



Alcohol and Economic Crises

Summary

- There is a relationship between a society's socioeconomic conditions (i.e. levels of income, education, unemployment, and job insecurity) and health outcomes.
- Economic crises can affect population health outcomes in several ways, including impacting health behaviours such as alcohol consumption.
- Evidence indicates that population-level alcohol consumption decreases during economic crises, but with increases in high-risk alcohol use seen among some subgroups.
- Suffering a more severe economic loss, being a man, being unemployed, and being less well educated may increase the likelihood of engaging in more/higher-risk drinking during an economic crisis.
- Mechanisms for increasing/decreasing alcohol consumption include psychological distress and tighter budget constraints.
- Targeted support for people experiencing unemployment, and population-wide measures to improve access to treatment and support, restrict marketing, and raise the prices of the cheapest alcohol could reduce levels of alcohol harm.

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INTRODUCTION

An economic crisis is loosely defined as a period in an economic cycle in which an economy faces difficulties for a long time, often marked by a sudden downturn in its aggregate output or real gross domestic product (GDP), a decline in real income per capita, and an increase in unemployment and poverty.¹

Economic downturns can impact health and health behaviours (e.g., alcohol consumption) in several ways, with outcomes varying across generations and socioeconomic groups. As well as directly influencing health behaviours (e.g., tobacco and alcohol use, diet, and exercise), broader socioeconomic changes in a downturn (e.g., increase in poverty, unemployment, or other deprivation) can also affect health outcomes, as can policy responses to these changes.

This briefing considers the impact on alcohol consumption and levels of harm during periods of economic difficulty (including during the COVID-19 pandemic) and includes recommendations for policy measures that might best protect public health in times of economic instability.

ECONOMIC CRISES AND HEALTH OUTCOMES

The economic context impacts health outcomes

Many non-medical factors influence health outcomes, known as the ‘social determinants of health’. These are the conditions in which we exist, and the wider set of forces and systems shaping daily life, including the economic context and government policies.²

There are several ways the economy can impact health, including: income and social protection; housing; environment; education; employment and job security.³ Figure 1 indicates how the various environmental factors influence our individual health.

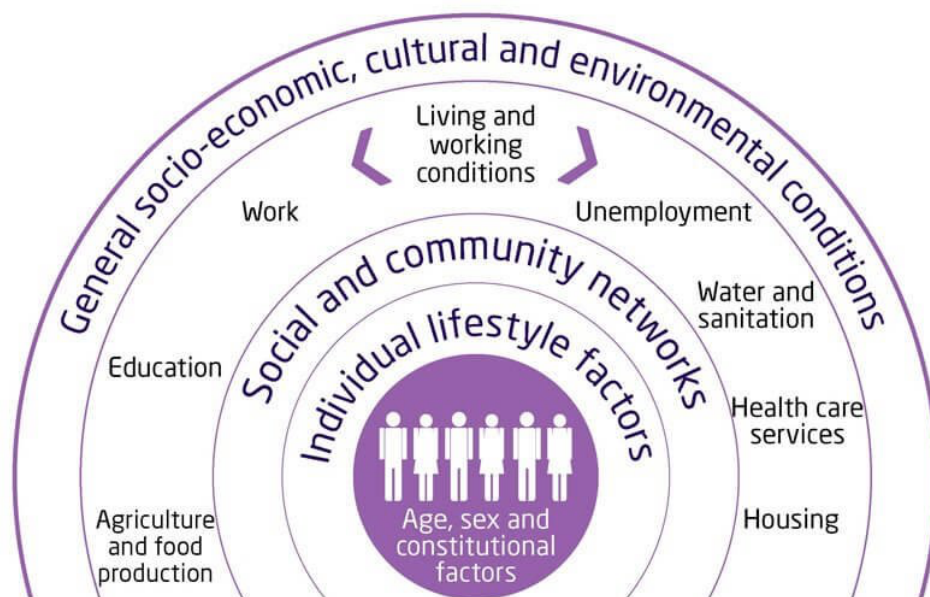


Figure 1. Dahlgren-Whitehead model of health determinants.

Source: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?

Poverty and health inequalities

Poverty is closely linked with health. ‘Absolute poverty’ denotes a level relative to a fixed ‘basic’ standard of living (e.g., food, shelter, clothing), whereas ‘relative poverty’ compares each household’s income to the average or typical living standard. Relative poverty is the most used approach in the UK context, where those with less than 60% of the average income are classified as below the poverty line.⁴

People living in poverty have a much lower life expectancy than those who are not, and are more likely to suffer from chronic diseases and diet-related problems.⁵ There is much debate around the interactions and relationships between poverty and health, which can exist as a negative cycle: unemployment and poverty contribute to poor mental and physical health, which in turn makes it more difficult to work or earn a living wage. Many people living in poverty cannot afford to meet their health and social care needs, resulting in their conditions worsening over time. This negative pattern can transfer across generations, begin pre-birth, and impact upon parenting, educational attainment, and employment.⁶

Specifically, the risk of experiencing health harms from alcohol consumption is disproportionately higher for those from disadvantaged groups.⁷ For example, in England, the rate of alcohol-specific deaths in the most deprived area is double that in the least deprived.⁸

Economic crises deepen poverty and worsen income inequality in several ways.⁹ In addition to job losses, real wage cuts, and relative price changes, policy responses to economic crises also impact health. This includes how quickly a government pulls the economy out of a recession, to what extent a government shields citizens from negative consequences e.g., welfare benefits, and how far a government feels it needs to engage in austerity (reducing public expenditure through cuts).

For example, the period of austerity in the UK following the Great Recession of 2008/9 impacted health through two pathways:¹⁰

- 1) The ‘social risk effect’ of increasing unemployment, poverty, homelessness, and other socio-economic risk factors, while cutting effective social protection programmes that mitigated risks to health.
- 2) A ‘healthcare effect’ through cuts to healthcare services, as well as reductions in health coverage and restricting access to care. For example, the overall public health grant has been cut by 28% on a real-terms per head basis since 2015/16.¹¹

TRENDS IN ALCOHOL CONSUMPTION DURING ECONOMIC CRISES

The evidence on the impact of economic crises on alcohol consumption and alcohol-related health problems is mixed, with different patterns identified in different contexts.¹² Specific characteristics of the crisis and the national context, e.g., policies in place and drinking culture, all play a role. The relationship between drinking and the economy also depends on the type of user, e.g., light, moderate or heavy drinkers.¹³ The below cases provide examples of trends during specific economic crises and conditions.

On average, alcohol consumption can fall slightly

During the Great Recession of 2008/9 in England, there was a small but statistically significant decrease in frequent drinking (defined as drinking on four or more days in the past week), from

27.1% in 2006 to 23.9% in 2009.¹⁴ There was also a decrease in the number of days that individuals reported drinking over the past seven days (from 2.38 in 2006 to 2.08 in 2010) (see Figure 2).¹⁵

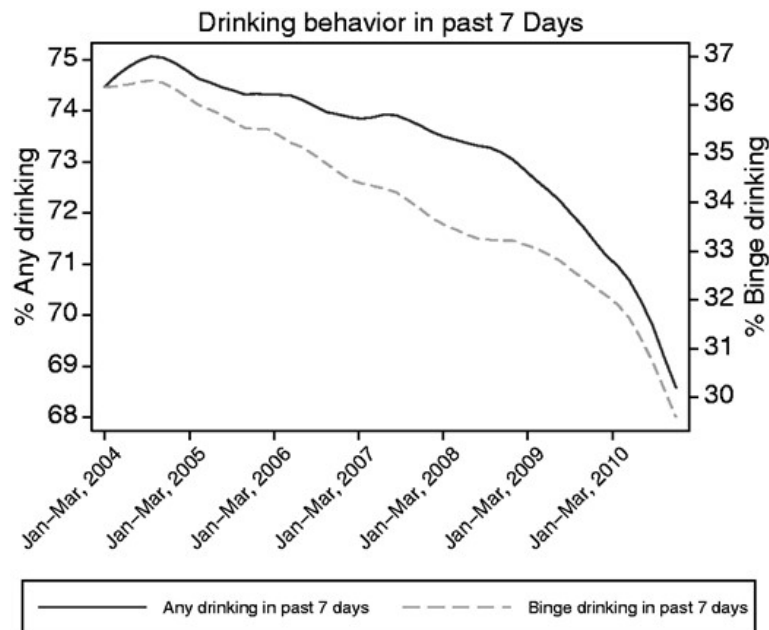


Figure 2. Drinking behaviour in England, 2004-2010
Source: <https://pubmed.ncbi.nlm.nih.gov/24058184/>

This pattern was echoed in the US, which saw a very small decline in population consumption, measured as any drinking in the past 30 days, from 52.0% in 2006-2007 to 51.6% in 2008-2009, corresponding to 880,000 fewer drinkers.¹⁶

The COVID-19 pandemic also provides a recent opportunity to assess drinking patterns during times of financial hardship, given the socioeconomic and employment consequences.¹⁷ A meta-analysis of observational studies across Europe found that slightly more individuals indicated a decrease than an increase in their alcohol use during the pandemic, with decreases also seen in drinking frequency, quantity consumed, and heavy episodic drinking.¹⁸

Another large-scale, cross-sectional online survey in 21 European countries identified decreases in consumption (driven by reduced frequency of heavy episodic drinking) in all countries except Ireland and the UK during the pandemic.¹⁹

But there are increases in high-risk alcohol use among some subgroups

However, overall population data masks trends within higher-risk subgroups e.g., unemployed people affected by economic crises, or those already drinking at high levels.

During the 2008/9 recession in the UK, despite overall less drinking, there was a significantly higher risk of heavy episodic drinking (often referred to as 'binge drinking') among current drinkers who were unemployed.²⁰ This polarisation was also seen in the US: despite an overall decline in alcohol consumption during the economic recession, there was an increase in the prevalence of heavy episodic drinking, from 4.8% in 2006-2007 to 5.1% in 2008-2009 - corresponding to 770,000 more frequent 'binge drinkers'.²¹

During the COVID-19 pandemic in the UK, although over a quarter of adults (26%) reported consuming less alcohol, the same amount reported drinking more than usual over the past week.²² Another study found that 30% of the participants reported drinking more frequently during lockdown.²³ 16% reported consuming more units when they did drink, and 14% reported an increase in heavy episodic drinking.²⁴

In their meta-analysis of alcohol use during the pandemic in Europe, Kilian et al. found that among those already drinking heavily, and/or with an alcohol use disorder, these drinking patterns appear to have solidified or intensified.²⁵ Other studies found greater increases in high-risk drinking among people in lower socioeconomic groups, and among women.²⁶

Another systematic review that brought together findings from 35 international papers reported that during economic crises, elderly men and those with relatively low levels of education are the most likely to experience increased levels of harmful drinking.²⁷ They also, however, identified a number of contrasting trends, which underlines how the specific characteristics of a crisis and the country-level context greatly influence how people might change their drinking habits during times of financial hardship.²⁸

TRENDS IN ALCOHOL HARM DURING ECONOMIC CRISES

With alcohol playing a causal role in more than 200 different diseases and injuries in addition to social consequences and harms to others, changes in alcohol consumption can have a considerable effect on public health and societal welfare.²⁹ Most of the health consequences of changes in alcohol consumption will take time to be realised, as these tend to be chronic conditions that develop over a long period of time.³⁰

Research from Finland tracking alcohol-related mortality during an economic boom at the end of the 1980s followed by a severe economic recession in the 1990s, found that mortality rates increased during the boom period and decreased slightly during recession. Further analysis showed that those with a lower socioeconomic status tended to be impacted more negatively, with a stronger than average increase during the economic boom and a smaller than average decrease during the recession.³¹ A subsequent study tracking 1,774 Finnish women and men between 1998 and 2018 found that the risk of alcohol-related diseases was more than four times higher among men who experienced recession-induced hardships compared to those who had not.³²

Following the 2008/9 recession in the UK, the rate of alcohol-specific deaths started to decline, decreasing from 12.2 deaths per 100,000 people in 2008 to 11.1 deaths per 100,000 in 2012 (see Figure 3) – the lowest rate in a decade.³³ During this time, an alcohol duty escalator curbed the rising affordability of alcohol by ensuring duty increased by 2% above inflation every year. As affordability is directly linked to levels of alcohol harm, this policy represents a potential protective measure to reduce consumption and subsequent harm during a period of economic crisis.

During the COVID-19 pandemic however, amidst huge restrictions on our daily lives, there was a sharp increase in alcohol-specific deaths across the UK, increasing by 27.4% between 2019 and 2021 (see Figure 3).³⁴ Specifically, deaths from alcohol-related liver disease were 58.1% higher in December 2020 compared to the corresponding baseline month.³⁵ In addition to changing alcohol consumption patterns, these figures will also have been affected by changes in how the healthcare

system was accessed. For example, in the first lockdown in Spring 2020, overall healthcare utilisation reduced sharply and took time to recover.³⁶

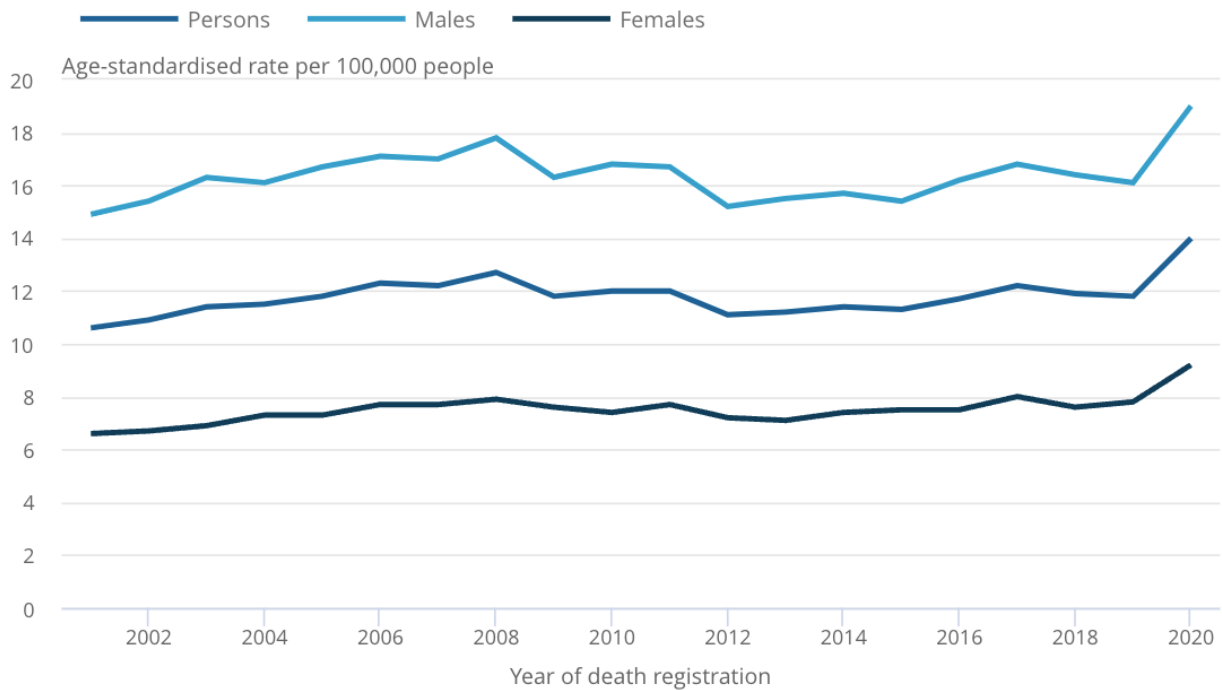


Figure 3. Alcohol-specific deaths in the UK registered in 2020

Source: Office for National Statistics (2021) [Alcohol-specific deaths in the UK: registered in 2020](#)

In Scotland, although the number of deaths from alcohol did increase between 2019 and 2021, this rise was less sharp than in England.³⁷ Again, this could be indicative of the protective nature of pricing policies, with minimum unit pricing (MUP) in Scotland reducing the availability of cheap, high-strength drinks.³⁸

The Institute of Alcohol Studies and HealthLumen modelled the long-term impact of the changes in alcohol consumption observed in the pandemic on nine alcohol-related diseases, projecting that if consumption patterns do not return to 2019 levels, there will be approximately 147,892 additional cases of disease and 9,914 additional premature deaths by 2035. The projected number of deaths is higher in the lower occupational social grade, with approximately 23% more premature deaths expected in the lower grade than the higher.³⁹

With You, a charity supporting people with mental health, alcohol, and drug use, carried out a recent survey on the impact of the cost-of-living crisis. Their findings suggest a shift towards home-drinking, with nearly half (47%) of respondents saying they were drinking at home instead of pubs, bars and restaurants due to financial pressures.⁴⁰ With You also reported that one of their services had seen a 70% increase in referrals support for alcohol use, with a significant amount of staff time dealing with issues outside of the recovery remit, e.g., housing support.⁴¹

RISK AND PROTECTIVE FACTORS FOR ALCOHOL HARM

Unsurprisingly, the severity of an individual's impact of an economic crisis has been identified as a risk factor.⁴² In the 2008/09 recession in the US, *severe* economic loss (job or housing loss) was associated with negative drinking consequences, whereas moderate loss (loss of retirement savings, reduced work hours/wages, trouble paying the rent/mortgage) was not associated with alcohol outcomes.⁴³

In research looking specifically at alcohol consumption during different business cycles, unemployment was identified as a factor driving persisting levels of alcohol consumption during contraction phases.⁴⁴ Empirical analysis looking at the public health effect of economic crises has reported that increases in unemployment contribute to excess alcohol-related deaths.⁴⁵

Gender may also impact the likelihood of experiencing alcohol-related harm during economic instability. Another US study found a link between financial strain and heavy drinking among men, but not women. For men, a one-point increase in financial strain (e.g., a change from 'none' to 'a little') was associated with a greater than 30% *increase* in the odds of heavy drinking. However, for women, the same increase in financial strain was associated with a 20% *reduction* in the likelihood of heavy drinking.⁴⁶

There is some evidence that education levels are also associated with changes to alcohol use during economic crises. The same study found that financial strain was associated with increased probability of heavy drinking for those with low levels of education, but not for those with high levels of education.⁴⁷

Risk factors do not exist in isolation and are often likely to compound one another. For example, a US study found that non-Black, unmarried men under 30 years, who recently became unemployed, were at the highest risk of frequent heavy episodic drinking during the 2008/9 recession.⁴⁸

MECHANISMS BETWEEN ECONOMIC CRISES AND ALCOHOL HARM

A realist systematic review of how economic crises affect alcohol harm synthesised 35 papers and found international evidence for two behavioural mechanisms:⁴⁹

- 1) Psychological distress triggered by unemployment and income reductions can increase drinking problems.
- 2) Less money spent on alcoholic drinks due to tighter budget constraints.

Psychological distress

Economic stressors (e.g., underemployment, wage reductions) can cause many forms of psychological distress, including depression, anxiety, irritability, denial, and anger. There is strong evidence for an association between alcohol use disorder, major depression, and any anxiety disorder,⁵⁰ and several studies have found psychological distress due to economic stress was linked with higher frequencies and volumes of alcohol consumption, and a higher prevalence of problem drinking.⁵¹

For example, during the 2008/09 recession in the US, economic stressors led to an increased frequency and volume of drinking and problem drinking through depression, denial, anger and anxiety,⁵² and through somatic symptoms (e.g., sleep problems, stomach problems, migraines and fatigue).⁵³ During the social and economic transition out of communism in Eastern Europe, psychological symptoms such as feeling stressed, lonely and low in confidence, and somatic symptoms e.g., insomnia and fatigue, were associated with a higher prevalence of frequent drinking.⁵⁴

Researchers investigating increases in Russian mortality in the 1990s suggested that psychological stress caused by abrupt and severe economic transition played a major role in the sharp rise, brought about in part by excessive alcohol consumption and its adverse health effects.⁵⁵

In terms of specific factors, unemployment appears to be one of the most important economic stressors, with psychological distress in unemployed people accumulating over time.⁵⁶ In Spain, almost one-third of patients' risk of common mental health disorders (including anxiety, depression, and alcohol use disorder) could be attributed to risks of household unemployment and mortgage payment difficulties due to the 2008 economic crisis.⁵⁷

Across many countries, this mechanism was seen mainly in men, with women less likely to use drinking as a stress-releasing coping strategy.⁵⁸ The authors suggest that their findings may indicate that alcohol is used to relieve the distress brought about by financial problems primarily among those with the least access to resources (e.g., social support) that could be used for more adaptive coping.⁵⁹

Tighter budget constraints

Income reductions or price increases during an economic crisis can lead to tighter budget constraints and less money being spent on alcoholic beverages, therefore leading to less alcohol consumption.⁶⁰ However, research has indicated that income reductions alone do not entirely explain observed decreases in alcohol consumption and alcohol-related mortality.⁶¹

Additionally, there are other ways people adapt to tighter budget constraints, such as switching to cheaper alcoholic drinks, or drinking at home rather than in the on-trade (e.g., pubs and bars).⁶² The shift to home drinking that With You reported demonstrates a continuation of a decades-long shift favouring off-trade alcohol sales (supermarkets and off-licences) over the on-trade,⁶³ expedited by the COVID-19 pandemic.⁶⁴ A qualitative study identified several reasons for home-drinking including convenience, safety, autonomy, and stress relief.⁶⁵ Consuming more alcohol at home runs the risk of higher overall consumption, due to risk-factors such increased 'pre-loading' (drinking before going out)⁶⁶ and pouring larger drinks measures than in the on-trade.⁶⁷

Case study: The UK cost of living crisis since 2021

The 'cost of living crisis' refers to the fall in real disposable incomes that the UK has experienced since late 2021.⁶⁸ This is caused in part by high global inflation, the economic impact of the COVID-19 pandemic, and international events such as Russia's invasion of Ukraine and the UK's departure from the European Union.

Broadbent et al. identified three potential pathways between the cost-of-living crisis and health outcomes:⁶⁹

- 1) Effects on health behaviour e.g., dietary intake, smoking, drug, and substance use
- 2) Material e.g., food and fuel poverty, housing insecurity
- 3) Psychosocial e.g., stress, reduced social activities, strain on personal relationships

Policy measures also have a significant impact. For example, a planned increase in the energy price cap was predicted to take 4.8 million more people into poverty. This was predicted to have a serious effect on people's mental health, with almost 110,000 additional working age adults, around 30,000 additional elderly people, and over 440,000 additional children suffering common mental disorders.⁷⁰ While this scenario only considered the impact of energy costs on mental health, the below diagram from Public Health Wales demonstrates the numerous other pathways through which the increased cost of living might impact health.

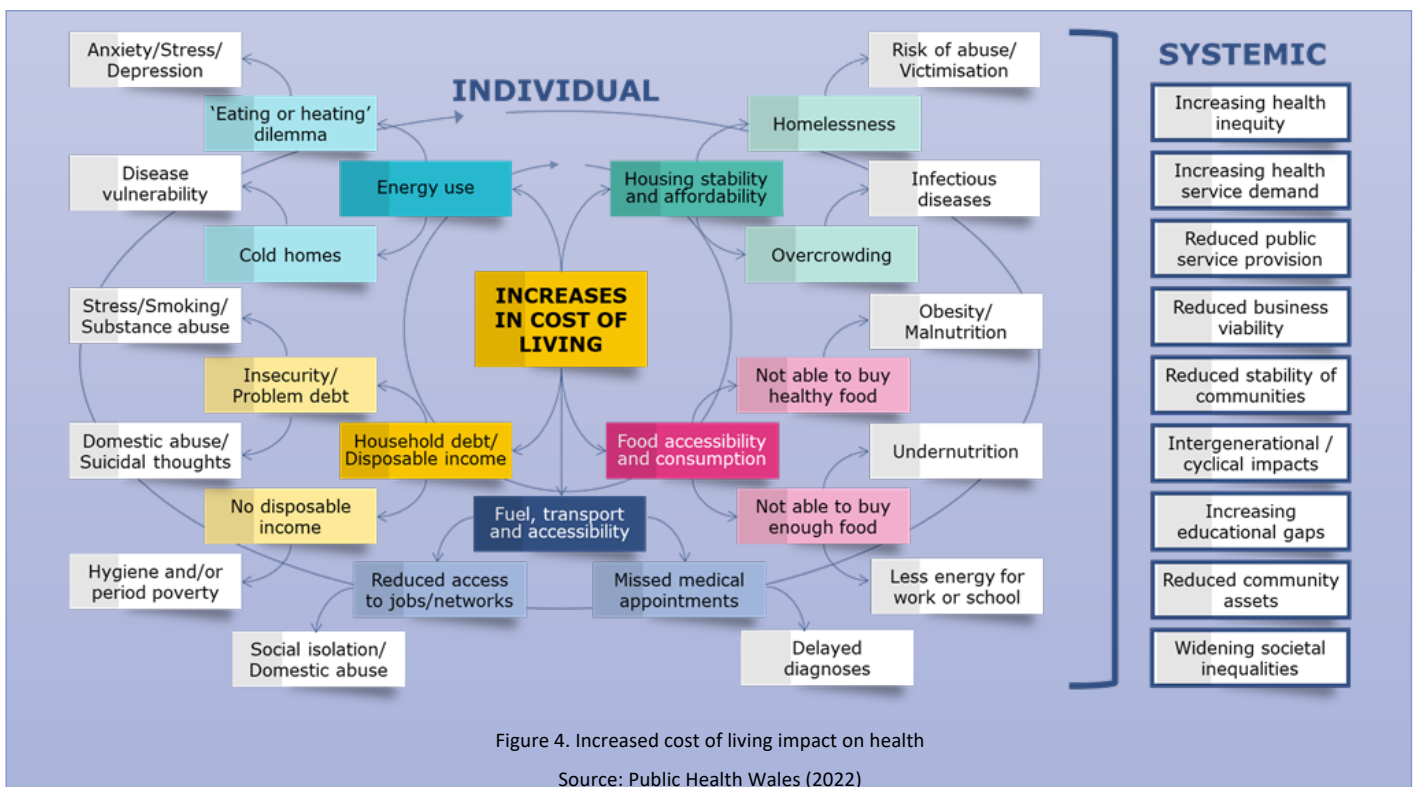


Figure 4. Increased cost of living impact on health

Source: Public Health Wales (2022)

RECOMMENDATIONS

Based on the evidence above, both targeted and population-wide alcohol policies may be especially necessary during economic downturns to reduce potential increases in alcohol harm.

Targeted measures for people experiencing unemployment

As unemployment has been identified as a significant risk factor for increasing alcohol consumption and the likelihood of heavy episodic drinking (along with a range of other health outcomes), welfare policies to reduce long-term and widespread unemployment would prevent some of these harms arising in the first place.⁷¹

For those already experiencing unemployment, targeted measures could be effective. Alcohol Change UK suggests recognising the important role Jobcentres could play in offering tailored support to job seekers with complex needs, particularly during periods of recession.⁷² In 2023, the Department for Work and Pensions announced a peer mentoring programme to help people experiencing addiction into work. The scheme will place mentors who have experienced drug or alcohol addiction themselves in Jobcentres to provide tailored support for others with dependencies.⁷³

A proof-of-concept report from the Department for Work and Pensions concluded that close collaboration between providers in employment support and dependency support sectors could provide positive outcomes for clients by helping to ensure that their preparation for employment does not adversely impact their treatment/recovery from addiction and vice versa.⁷⁴

Population-wide measures

The below measures are backed by the World Health Organization as some of the best evidence-based, cost-effective interventions to reduce alcohol-related harm.⁷⁵

- Facilitating access to treatment
 - Every £1 spent on alcohol treatment yields £3 of social return, increasing to £26 over 10 years,⁷⁶ and recent data indicates that 59% leave services following successful treatment.⁷⁷ Yet only 1 in 5 of dependent drinkers are predicted to be in treatment in England,⁷⁸ and services have faced cuts in recent years: the amount local authorities reported spending on drug and alcohol services fell by 27% in real terms from 2014–15 to 2021–22.⁷⁹ Despite recent increases as a result of the government's 10-year drug strategy,⁸⁰ spending has still not matched 2014-15 levels, and is not sufficient to tackle the massive unmet need for alcohol treatment.⁸¹
 - Increasing and ringfencing alcohol-specific treatment funding would support increased treatment engagement and protect these services from facing cuts during times of economic instability.
- Restrictions on alcohol advertising, sponsorship, and promotion
 - Alcohol marketing directly influences alcohol consumption, and often presents alcohol use as a way to relieve stress.⁸² Comprehensive restrictions would challenge the normalisation of alcohol as a stress relief and protect people from exposure.
- Raise prices through excise taxes and pricing policies
 - The level of alcohol harm is directly linked to affordability, which has increased significantly in recent decades.⁸³ Increasing alcohol duty would reduce alcohol-attributed cancers and death rates, and provide other public health benefits such as

reducing obesity.⁸⁴ Alcohol duty can also raise much-needed revenue to be redistributed in society or spent on public services.

- Minimum unit pricing (MUP) targets the cheapest, strongest products sold in the off-trade that cause the most harm. In Scotland, MUP reduced alcohol-specific deaths by 13.4% within two years of implementation. These were greatest among the four most socio-economically deprived areas.⁸⁵

Research

Additional research is also needed to fill several evidence gaps, including:

- More international evidence on a broader range of economic shocks, beyond the Great Recession of 2008/9.
- On the medium to long-term impacts of economic crisis. For example, it is not yet well understood how changes in response to economic crises (e.g., drinking more at home during COVID-19) may become embedded into broader longer-term trends in alcohol consumption patterns in the on/off trade, and what risks this entails.
- On how economic crises may interact with and impact non-health harms associated with alcohol use. For example, what happens to rates of alcohol-related violence.
- How to tailor alcohol screening and interventions for people who ‘drink to cope’ with stress, including financial stress.

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