Technical report

A healthier future: A long-term vision to tackle alcohol harm in the UK

November 2025

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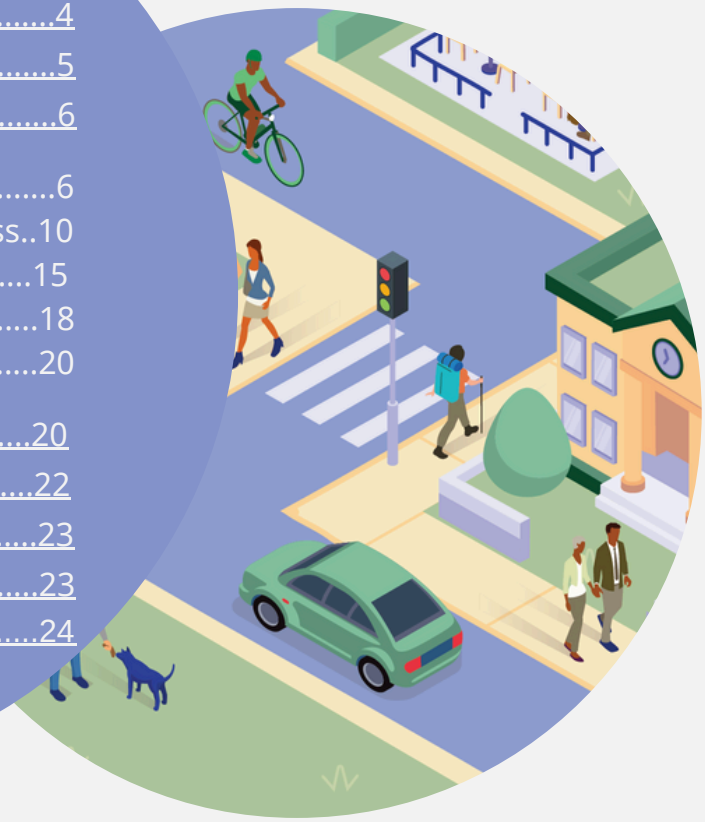

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Acknowledgements
Thank you to the expert panellists who contributed to this project. A full list of contributors is included in the Appendix.

About IAS
IAS is an independent institute bringing together evidence, policy and practice from home and abroad to promote an informed debate on alcohol's impact on society. Our purpose is to advance the use of the best available evidence in public policy discussions on alcohol. IAS is a company limited by guarantee (no. 05661538) and a registered charity (no. 1112671).

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Executive summary

This technical report accompanies the policy briefing *A healthier future: A long-term vision to tackle harm in the UK.* It outlines the methods, process, and key findings of a Delphi study used to develop a unified long-term vision for reducing alcohol harm across the UK.

The study involved:

- Engaging alcohol policy experts from across the UK through three Delphi rounds.
- Agreeing on a collective vision statement for reducing alcohol harm.
- Identifying key strategic goals, indicators, and milestones.
- Prioritising targets and evaluating policy options.
- Developing a roadmap and theory of change to guide future actions.

Background

Alcohol harm is a serious and growing concern in the UK, impacting people's health and wellbeing, the NHS, social services, criminal justice, and our economy. These impacts are felt most by people on low incomes or who live in deprived areas.

With the last UK alcohol strategy published in 2012 barely implemented and alcohol deaths at an all-time high, the time for meaningful, evidence-based policy action is now. The lack of commitment to prevent alcohol harm in the 2025 Labour Government's 10 Year Health Plan is driving calls for a standalone strategy to get to grips with the alcohol harm emergency.

To push alcohol harm up the political agenda and affect change, clear objectives, strong advocacy networks, and close collaboration are crucial. This project brought together a group of independent experts in alcohol policy, research, and treatment to formalise a unified long-term vision for tackling alcohol harm. Informed by the Delphi method, we gathered expert opinion and assessed support for strategic goals and the key milestones required to achieve them.

The final policy briefing provides a key advocacy tool to guide policy debates on alcohol harm at both national and local levels.

Although the study was UK-wide and invited participation from all devolved nations, we recognise that health policy is devolved, and alcohol policy progress differs across the four UK nations.[1]

Objectives

This project aimed to identify a collective consensus on a long-term vision to address alcohol harm in the UK , which includes targets and indicators that are relevant to all four nations, acknowledging where policies are a devolved matter.

Methods

The Delphi method is a structured process for collecting and distilling knowledge from a group of experts through iterative surveys. It is particularly well suited to developing consensus where controversy, debate, or a lack of clarity exist, for example on complex public health challenges.[2]

We identified an expert target list of 53 individuals spanning civil society organisations, treatment providers, family support services, local government, civil service, public health, and academia. We ensured this list invited participants from all four nations, included representatives with lived experience, and organisations that specialise in providing culturally sensitive support.

Survey rounds

Phase one: idea generation

The first survey round invited experts to respond to open-ended questions about their long-term vision for addressing alcohol harm in the UK, how progress towards this should be measured, what policies should be prioritised, and what they considered to be key barriers and facilitators to change. The response rate for phase one was 72% (38 out of 53 experts).

Phase two: prioritisation

Thematic analysis of phase one findings identified key ideas which were further explored in a second survey. These ideas included options for a long-term vision statement, key progress indicators, policy priorities, and barriers and facilitators to change. Experts were invited to rank ideas by importance. Scores were weighted to reflect the preference rankings, with greater weight given to the options ranked higher — e.g. a respondent's number one choice would get the most points. The response rate for phase two was 92% (35 out of 38 experts who had participated in phase one).

Phase three: consensus building
Consensus was reached for most ideas during phase two. However, two of the vision statement options received similar ranking scores. Phase three involved circulating revised vision statements for voting. With only a slim majority preference for one statement (18 votes to 15 votes), facilitated discussions followed. Final consensus was achieved after circulating the full results in a policy brief which all experts were invited to comment on.

During phase three the government published its 10 Year Health Plan for England.[2] Experts therefore provided insight into how the brief could be most effective following the government announcements regarding alcohol prevention measures in the 10 Year Plan. The response rate for phase three was 87% (33 out of 38 experts).

Results

Developing our mission

Expert responses to phase one relating to a vision for reducing alcohol harm included desired political and regulatory changes, most frequently in the form of a national strategy or comprehensive policy package to reduce alcohol consumption and levels of harm. Respondents described action in specific policy areas, namely: pricing policies, marketing regulations, changes to licensing measures, raising public awareness, and health education campaigns. Responses emphasised the central role of Government in delivering on this, and the need for cross-government working and specific targets.

Participants described a reduction in the overall burden of alcohol harm as a key element of their vision, where people consume less alcohol, alcohol deaths fall year-on-year, dependency is a rarity, and those living in the most deprived areas no longer bear the brunt of the harm.

"The society I want to work towards is one in which **pleasure** produced by alcohol consumption is not outweighed by the **unhappiness and harm** it generates."

"For the UK to be a **vibrant, thriving, healthy** society."

"Individuals, families and communities have the **right to health** and the right to a life free from the harms of alcohol."

"To **minimise** the harm from alcohol in the UK."

Changing our societal relationship with alcohol was a recurring theme in the responses. This could mean creating better options for socialising without alcohol, e.g., more alcohol-free spaces and options, tackling stigma, and making alcohol less desirable. This would involve better public awareness about the risks associated with alcohol consumption, but also the creation of an environment where it was easier to make healthier choices.

"Alcohol is viewed as an **occasional treat** and not an **essential commodity.**"

"That alcohol is **no longer the central lynchpin** of UK society and socialising."

Some respondents highlighted how this would align with a broader shift towards a "genuine wellbeing economy," which addressed economic inequality, and saw health-harming industries take responsibility for poor health outcomes. Similarly, many responses underlined that the alcohol industry would be excluded from health policy-making in their future vision: "no longer treated as a public health expert but as the profit-driven industry that it is," much like the tobacco industry.

Finally, an improved health service response was frequently identified as a significant factor in participants' long-term vision for addressing alcohol harm. People mentioned easily accessible, person-centred, and joined-up care, ensuring early intervention was possible. They also highlighted the need for support for family members in the ideal care package.

Four vision statements were developed based on responses to phase one and circulated to experts for prioritisation in phase two.

Figure 1 shows the results of this initial vote on a vision statement.

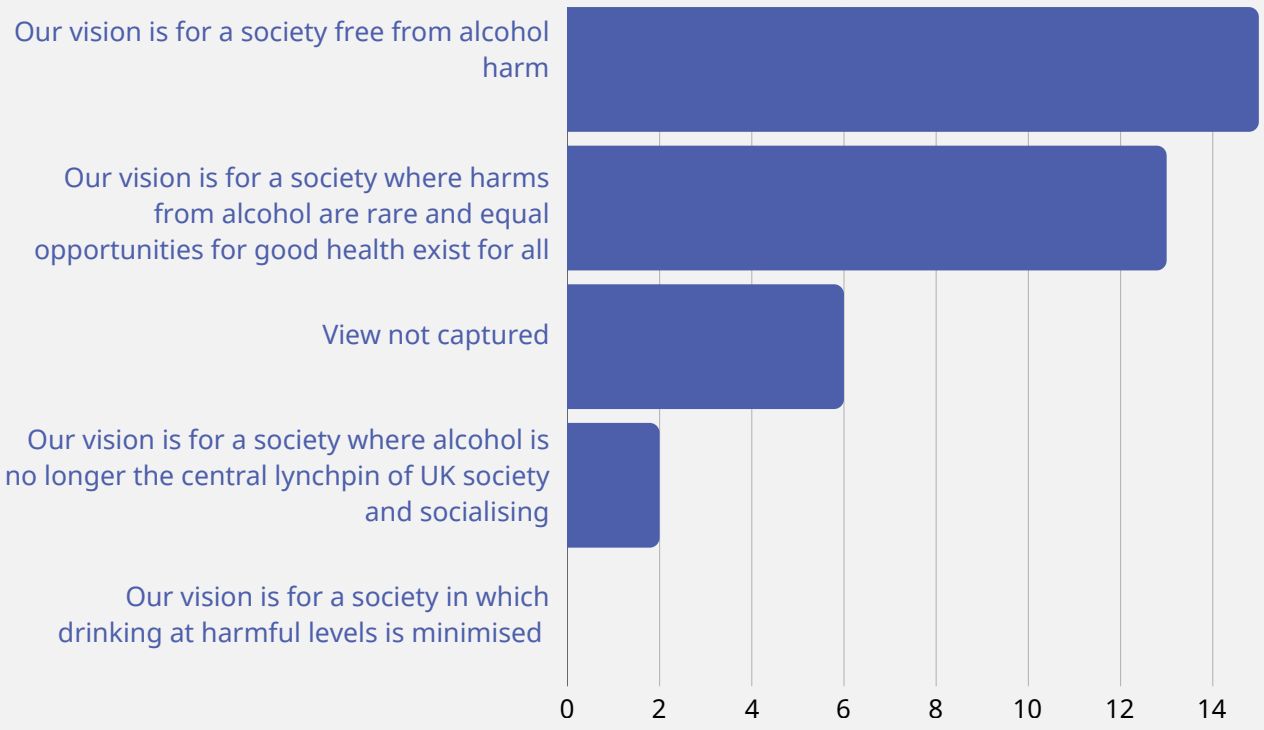


Figure 1. Number of votes for initial suggested vision statements

Participants' responses were predominantly split between advocating for a **society free from alcohol harm**, and a **society where harms from alcohol are rare and equal opportunities for good health exist for all**. Six participants felt their view was not captured in the suggested statements and provided comments on alternative options. These included focusing on "minimising" harmful alcohol consumption and creating the conditions where everybody can "realise their right to health." Some participants shared that they were wary of calling for zero alcohol harm as an unrealistic vision which would demand a society with no alcohol, although it was recognised that "minimal" or "rare" levels of harm are non-specific.

Considering the feedback, the two most popular options were refined and returned to participants for voting during phase three (see **Figure 2**).

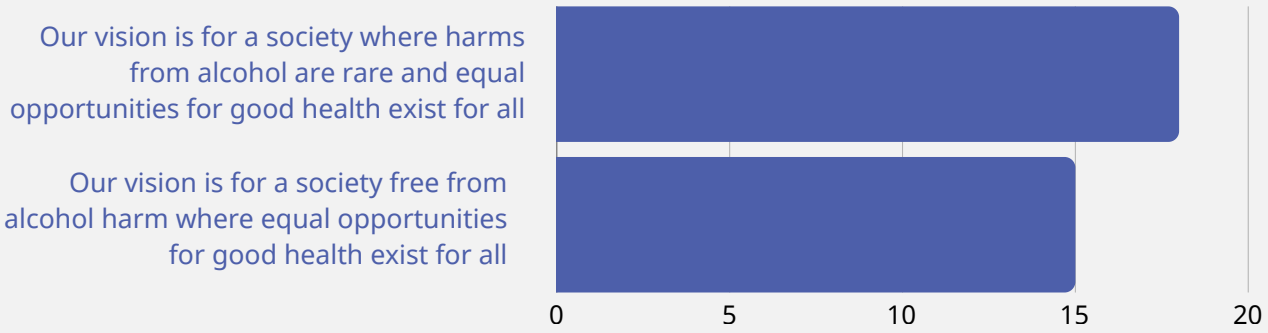


Figure 2. Number of votes for amended suggested vision statements

Both statements emphasised creating the right environmental conditions that enable people to live healthy lives, taking the onus off individual choices, and ensuring a more equitable approach to improving health and wellbeing.

The first vision statement calls for a society 'free from alcohol harm'. Given that there is no safe level of alcohol consumption, achieving this vision would require zero alcohol consumption across the population. This was raised by several participants as a problematic and unrealistic advocacy goal.

The second option recognises that alcohol will exist in society, with a focus on reducing the harmful impacts. As a result, a wide range of harms from alcohol would not be commonplace.

Results of phase three showed that the second statement (harms from alcohol are rare) was the most popular among experts, although there remained considerable support for the first statement (society free from harm). Further feedback was sought from experts when the second statement was included in the draft policy brief and comments were invited on any suggested amends. The final agreed statement which was approved by experts is as follows:

> Our vision is for a society where alcohol harm is rare and equal opportunities for good health and wellbeing exist for all.

Identifying how to measure progress

We asked our experts how they thought we could best measure progress on reducing alcohol harm. Thematic analysis of the responses identified key themes, including alcohol availability, affordability, advertising, treatment and support, industry influence on policymaking, consumption patterns, harms and societal costs, public awareness, and research/data collection.

In phase two, we asked participants to choose their top five priority areas to measure progress and rank these according to their importance. The average ranking for each answer calculated applying weights to account for the respondents' preference for each choice, so their most preferred choice was given the largest weight.

The following measurable indicators were most often ranked in peoples' top choices:

Priorities for measuring progress on reducing alcohol harm	Score
Improved alcohol care, treatment and recovery pathways	**2.92**
Lower levels of harm from alcohol	**2.58**
Alcohol industry removed from policymaking	**1.89**
Alcohol being less affordable	**1.83**
Alcohol being advertised less	**1.58**

Table 1. Top five priority areas to measure progress on alcohol harm

Although 'improved alcohol care, treatment and recovery pathways' scored highest overall, it appeared most commonly as a third or fifth priority. Over half (51.42%) of respondents put 'lower levels of alcohol harm' as either their first or second priority.

The below section provides more in-depth analysis of participants' views on how to measure progress of reductions in consumption, harm, and improving treatment.

Reductions in alcohol consumption

In phase one, experts identified alcohol consumption as a key indicator to measure progress on reducing alcohol harm. However, there was variation in exactly what we should be working towards. Some people spoke about reducing overall population alcohol consumption, others referred to the proportion of people drinking within the Chief Medical Officers' (CMO) guidelines as a specific level to work towards.[4] Other suggestions included focussing on the age of onset, and the importance of collecting individual level consumption data.

In the second survey we summarised the contributions into six options for participants to prioritise, which were voted in the following order as most popular to least.

Priorities for reducing alcohol consumption	Score
Fewer people drinking at 'increasing or high-risk' levels (above the Chief Medical Officers' low-risk drinking guidelines)	**5.46**
Reduced alcohol consumption at the population-level	**4.74**
Fewer people engaging in heavy episodic or 'binge' drinking	**3.57**
Reduced alcohol consumption among under-18s	**3.06**
Consumption changes among specific population groups (e.g., age, sex, socioeconomic status)	**2.54**
More people abstaining from alcohol	**1.63**

Table 2. Top priorities for reducing alcohol consumption

Reductions in alcohol harm

Participants identified the reduction of a range of harms by which progress could be measured. The number of deaths and hospitalisations due to alcohol ranked highest as the best ways to measure alcohol harm, followed by the prevalence of alcohol dependence. The next popular priority was a reduction in the difference in the rate of alcohol-related deaths between the most and least deprived.

Priorities for indicators for reduced alcohol harm	Score
Fewer alcohol-related deaths	**3.35**
Fewer alcohol-specific deaths	**3.06**
Fewer alcohol-related hospital admissions	**2.06**
Fewer alcohol-specific hospital admissions	**1.65**
Fewer people dependent on alcohol	**1.29**

Table 3. Top five indicators for reduced alcohol harm

A full list of measures and scores is available in the Appendix.

As indicated by the scores above, participants tended to favour alcohol-related metrics over alcohol-specific ones, to reflect the wider impacts of alcohol.

However, following discussion emphasised that measuring alcohol-specific deaths over time provides a more consistent indicator of trends in alcohol mortality compared to alcohol-related deaths, which are subject to changing coding practices and wider health trends, making long-term comparison less reliable. Given the long-term nature of the targets within this report it was agreed to use alcohol-specific deaths as the main indicator for measurement against an agreed target.

Alcohol-specific deaths are deaths from conditions caused entirely or exclusively by alcohol consumption. This definition primarily covers long-term conditions associated with alcohol consumption and also includes deaths from alcohol poisoning, whether accidental, intentional, or of undetermined intent. Around three quarters are caused by alcohol-related liver disease. Alcohol-specific deaths mainly reflect the effects of long-term, heavy alcohol consumption rather than lower or moderate drinking patterns.

Alcohol-specific deaths are arguably the most reliable way to compare mortality trends over time, and the best comparator between geographical areas. This is because England is currently the only nation to publish annual alcohol-related deaths data, and these calculations can change depending on the latest data on the risk of each alcohol-related disease combined with the level of drinking across the population.

Alcohol-related deaths refer to all deaths where alcohol is a contributing factor. This includes alcohol-specific deaths, but also deaths from conditions that are partly, not solely caused by alcohol, such as cancer and heart disease. Deaths caused by alcohol are calculated using alcohol-attributable fractions (AFFs). AFFs estimate how much alcohol contributes to each condition, based on the latest research. Alcohol-related death figures are then calculated using the latest data on the risk of each disease combined with the level of drinking across the population.

This metric can give a truer estimate of the number of diseases and deaths caused by alcohol consumption, and the associated costs to the health and social care system.

Improved treatment

We also asked participants how best to measure improved alcohol care, treatment and recovery pathways. The below options were generated from responses to the first survey, receiving the following scores:

Priorities for measuring improved alcohol treatment	Score
A reduction in the gap between those in need of and those accessing treatment	**4.42**
Level of funding provided for treatment	**3.14**
Improved referral process/better integration with other services	**2.86**
Number of people successfully completing treatment programmes	**2.56**
Improved access to treatment services for children	**2.30**

Table 4. Priorities for measuring improved alcohol treatment

The majority of participants (86%) chose reducing the gap between those in need and those accessing treatment as either their first or second choice. This is unsurprisingly a priority given the considerable level of unmet need: the latest figures suggest that only 22% of those in need of specialist alcohol treatment are estimated to be accessing it.[5]

Developing specific targets

In the first survey, having specific, measurable targets emerged as a key indicator of progress and means of holding the government accountable for change.

We developed targets based on responses calling for reductions in alcohol consumption, alcohol-specific deaths, and numbers of those in need but not accessing specialist treatment. With the government developing a 10-year health plan, we suggested these be set for a decade, and asked participants to comment on whether they considered them to be too high, low, or about right.

Target	Too low	About right	Too high
Returning to pre-pandemic rate of alcohol-specific deaths (n=36)	58.33%	38.89%	2.75%
Halving prevalence of increasing and higher risk drinking (n=35)	22.86%	71.43%	5.71%
Increasing access to specialist treatment to 50% of those in need (n=36)	41.67%	52.78%	5.56%

Table 5. Feedback on initial targets

Rate of deaths

The majority of respondents thought that a return to pre-pandemic rate of alcohol-specific deaths was not ambitious enough. Comments indicated that although alcohol-specific deaths did spiral when lockdown measures were introduced to manage the COVID-19 pandemic, alcohol harm is not a "pandemic phenomenon," and that the death rate prior to this was already too high.

> I think we need to communicate that there are other drivers. Pandemic shouldn't dominate the issue.

Alternative options included: a return to the lowest rate of alcohol deaths in this century, using the pre-pandemic rate as a halfway marker to indicate we are moving in the right direction, or emphasising a reduction in the inequalities gap of who is more likely to die from alcohol. Participants also favoured measuring alcohol-related deaths rather than alcohol-specific, as a "truer measure of burden."

Taking the comments into account, we amended the target to be more ambitious, while acknowledging the impact of the COVID-19 pandemic:

Reverse the trend of alcohol-specific deaths, returning to the pre-pandemic rate within 5 years, and subsequently to 2012 levels within 10 years.

This would bring the alcohol-specific death rate down from 15.9 per 100,000 to 11.8 per 100,000 over five years and then sustain progress by securing a further reduction to 11.1 per 100,000. Meeting this target would represent a 30% reduction of alcohol-specific death rates across the UK, and a return to the lowest rates seen so far in the 21st century.[6]

Alcohol consumption

71% thought that halving the prevalence of increasing and higher risk drinking was an appropriate target for the next 10 years.

The latest data from the Health Survey for England (HSE) indicate that currently, almost a quarter of adults in England (24%) drink at levels which put them at increasing or higher risk of alcohol-related harm (more than 14 units per week).[7] Data from the UCL Alcohol Toolkit Study (ATS) show almost one in three UK adults drink at risky levels, as measured by the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C). Feedback from participants during phase three suggested the ATS would be a better indicator to monitor changes in alcohol consumption over the next decade as it collects data in England, Scotland and Wales on a monthly basis. The ATS is specifically designed to assess alcohol consumption patterns and related attitudes and behaviours, and therefore focuses on alcohol-related issues more directly than broader health surveys such as HSE. The agreed target for reducing alcohol consumption was:

Halve the prevalence of risky drinking over the next ten years from 1 in 3 UK adults to 1 in 6.

Access to treatment

Several needs assessments in the UK have shown a considerable unmet need for alcohol treatment and support services with at best one in four people with alcohol dependence who want treatment in contact with services (not including the needs of people who do not meet the criteria for dependence but are experiencing alcohol-related harm.)[8] 53% of our participants thought that over the next decade, access should increase from this level to cover half of those in need. Another 42% felt this wouldn't go far enough, demonstrable of the difficulty in striking a balance between what feels achievable and what feels acceptable:

> A couple of these targets feel like they are leaning towards realistic more than ambitious. Whilst the current treatment access figures are pretty terrible, and increasing to 50% would represent a huge improvement, only 50% of those needing treatment being able to access treatment nonetheless seems poor.

Participants suggested increasing access to a similar rate seen with other chronic conditions, e.g., 70% healthcare service access for those with diabetes.

> There's no reason why we should advocate for a lower rate of access for those with alcohol use disorder compared to other chronic conditions.

We incorporated these ideas into an amended target that used the initial target as a mid-point milestone:

Increase the proportion of people with alcohol dependency accessing specialist alcohol treatment to 50% within 5 years and build capacity in the system for 80% of people with alcohol dependency to have access to treatment within 10 years.

Experts were keen to make explicit reference to the required conditions to meet this target. Namely, increased and protected funding, whole-system efforts to identify and make referrals at scale, and political buy-in locally and nationally.

Priority policy measures

Our experts identified several policies that the UK government and/or devolved administrations could use to address alcohol harm. We collated the suggestions and asked participants to rate each out of 10, considering their knowledge of the policies' effectiveness, cost-effectiveness, and implementability.

Policy option	Score out of 10
Minimum unit pricing	**8.47**
Reintroducing the alcohol duty escalator to ensure alcohol duty rises faster than inflation	**8.33**
Increased and sustained investment in alcohol prevention and treatment	**8.44**
Reduce the drink driving limit to 50mg/100ml for all drivers (in England/Wales and Northern Ireland)	**8**
Alcohol embedded in government's missions to reduce health inequalities	**8.61**
Introduce national and local government guidelines on managing conflicts of interest and interactions with alcohol industry representatives	**8.56**
Exclude alcohol industry from all policy development	**8.44**
Restrictions on alcohol marketing in line with those applied to HFSS as well as extended alcohol-specific restrictions (e.g., all sports sponsorship ban, to within alcohol environments only)	**7.86**
Restricted availability (e.g., reduced hours of sale, designated hours of sale, regulation of online sales)	**7.97**

Table 6. Highest rated policy options to tackle alcohol harm

To tackle alcohol harm in a meaningful way, several policy components that make up a comprehensive strategy are required. The full list of policy options identified by our experts and scores is available in the appendix.

Following the publication of the government's 10 Year Health Plan for England, [3] and consensus-building work elsewhere in the field (e.g., the consensus statement on drink driving co-ordinated by the British Medical Association[9]) facilitated discussion took place with experts to review and refine the list of policy priorities.

The final agreed list of policy recommendations was as follows:

1. Introduce minimum unit pricing at 65p per unit in England and increase in line with inflation.
2. Re-introduce the alcohol duty escalator at a minimum of 2% above inflation.
3. Introduce restrictions on alcohol marketing, as a minimum equal to those applied for unhealthy food and drink.
4. Empower local authorities to regulate hours of sale and online deliveries of alcohol.
5. Provide increased and sustained investment in alcohol prevention and treatment.
6. Introduce mandatory product labels that include health warnings, ingredients and nutritional information and the UK low risk drinking guidelines.
7. Lower the legal blood alcohol content (BAC) limit for driving to 20mg/100ml (0.02%) for new and commercial drivers, and 50mg/100ml (0.05%) for all other drivers, with the ambition to reach 20mg/100ml for all drivers as soon as possible.
8. Introduce national and local government guidelines on managing conflicts of interest and navigating interactions with alcohol industry representatives (intended or unintended).

Barriers and facilitators

Experts were invited to identify (in phase one), and then rate (in phase two), the biggest barriers and facilitators of progress for reducing alcohol harm.

These were:

Facilitators	Barriers
Growing awareness amongst policymakers	Alcohol industry activities
The need to reduce costs to the public purse	Lack of political will from MPs/policymakers
Strong evidence-base for effective policy solutions	Lack of understanding from MPs/policymakers
The election of the new UK government	Incoherent government policy
Decline in youth drinking	Cultural norms

Table 7. Barriers and facilitators of progress for reducing harm

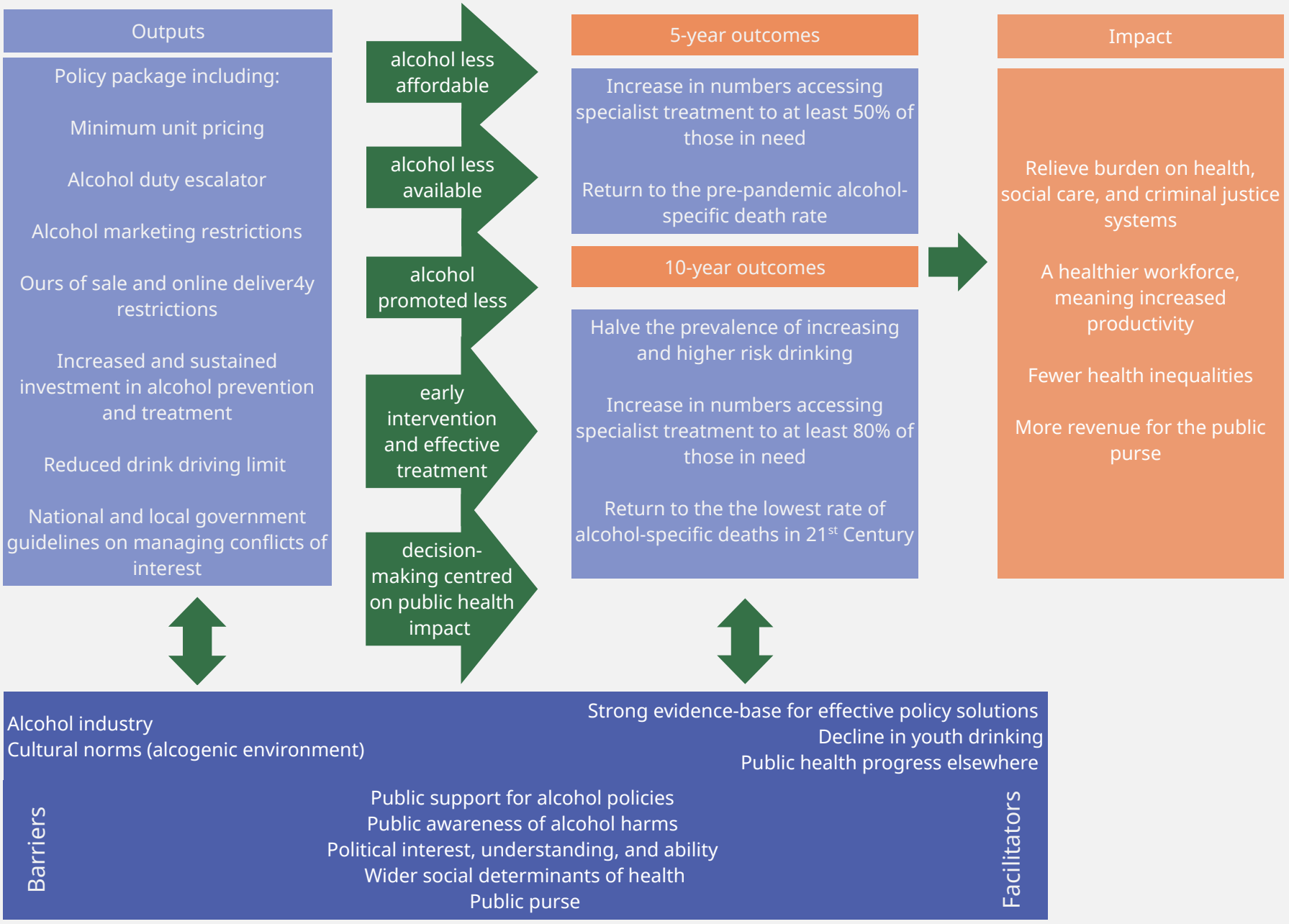
Experts recommended emphasising the barrier presented by alcohol industry activities when communicating the long-term vision. Evidence shows that alcohol industry activities have defeated, delayed or weakened the design, implementation and evaluation of policies designed to reduce alcohol harm, which is why it is essential that public policymaking be protected from vested commercial interests.[10].

A full list of all suggested barriers and facilitators is included in the Appendix.

Theory of change

Drawing on the goals, policies, barriers and facilitators identified above, we developed a theory of change towards achieving our long-term vision.

As alcohol harm involves a wide range of behaviours and outcomes, action is required at multiple levels. As progress is made, the barriers identified will decrease in impact, while external factors such as public support, political interest, and size of the public purse, will shift to facilitate further progress. We used this theory of change to develop a visual roadmap for our long-term vision to aid in advocacy purposes.


Outputs
Policy package including:
Minimum unit pricing
Alcohol duty escalator
Alcohol marketing restrictions
Ours of sale and online deliver4y restrictions
Increased and sustained investment in alcohol prevention and treatment
Reduced drink driving limit
National and local government guidelines on managing conflicts of interest
alcohol less affordable
alcohol less available
alcohol promoted less
early intervention and effective treatment
decision-making centred on public health impact
5-year outcomes
Increase in numbers accessing specialist treatment to at least 50% of those in need
Return to the pre-pandemic alcohol-specific death rate
10-year outcomes
Halve the prevalence of increasing and higher risk drinking
Increase in numbers accessing specialist treatment to at least 80% of those in need
Return to the the lowest rate of alcohol-specific deaths in 21st Century
Impact
Relieve burden on health, social care, and criminal justice systems
A healthier workforce, meaning increased productivity
Fewer health inequalities
More revenue for the public purse
Alcohol industry
Cultural norms (alcogenic environment)
Strong evidence-base for effective policy solutions
Decline in youth drinking
Public health progress elsewhere
Barriers
Public support for alcohol policies
Public awareness of alcohol harms
Political interest, understanding, and ability
Wider social determinants of health
Public purse
Facilitators

Our vision is for a society where alcohol harm is rare and equal opportunities for good health and wellbeing exist for all.

5-year targets

- Increase the proportion of people **with alcohol dependence accessing alcohol treatment to 50%.**
- Reverse the trend of alcohol-specific deaths, returning to the pre-pandemic rate.

10-year targets

- Halve the prevalence of risky drinking from **1 in 3 UK adults** to **1 in 6.**
- Build capacity in the system for **80%** of people with alcohol dependence to have **access to treatment.**
- Return to the 2012 rate of alcohol-specific deaths - **the lowest in the 21st century.**

This will mean...

- Less burden on public services.
- A healthier workforce.
- Fewer health inequalities.
- More revenue for the public purse.

Higher standards for alcohol marketing to **protect children** and **people impacted by alcohol harm**

Earlier intervention, better treatment options, and fewer children living with parental alcohol problems

Local authorities **empowered to manage the availability of alcohol** according to local needs

Better public awareness from **clear and mandatory alcohol labelling**

Revenue raised for public services with alcohol duty

A lower drink-driving limit to save lives

Fewer cheap, high-strength products that cause the most harm with minimum unit pricing

GYM

Shop

Conclusion

This report presents an expert-led, consensus-based vision and action plan for reducing alcohol harm. The findings directly support advocacy for a standalone UK cross-government alcohol strategy and provide a foundation for national and devolved governments to set clear, measurable goals. Moreover, this work aligns with increasing public and political appetite for bolder public health action, as shown in recent polling. IPPR and Public First[11] surveys show majority support for stronger alcohol controls, and Health Foundation/Ipsos data[12] reflect growing public concern about the impacts of alcohol on NHS capacity and inequality. Cross-party consensus is building around the need for clearer alcohol harm reduction policies. These findings reinforce the relevance of this vision and the opportunity for political leadership to act on public support.

References

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[10] Institute of Alcohol Studies (2024) Good governance in public health policy: Managing interactions with alcohol industry stakeholders
[11] Public First (2025) New polling for Action on Smoking and Health
[12] The Health Foundation (2025) Public backs action to tackle tobacco, unhealthy food and alcohol amidst health crisis

Appendix

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Table 1. How to measure progress on reducing harm

Measure	Score
Fewer alcohol-related deaths	**3.35**
Fewer alcohol-specific deaths	**3.06**
Fewer alcohol-related hospital admissions	**2.06**
Fewer alcohol-specific hospital admissions	**1.65**
Fewer people dependent on alcohol	**1.29**
Reduction in difference in the rate of alcohol-related deaths between the most and least deprived	**1.21**
Fewer incidences of alcohol-related violence	**0.71**
Fewer incidences of deaths and serious injuries from drink driving	**0.44**
Fewer children living with a parent with alcohol dependence	**0.29**
Reduction in the gap in healthy life expectancy between more and less deprived groups	**0.24**
Fewer alcohol-related A&E attendance	**0.21**
Fewer alcohol-related child services referrals	**0.18**
Fewer incidences of alcohol-related sexual assault	**0.09**
Fewer alcohol-related ambulance call-outs	**0.09**
Fewer incidences of alcohol-related anti-social behaviour	**0.09**

Table 2. Policy options for reducing alcohol harm rated against their effectiveness, cost-effectiveness, and implementability

Policy	Mean score out of 10	Min score-max score
Availability		
Restricted availability (e.g., reduced hours of sale; designated areas of sale; regulation of online sales)	**7.97**	**4-10**
Review of the Licensing Act and its relevance to today's alcohol consumption trends	**6.51**	**1-10**
Introduction of a fifth licensing objective to protect and promote public health in England and Wales	**6.43**	**1-10**
Price		
Minimum unit pricing (e.g., including introduced entirely in England, introducing an uprating mechanism elsewhere)	**8.47**	**3-10**
Reintroducing the duty escalator to ensure alcohol duty rises faster than inflation	**8.33**	**2-10**
Setting a target to increase alcohol duty over time to ensure it meets the societal costs of alcohol harm	**7.89**	**3-10**
Marketing		
Comprehensive ban of all alcohol marketing	**6.86**	**2-10**
Restrictions in line with those applied to food high in fat, salt and sugar (HFSS) (e.g., watershed ban, restrictions on promotion deals)	**7.50**	**2-10**
Restrictions in line with those applied to HFSS extended to alcohol-specific restrictions (e.g., all sports sponsorship ban, to within alcohol environments only)	**7.86**	**4-10**
Public information		
Mandatory alcohol product labelling (including health warnings; nutritional info; ingredients; units as % of low risk drinking guidance)	**7.61**	**2-10**
Public information campaigns	**6.53**	**1-10**
Educational resources in schools free from alcohol industry involvement	**6.69**	**2-10**
Apps/tools made for reducing/measuring alcohol consumption free from alcohol industry involvement	**6.89**	**2-10**

Policy	Mean score out of 10	Min score-max score
Health/social services		
Increased and sustained investment in alcohol prevention and treatment	**8.44**	**4-10**
Introduce universal screening for alcohol use disorders in acute hospitals and primary care	**7.39**	**1-10**
Ensure joined-up services (e.g. alcohol treatment and mental health) to operate a 'No Wrong Door' policy	**7.86**	**4-10**
Establish Alcohol Care Teams in every acute hospital	**7.75**	**3-10**
Enhanced access to fibroscans	**7.00**	**3-10**
Support for children & families affected	**7.60**	**3-10**
Alcohol free and low-alcohol drinks		
Make no- and low-alcohol drinks more accessible in licensed venues	**5.83**	**1-10**
Make no- and low-alcohol drinks more affordable than standard alcoholic drinks	**6.44**	**0-10**
Introduction of a 'polluter pays' mechanism to fund prevention/treatment/research		
Hypothecation of taxes on alcohol	**7.17**	**3-10**
Levy on alcohol retailers	**7.40**	**3-10**
Drink driving		
Reduce drink driving limit to 50mg/100ml for all drivers (in England/Wales and Northern Ireland)	**8.00**	**2-10**
Introduce alcohol locks for commercial drivers	**7.17**	**2-10**
Tackle social determinants of health/policies to reduce inequality		
Alcohol embedded in government's mission to reduce health inequalities	**8.61**	**5-10**
Include alcohol dependence in the definition of disability within the Equalities Act	**6.19**	**2-10**
Alcohol industry		
Introduce national and local government guidelines on managing conflicts of interest and interactions with alcohol industry representatives	**8.56**	**4-10**
Exclude alcohol industry from all policy development	**8.44**	**2-10**

Table 3. List of barriers and facilitators

Facilitator	Barrier
Growing awareness amongst policymakers	Alcohol Industry activities
Need to reduce costs to public purse	Lack of political will from MPs/policymakers
Strong evidence-base for effective policy solutions	Lack of understanding from MPs/policymakers
New UK government	Incoherent government policy
Decline in youth drinking	Cultural norms
Progress on other preventable risk factors for ill-health e.g., smoking	Wider social determinants of health
Dedicated civil society organisations	Lack of capability from MPs/policymakers
Taking a human rights approach to public health	Lack of support from news media
Innovation in other countries	Prioritisation of policies to address illicit drugs
Lived experience	Lack of public support
No/low drinks	Stigma surrounding alcohol problems
Local authority willingness to act	Too much focus on treatment/not enough on wider prevention
Medical voices	People enjoy drinking
Emerging areas (e.g., social media, online, no/low drinks) as opportunities for interventions	Poor treatment commissioning and provision
Support for hospitality	Lack of resource to properly organise civil society organisations
Health and wellbeing lifestyle movement	National borders/devolution
Positive social networks/community building	Research gaps/lack of data