantities consumed are not measured and are likely to be larger than those dispensed in licensed premises³¹. Although the General Household Survey, which since 1978 has asked people about their drinking habits, suffers from under-reporting, the total number of people saying that they drink on 5 or more days per week is persistently high, at around 17%. This is reflected in the hospital

admission data which shows a high (and growing) level of alcohol-related hospital admissions each day of the week with a predictable peak at the weekends.

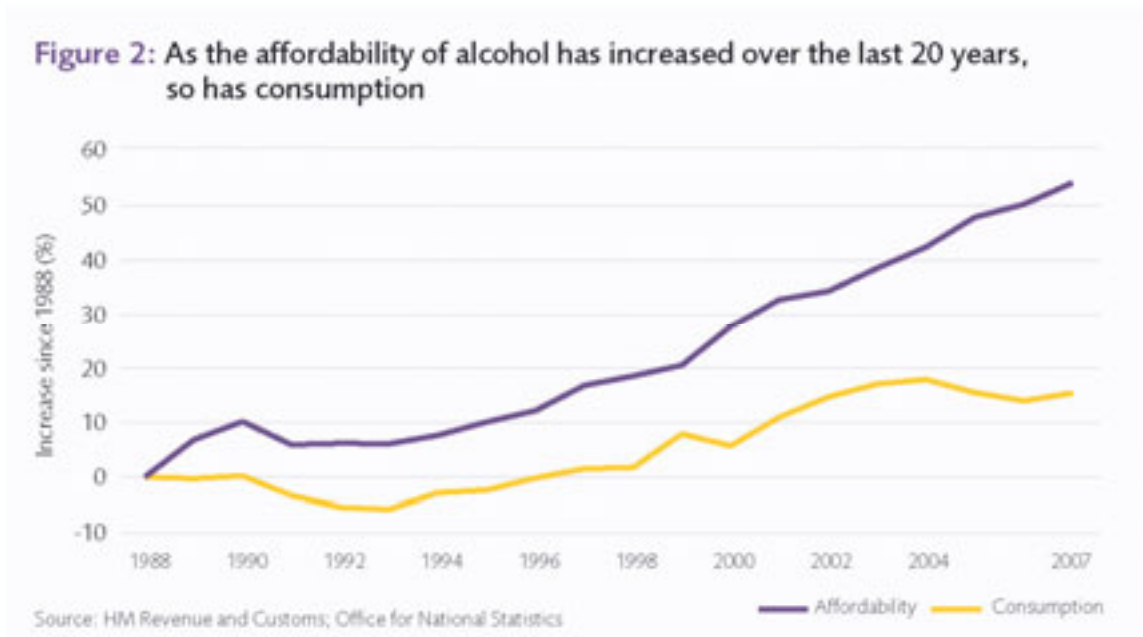
	% of persons aged over 16 who drank 5 or more times last week							
	2000	2001	2002	2003	2004	2005	2006	2007
Men	22%	22%	22%	23%	23%	22%	21%	22%
Women	13%	13%	13%	13%	13%	13%	11%	12%
All	17%	17%	17%	18%	17%	17%	16%	17%

Source: General Household Survey. 2000 - 2007

Recommendation: Government education campaigns on alcohol should promote ‘dry days’, including a focus on weekend abstinence. The effectiveness of these campaigns should be monitored through hospital admission data for alcohol related conditions.

Encouraging lower-strength alcoholic drinks

There is a clear and consistent relationship between the price of alcohol and its level of consumption. A wealth of evidence demonstrates that, at a population level, increasing the price of alcohol through taxation reduces consumption, alcohol related harm and overall costs to society.³² Furthermore, the effects of price changes on alcohol consumption are more effective than other alcohol policy interventions, such as restricting the number of outlets, or bans on advertising or price promotion.³³



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Despite the overwhelming evidence linking alcohol consumption and price, the last 14 years have seen an unprecedented rise in the affordability of alcohol which has been caused, principally, by static duty rates in an era of rising disposable income. Until the 2008 Budget, duty rates on spirits had not increased since 1998; those for beer and wine were increased, at most, by the level of inflation. Duty on cider was even cut in 2002

when only ‘alcopops’ were singled out for a rise in duty. The HM Treasury press notice accompanying the 2002 Budget remarked triumphantly, “*In real-terms, the cuts in spirits, beer, wine and cider duties in the last two Budgets have saved the nation's drinkers around £200 million, and given a valuable boost to drinks producers, pubs and other retailers*”. Over the same period, the number of people admitted to hospital with a diagnosis specifically related to alcohol rose by 11,247.³⁴

Alcohol duty is an effective lever

In 2007, against a background of increasing alcohol related harm, the Government published its second alcohol strategy in three years and at the same time commissioned an independent review of evidence on the relationship between alcohol price, promotion and harm.³⁵ The resulting series of reports by the University of Sheffield are a comprehensive study into the consumption and harmful effects of alcohol pricing and promotion. The final report models a number of specific policy options, including the 50 pence per unit minimum pricing regime favoured by the Chief Medical Officer. There are, however, differing legal opinions as to whether a minimum unit pricing regime could be in breach of EU law.³⁶ European Treaty Articles on the free movement of goods and services have already been used to undo national public health legislation such as the Swedish law banning alcohol advertising.³⁷

Although, the 50 pence per unit minimum pricing regime has been shunned politically,³⁸ it is interesting to note that the same overall reduction in alcohol consumption predicted by a 50 pence per unit minimum pricing regime can be achieved by raising the general price of alcohol by 16%.³⁹ This approximates⁴⁰ to the same level of price increases as a result of two substantial alcohol duty increases in 2008: 9% in the 2008 Budget and a further 8% in Pre-Budget Report.⁴¹ Alcohol duty rates were increased by a further 2% in the 2009 Budget in accordance with a duty escalator which will increase alcohol duty at 2% above the rate of inflation to keep duty rates in line with rising incomes.⁴² From a public health perspective, the benefit of using taxation as an instrument for reducing alcohol consumption is that any additional revenue raised goes to the Treasury; whereas with a minimum unit pricing regime any additional income from consumers is likely to be channelled direct to the drinks industry, since it is suggested that manufacturers and suppliers would simply increase prices to meet the proposed minimum unit price.

The effect of price increases on patterns of consumption is that health and crime harms are reduced the most in harmful and hazardous drinkers. Therefore, to achieve reductions in harm and realise the long-term health benefits from the substantial 2008 duty increases, long-term duty rates should, as a minimum, be fixed to the Retail Price Index (RPI). Duty increases in excess of the RPI should be modelled against their effect of reducing the number of hazardous drinkers. However, before introducing this measure the duty regime should be re-structured to encourage the production and consumption of lower alcohol products.

Recommendation: A public health duty escalator should be introduced where future alcohol duty rates are set in excess of the Retail Price Index with a specific aim of reducing the number of harmful drinkers in the population.

Introducing duty bands to promote lower-strength alcoholic products

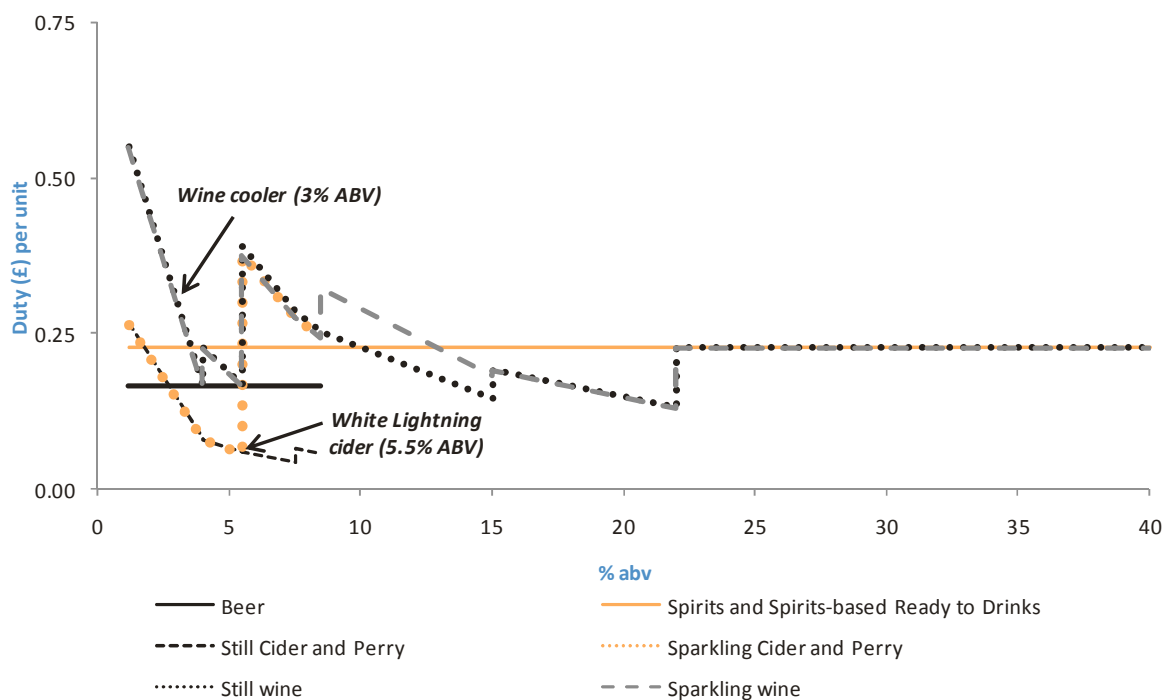
Despite the use of alcohol taxes being the most effective instrument for controlling alcohol related problems,⁴³ tax-based policy options were specifically excluded from the University of Sheffield study. We believe that a duty regime which recognises that people buy, and consume, alcohol in standard measures of

drinks – pints and cans, bottles and glasses - and not by counting units displayed on packaging or calculated on a website, can help in reducing overall alcohol consumption, and therefore alcohol-related harm.

However, the UK’s ability to apply progressive duty rates according to the strength of an alcoholic product is severely restricted by EU Law. The relevant directive requires that, beyond 10% abv duty on spirits should be charged at a flat rate per unit while, confusingly, duty on wine should be applied according to the volume of the finished product, rather than its alcohol content. There is more flexibility with respect to beer and cider although duty on beer in the UK is currently levied at a flat rate per unit.

Consequently, the current duty regime in the UK for alcoholic products is a very confusing picture with some products having duty bands, while others do not. Crucially, the graph below - in which calculations of the duty per unit have been made from HM Revenue & Customs duty rates - demonstrates that as cider and wine become stronger within each duty band, they attract less duty per unit of alcohol. This introduces an incentive for some consumers, particularly problem drinkers, to maximise the number of units per purchase and tend towards strong ciders or fortified wines. For example, the analysis below shows that even at a reduced strength of 5.5% abv ‘White Lightning’ cider still sits at a position of relative duty advantage. Beer, and spirits are subject to flat duty regime with no incentive for producers to make, or consumers to drink, products containing less alcohol. And perversely, low-strength wine coolers at 3% abv are subject to among the highest rates of duty per unit of alcohol.

Duty per unit applied to different strength alcoholic drinks



Source: HM Treasury Press Notice (http://www.hm-treasury.gov.uk/bud_bud09_press02.htm) April 2009

Units of alcohol

In the UK one unit is 10ml or 8g of pure alcohol. The number of units in a drink depends on what you are drinking – how strong it is and how much there is. Half a pint of 3.5% beer/lager/cider is one unit; one small glass (125ml) of wine at 9% is one unit.

Despite the health messages around safe drinking being based on units, there is no correlation or crossover of units of alcohol into the duty system. Moreover, a significant number of drinkers do not know how the units system translates into actual measures: 77% of people don't know how many units are in a large glass of wine, (Answer: 2 units at 9% abv, or 3 units at 12% abv) and 35% don't know that an 'average' pint of beer (at 3.5% abv) contains 2 units⁴⁴. Furthermore, the average alcoholic strengths of wine⁴⁵ and beer⁴⁶ are steadily increasing, which has recently required the Office for National Statistics to revise upwards its estimates for alcohol consumption.⁴⁷

In terms of total consumption of pure alcohol in the UK, beer accounts for 39%, wine for 33%, spirits for 21% and cider 7%.⁴⁸ In order to help reduce the overall level of pure alcohol consumption, we propose that duty bands should be introduced for beers of different strengths. These new duty bands should also include – to the extent that they can under EU law⁴⁹ – still and sparkling cider so that beverages served and consumed in similar quantities are subject to the same duty regime. Duty should be cut on beer and cider where the alcoholic strength is less than, or equal to, 2 units per pint (up to 3.5% abv) whereas duty should be raised for beer and cider where the alcoholic strength exceeds 2.5 units per pint (over 4.4% abv). These changes would encourage the production, and consumption, of lower strength alcoholic beverages and reduce population level alcohol consumption.

Duty banding has already been used in the UK and elsewhere with some success. In the UK, an additional duty band for strong cider was introduced in 1996, and HMRC data shows a subsequent reduction in its overall consumption, although long-term reductions were not achieved because duty rates failed to rise in line with inflation.⁵⁰ In Australia's Northern Territories substantial reductions in alcohol consumption were achieved through a range of measures, including a levy on alcoholic beverages with alcohol content over 3%.⁵¹ At the same time, increases in revenue were committed to prevention and treatment programmes.

Only small reductions in % abv are required to produce relatively large reductions in overall pure alcohol consumption. For example, a reduction in the average alcohol content in a pint of beer by just 1% abv from its current level of 4.2%⁵² to 3.2% would effectively reduce its pure alcohol content by 22%, with no detrimental effect to the profitability of the drinks industry.

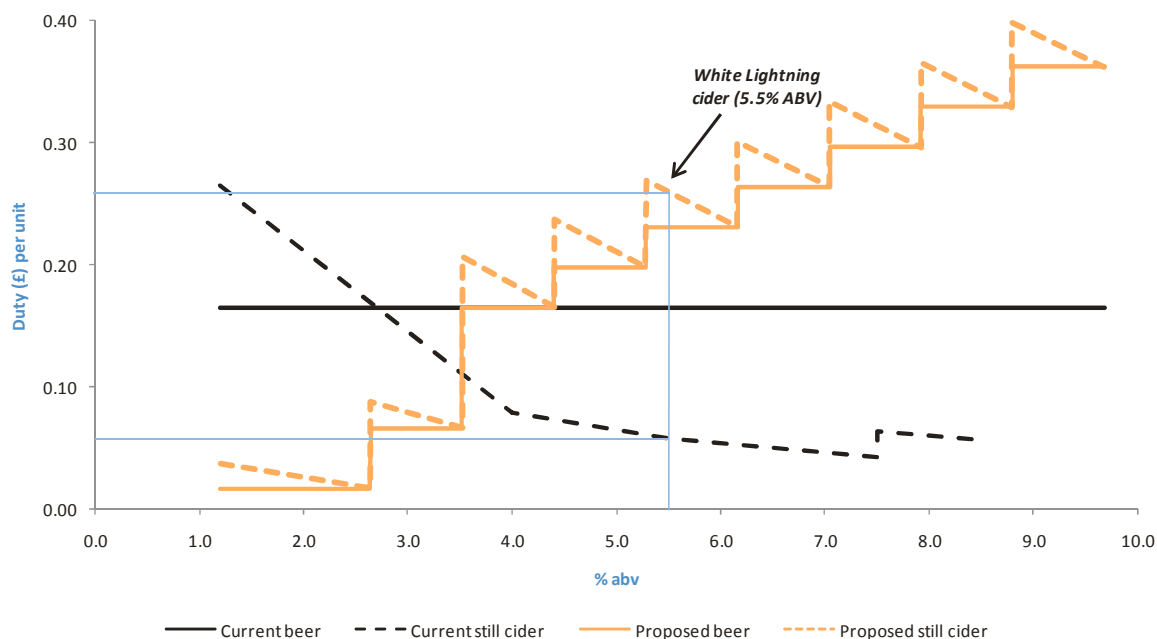
Introducing duty bands for beer

Beer (% abv) ⁵³	Product example	Number of units in a pint	Duty per unit (pence)		Typical price per pint (£)**	
			Current	Proposed*	Current	Proposed
Above 1.2 to 2.6	Carling C2 Draught (2% abv)	≤ 1.5	16.5p	1.5p	£2.44	£2.18
“ 2.6 to 3.5	Brakspear Bitter, Draught (3.4% abv)	≤ 2	16.5p	7p	£2.53	£2.30
“ 3.5 to 4.4	Foster's Draught (4% abv)	≤ 2.5	16.5p	16.5p	£2.62	£2.62
“ 4.4 to 5.2	Kronenbourg Draught (5.0% abv)	≤ 3	16.5p	20p	£2.72	£2.83
“ 5.2 to 6.2	Bishop's Finger Bottled (5.4% abv)	≤ 3.5	16.5p	23p	£2.81	£3.08
“ 6.2 to 7.0	Leffe Blonde Bottled (6.6% abv)	≤ 4	16.5p	26p	£2.91	£3.36
“ 7.0 to 7.9	Meantime India Pale Ale, Bottled (7.5% abv)	≤ 4.5	16.5p	30p	£3.00	£3.68
“ 7.9 to 8.8	Gold Label Canned (8.5% abv)	≤ 5	16.5p	33p	£3.10	£4.04
“ 8.8 to 9.7	Tennents Super Canned (9% abv)	≤ 5.5	16.5p	36p	£3.19	£4.44

* Some rounding necessary due to conversion from duty rates given as £ per cent of alcohol in the beer.

**Typical price per pint calculations based on £1.87 pre-tax price of beer at 4.1% abv in HM Revenue & Customs Alcohol Factsheet. July 2008. VAT charged at 15%.

Current and proposed duty per unit applied to different strength beer and cider



The introduction of additional duty bands for beer and cider would be likely to result in large reductions in consumption of these products by harmful and hazardous drinkers since these groups are particularly price sensitive. In addition, young males, who cause the greatest amount of harm in terms of alcohol related crime, are also highly sensitive to the price of beer.⁵⁴

Low alcohol doesn't mean less enjoyment

An interesting study from the USA suggests that drinkers would not consume more low alcohol beer in an attempt to get drunk. The controlled study found that young college drinkers indicated similar levels of enjoyment for two strengths of beer at 3% and 7%. Most significantly, however, those drinking the 3% beer did not compensate for drinking the lower alcohol beer by increasing the number of drinks they consumed.⁵⁵ The overall result was lower blood alcohol concentrations which translate into reduced levels of harm.

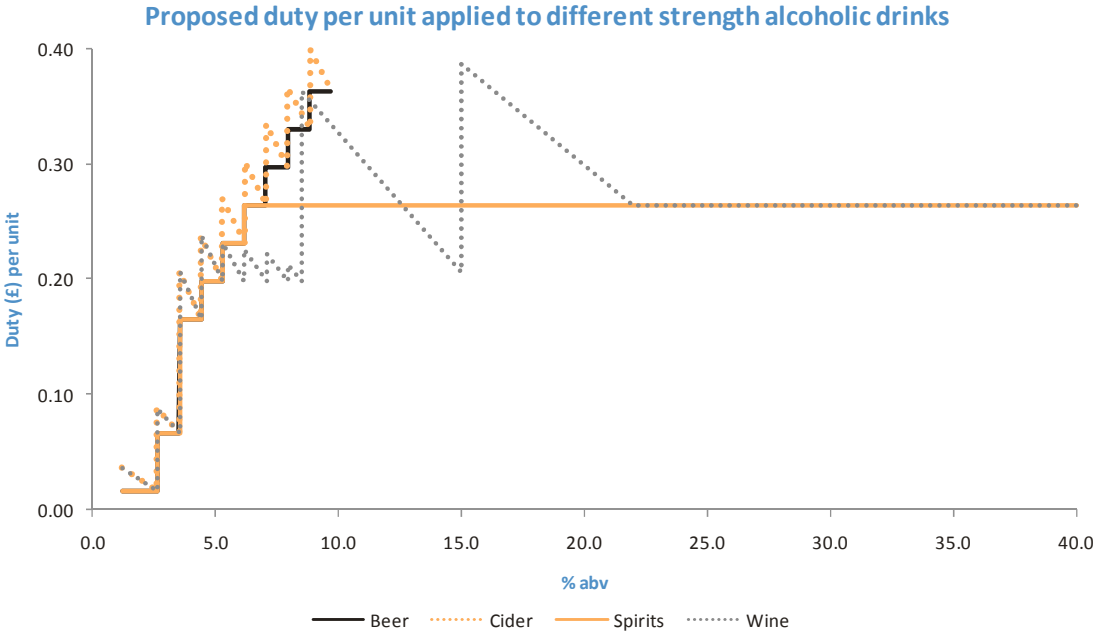
Wine accounts for 33% of the UK's total pure alcohol consumption. But since EU law⁵⁶ requires duty on wine to be applied to the volume of the finished product (i.e. alcohol content is irrelevant) there are limited options for using the tax system to reduce overall pure alcohol consumption from wine. It is possible, however, under EU law to significantly reduce duty on wine of less than 8.5% abv to encourage the production and consumption of lower strength wines.

The market for lower strength wine is currently under developed and the majority of alcohol consumption through wine takes place in the 8.5 – 15% abv bracket, where EU law prevents the levying of duty in relation to alcoholic strength. The Wine & Spirit Trade Association (WSTA) report that consumers of wine base their purchase decisions on specific price points as they see price as an indication of quality. Typical price points are £3.49, £3.99, and £4.49 and previous attempts to pass through duty increases with prices such as £4.03 have failed.⁵⁷

Since EU law does not allow duty on wine to be applied in relation to its alcoholic strength – as is proposed for beer and cider – general price increases are necessary to encourage producers and consumers of wine to switch into lower alcohol products. We believe that as part of a wider re-structuring of the duty regime, duty levels for wine over 8.5% abv should be increased so that prices are more likely to correspond to recognised price points. So, for example, wine currently sold at £3.49 would increase to £3.99. Not all the increase in price should be taken in duty and VAT; there should be an element of return to the wine industry, so that investment could be made into the production of lower alcohol wines.

The position with spirits is also hampered by EU law, which requires the same level of duty to be applied to spirits over 10% abv. If the proposed duty regime is adopted the duty on a bottle of whisky would increase from £13.40 to £14.70.

The likely behaviour of the population in response to price changes also needs to be considered. The University of Sheffield review found that patterns of product switching are complex, and that as well as absolute price, individual preferences for beverages, drinking location and price points for the relevant consumers all play a part. However, in response to price, hazardous and harmful drinkers tend to display more product switching than moderate drinkers. By increasing the price of strong beer and cider and lowering that on wine of similar strength there would be some incentive for harmful and hazardous drinkers to switch to wine; but cross-price elasticity data suggests that harmful and hazardous drinkers would not significantly shift their consumption into low-alcohol wine as much as they would reduce consumption of strong beer and cider.⁵⁸



There are obviously significant revenue impacts associated with changes to the duty regime. The duty levels outlined in the research paper are only indicative and it is acknowledged that further research is required.

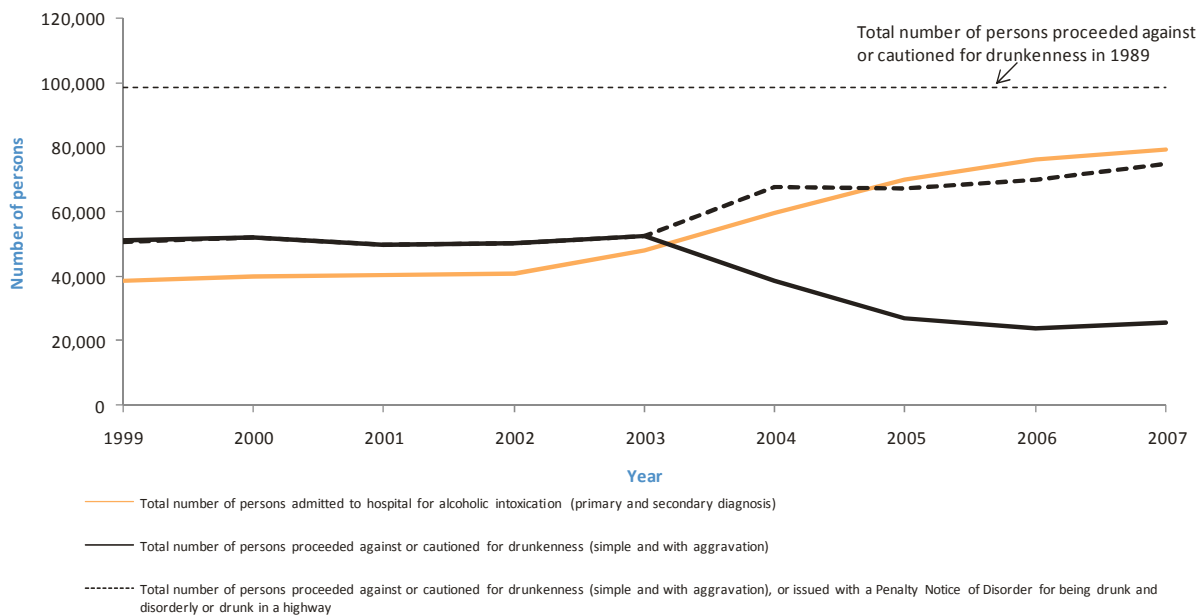
Recommendation: There should be a fundamental review and restructuring of the alcohol duty regime in order to promote the production, and consumption, of lower alcohol products. Duty should be cut on beer and cider where the alcoholic strength is less than, or equal to, 2 units per pint whereas duty should be raised for beer and cider where the alcoholic strength exceeds 2.5 units per pint.

Enforcement & intervention: reducing the problem of alcohol misuse

Despite the huge costs associated with dealing with alcohol misuse, in 2008 the National Audit Office found that over 40% of Primary Care Trusts (PCTs) did not have a preventative strategy for dealing with alcohol misuse and those that did only spent a little over 0.1% of their budget on alcohol services. This represents £600,000 for a typical PCT and about £90 million nationally, compared to £800 million spent on drug treatment⁵⁹ and the £2.7 billion it costs the NHS for dealing with alcohol related illness.

Set in a context of limited NHS funding for prevention, we also see that the burden of dealing with acute alcohol excess has shifted from the police to the NHS. Cautions and prosecutions for public drunkenness and disorder have largely been replaced with Penalty Notices for Disorder, but these new measures have not kept pace with the steep rise in hospital admissions. Our analysis shows that more people suffering with alcohol excess are now admitted to hospital than are dealt with by the police. Of course, there are good medical and safety reasons why hospital is the best place for those that are acutely intoxicated; however, the costs of irresponsible use of alcohol in the night-time economy are placing considerable burdens on the NHS. We believe that the dramatic reduction in police intervention for public drunkenness has contributed to the rise in hospital admissions for acute intoxication.

Persons admitted to hospital for alcoholic intoxication, and those dealt with by the police for public drunkenness



Sources: ICD-10 Codes F10.0, F10.1, T51.0, Y90. 4, Y90.5, Y90.6, Y90.7, Y90.8, Y90.9, Y91.2 & Y91.3, NHS Hospital Episode Statistics. Data courtesy of CHKS Ltd; Criminal Statistics England and Wales. Supplementary Tables 2007; House of Commons Hansard Written Answers, 25 Nov 2008; NHS Information Centre, Statistics on Alcohol: England 2008.

Policing public drunkenness

Penalty Notices for Disorder (PNDs) were introduced in late 2003 to provide the police with a quick and effective means of dealing with low level nuisance behaviour - particularly alcohol-related - that occurs in city centres at night and weekends. The scheme has two penalty tariffs: £50 and £80. The person issued with the PND has 21 days to pay the penalty or request a court hearing. If the penalty is paid all liability for the offence is discharged and there is no criminal record. If the penalty is not paid within 21 days a fine of one and a half times the penalty is registered and enforced through the courts in the normal way. The average cost of issuing a PND on the street is £33.⁶⁰

Twenty years ago, just under 100,000 people were dealt with by the police for their public drunkenness.⁶¹ Even with the introduction of PNDs, today that figure has fallen to 75,000. To prevent even greater burdens on the NHS, and as a matter of public health, we believe that there should be a greater focus on policing public drunkenness and increased use of Penalty Notices for Disorder to act as a disincentive to consume alcohol to excess.

The PND scheme was based on the Fixed Penalty Notice (FPN) scheme for road traffic offences where the concept of an educational course paid for by individuals issued with a Fixed Penalty Notice was first used. This scheme for speeding drivers has proven to be effective and the concept has been applied successfully in providing educational courses for individuals issued with alcohol-related PNDs. These schemes are largely self-financing, so national roll out should be a priority for a Government wishing to tackle alcohol-related disorder.

Hertfordshire Police – Alcohol Diversion Scheme

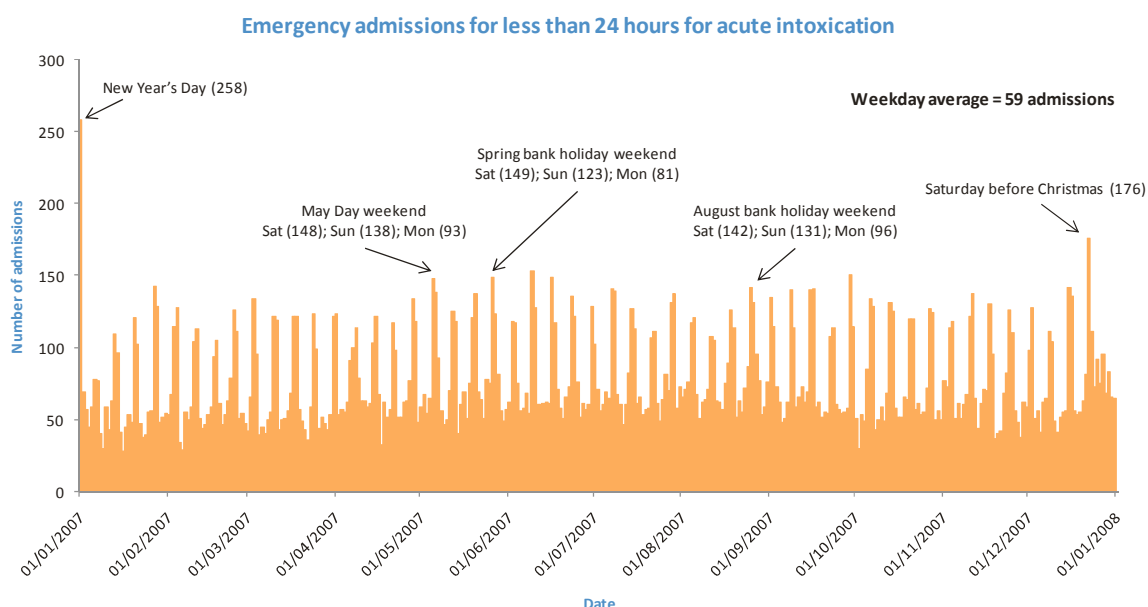
The Alcohol Diversion Scheme set up by Hertfordshire police targeted individuals issued with an £80 Penalty Notice for Disorder for an alcohol related incident and offered them the opportunity to attend a three-hour education and awareness course at a reduced cost of £40. The course was piloted in the West of Hertfordshire for six months commencing August 2007; it was reviewed for effectiveness at the six-month stage. Due to the success of the project it was rolled out across the whole of Hertfordshire in April 2008.

In follow up 6-9 months later three quarters of course participants said their alcohol consumption had reduced and almost all reported increased awareness and understanding of the part alcohol plays in violence. The primary group engaged with the course is 18-25 year old males who are identified in the Governments' Alcohol Harm Strategy as typical binge drinkers.

Although the total numbers were small the Alcohol Diversion Scheme delivered a zero re-offending rate during the first year for participants on the course. The course achieved an attendance rate of 18% of all PNDs issued to for alcohol related disorder and was largely self-financing.⁶²

Recommendation: More focus on policing public drunkenness and the greater use of Penalty Notices for Disorder, and a national roll out of Alcohol Diversion Schemes, moving those issued with PNDs into education and awareness courses.

Reducing burdens on the NHS



Source: ICD-10 Codes F10.0 & F10.1, NHS Hospital Episode Statistics. Data courtesy of CHKS Ltd.

If the costs to society from dealing with alcohol misuse are to be reduced there needs to be a coordinated effort by the police and NHS. Currently, less than half of Primary Care Trusts report that A&E Departments in their areas offer alcohol screening and brief interventions, and in these areas only two-thirds of A&E Departments were providing such advice.⁶³ We believe that all people attending Accident & Emergency Departments with alcohol related conditions should be screened for alcohol misuse. The Paddington Alcohol Test (PAT) is one of the best ways for doing this. It is cost-effective and has a 17 year history of reducing alcohol consumption and re-attendance rates at Accident & Emergency.⁶⁴ Although the majority of alcohol related conditions are treated in Accident & Emergency departments, there are a significant and growing number of people admitted to hospital for less than 24 hours just to recover from being drunk.

With the introduction into the NHS of Payment by Results it is possible to give a reasonably accurate cost for such admissions. The most recent tariff⁶⁵ for an acute admission for 'ingestion poisoning' is £532, which makes the total cost to the NHS for admissions to hospital to recover from being drunk as £15 million per year. We believe that these costs should not be covered by the NHS, but should be borne by the relevant individuals themselves. The principle of cost recovery is not a new one for the NHS - it has been used for road traffic accidents since the 1930s.⁶⁶ The current NHS Injury Costs Recovery (ICR) allows the NHS to reclaim the cost of treating injured patients to all cases where personal injury compensation is paid. The bulk of these costs are recovered from compulsory motor insurance, which are in turn passed on to the public in the form of increased premiums.⁶⁷

Patients admitted to hospital for less than 24 hours with the acute effects of alcohol should be personally charged the NHS tariff cost for their admission. Hospital trusts already have revenue protection officers to deal with the Injury Cost Recovery scheme and to recover costs from overseas patients not covered by reciprocal arrangements. However, people being charged for admission to hospital should be offered the alternative of paying a reduced fee - as with the Alcohol Diversion Scheme - to cover the full costs of

providing an education and awareness intervention to help reduce their alcohol consumption and future drain on the NHS.

Recommendation: Extending the use of cost recovery in the NHS to cover those admitted to hospital with acute alcohol intoxication, but offering reduced fees to incentivise the uptake of education and awareness courses. These courses would be fully funded by the reduced fee income.

Spreading best practice on reducing alcohol related harm

The numbers of drinkers coming to the attention of the police or A&E Departments are relatively small compared to the figure of over 10 million people that are estimated to be drinking at harmful and hazardous levels. There is already a substantial body of research which shows that problem drinkers can be identified and managed in a primary care setting, long before they require specialist costly hospital based interventions.⁶⁸ The mainstay of identifying these patients is through the use of simple screening questionnaires with those identified as being at risk offered a brief intervention.

Brief interventions

A brief intervention is an assessment of alcohol intake coupled with information on hazardous and harmful drinking and clear advice for that individual, often with booklets and details of local alcohol services. The interventions are usually carried out by generalist workers in non-specialist settings and are brief and user-friendly.⁶⁹

Although the Department of Health is currently piloting the use of brief interventions in the Screening and Intervention Programme for Sensible Drinking (SIPS), the 3 year programme does appear somewhat lengthy considering there is already overwhelming evidence that such schemes are cost-effective.⁷⁰ There is a plethora of research into the problems, costs and interventions for alcohol misuse, but very little effort focusing on the dissemination of best practice or spreading the existing evidence base. For example, alcohol screening and intervention does not appear in the Quality and Outcomes Framework nor in the recently announced health screening programmes for the over 40s. And Wirral PCT spent time and effort developing an alcohol screening programme through its local pharmacy network only to discover that a similar scheme had already been trialled in Monmouthshire.

The National Audit Office has recently suggested a professional network of Regional Directors of Public Health to help promote good evidence-based practice on alcohol harm across PCTs. However, dissemination of best practice is already within the remit of both the Alcohol Education and Research Council (AERC) and the National Treatment Agency for Substance Misuse (NTA). The operating cost for each of these organizations is approximately £10 million. The persistent rise in morbidity and mortality for alcohol misuse suggests that these organizations are ineffective and we believe they should be merged and given a renewed focus on spreading best practice on reducing alcohol related harm.

Alcohol screening in local pharmacies

Wirral PCT has the fourth highest number of alcohol related hospital admissions in the UK. To try to reduce this figure it has developed an alcohol screening programme using the AUDIT assessment tool which is currently offered in 57 out of a possible 76 local pharmacies. One major advantage of utilizing pharmacies is that they reach people who may not otherwise come into contact with health professionals. In the last 12

months over 2,000 screenings have taken place and in follow up, many people reported that they were not aware of how many units they were drinking and the risks of exceeding recommended guidelines until they took part in the screening.

Pharmacy counter staff complete a half-day study course organised by the PCT and are trained to use tactful ways to introduce the subject of drinking and invite their customers to complete a short questionnaire. Customers are targeted; for example, those purchasing indigestion remedies. Willing customers answer 10 questions to determine whether they are at low risk, hazardous, harmful or dependent levels of drinking. All participants are given a booklet with further advice and are invited to receive telephone follow-up after 8 and 52 weeks. Participants who score “harmful” or “dependent” are asked whether they would like to be referred to Wirral PCT’s alcohol service. Not all customers were ready to be referred straight away, although anecdotal evidence suggests that many do return to seek help at a later date.

Payments to the pharmacy are linked to screenings rather than to the numbers receiving a referral or brief intervention. Each screening costs the PCT just £11.50.

Recommendation: The Alcohol Education and Research Council (AERC) should be merged into the National Treatment Agency for Substance Misuse (NTA) and given a renewed focus on spreading best practice and promoting evidence-based interventions to reduce alcohol-related harm. For example; NHS alcohol screening can be delivered in local pharmacies to ensure large population coverage at relatively low cost.

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research note



The work of the Health & Social Care unit at Policy Exchange

Public health and preventive medicine are too often seen as a low priority. We believe that it makes better medical and economic sense to prevent illness rather than spend more on treatment in the future. Our previous research in public health, *Weighing In*, called for a systematic review into the effectiveness of interventions aimed at tackling obesity. We are currently working on a project which will examine choice in primary care and consider whether new forms of providing primary care services can both improve health outcomes for patients and provide better value for money for the taxpayer.

For more information on the work of the Health & Social Care unit, please contact Henry Featherstone, Head of the Health & Social Care unit at henry.featherstone@policyexchange.org.uk

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