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SARN

Beyond behaviours: How health inequality theory can enhance our understanding of the 'alcohol harm paradox'

Jennifer Boyd, PhD Student, University of Sheffield

SHAAP/SARN 'Alcohol Occasional' Seminar
Wednesday 20th January 2021, hosted on Zoom

Scottish Health Action on Alcohol Problems (SHAAP) and the Scottish Alcohol Research Network (SARN) are proud to support the lunchtime *Alcohol Occasionals*, which showcase new and innovative research on alcohol use. All of the seminars are run in conjunction with the Royal College of Physicians of Edinburgh (RCPE). These events provide the chance for researchers, healthcare professionals, policy makers and members of the public to hear about alcohol-related topics and discuss and debate implications for policy and practice.

The current theme is '*Alcohol and inequalities*'. Briefing papers aim to capture the main discussion points and communicate these to a wider audience. SHAAP is fully responsible for the contents, which are our interpretation.

Introducing the seminar, Interim SHAAP Director Lindsay Paterson welcomed **Jennifer Boyd** (@jenniferevab) on behalf of SHAAP and SARN. Jennifer Boyd thanked SHAAP and SARN for the invitation, her supervisors, and funders (Wellcome Trust).

In the first section, **Boyd** first explained health inequalities: systematic differences in health between groups of different socio-economic status (SES), which are socially produced and thus avoidable. **Boyd** then described the 'alcohol harm paradox' (AHP): poorer people suffer more harm from alcohol than richer people, despite drinking the same or less. Boyd illustrated the AHP using Understanding Glasgow data, although made clear that the AHP is not unique to Glasgow or Scotland: it is a consistent finding internationally. Research has shown that at every level of alcohol consumption (including for never or ex-drinkers), harms are greater for the more disadvantaged.

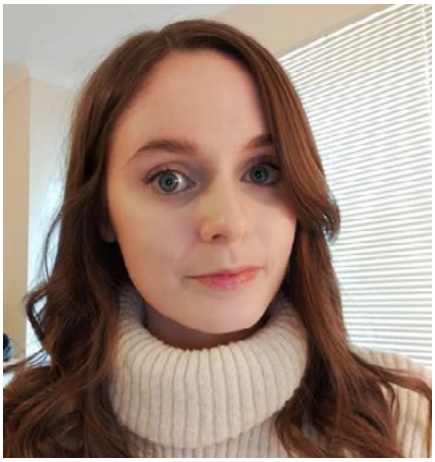
Boyd described the three prominent explanations for AHP:

i) different consumption patterns (more binge drinking in those of low SES)

ii) multiple unhealthy behaviours (e.g. smoking, physical inactivity and poor diet alongside alcohol consumption) in those of low SES

iii) methodological issues (inaccurate self-reporting by low SES groups).

Boyd explained that whilst the first two behavioural explanations play a role, they do not fully explain the AHP, meanwhile self-reporting can be worse in high SES groups (due to not reporting 'special occasion' drinking, such as at weddings). She also highlighted proposed hypothetical explanations of materialism and inequalities in access to healthcare, as reviewed by the Institute of Alcohol Studies (IAS).



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Boyd next discussed her forthcoming literature review of explanations for the AHP, which found 41 distinct explanations in 16 themes, which can be grouped into six broad domains: artefact, lifestyle, individual, contextual, disadvantage, and upstream (learn more). The review finds that, until now, research has focussed on risk behaviours, neglecting non-behavioural explanations.

We then broke for discussion, which included: the role of health literacy and the ability to recognise

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and in turn respond to healthcare needs; more dangerous drinking environments with alcohol-related violence (upcoming event) causing inequalities in alcohol-related harm; and alcohol marketing as an upstream activity influencing the AHP, particularly through sports sponsorship.

In the second section, **Boyd** first emphasised that the AHP is an issue of health inequality – alcohol-specific deaths contribute to inequalities in life expectancy between SES groups. Boyd then went on to describe her research, explaining how health inequality theory frameworks, such as Social Determinants of Health (SDH) and Fundamental Cause Theory (FCT), can help us to understand the AHP.

Boyd explained that SDH covers social and economic factors that shape health and health behaviours. SDH provides a multi-level approach which includes four explanations: culture-behaviour (lifestyle factors and shared group behaviours); materialism (wealth and health, and public policy and services); psychosocial (psychological experience of comparing yourself to others of a higher SES, and the stress this can cause); and lifecourse (timing and accumulation of risks, including risks passing from one generation to the next). These explanations add and interact to produce health inequalities.

Boyd's research involved applying the SDH framework to previous research on the AHP to identify research gaps. Particular gaps are found for materialism and psychosocial explanations, and she discussed areas for future research, such as measuring individual and environmental resource availability (*materialism*) and taking a social capital approach to explore the positive and negative impacts of social networks on alcohol-related harm (*psychosocial*) – learn more.

In contrast, **Boyd** explained that FCT looks at fundamental resources (power, money, knowledge, social connections and prestige) associated with being poor, which limit ability to adapt to preventable health risks. Boyd illustrated this by sharing research that found that those of high SES have disproportionately benefitted from the knowledge that smoking causes lung cancer, with improvements in death rates far exceeding those of low SES – a trend not seen for pancreatic cancer where there have been no major advancements in prevention. FCT has not yet been explored in AHP research, but Boyd will pursue this area.

We then broke for discussion, which included the impact of COVID-19 and lockdown on drinking behaviours (upcoming event). Research has described polarised drinking during lockdown, with those of higher incomes reporting drinking more often than usual and more heavily – we questioned what impact this may have on the AHP.

In the third and final section, **Boyd** discussed research and policy implications of using health inequality theory. For research, health inequality theory requires a paradigm shift to a wider outlook and multi-disciplinary working. For policy, interventions must be equitable otherwise they risk entrenching health inequalities, and they should not only aim to improve health of the population on average, but also reduce inequalities in health. For example, an education campaign on alcohol harm inaccessible to those of lower SES will widen inequalities. The scope of policies should also be broad, tackling education, employment, and housing. To conclude, Boyd emphasised that we need a shift from individual and behavioural factors to a multilevel approach rooted in social causes of health inequality.

In the final discussion, the audience agreed that progressive and collaborative multi-sector policies are required. This should include ensuring safe and secure communities are built with health and health inequalities in mind (with the importance of greenspaces noted; upcoming event), which can be supported with the Place Standard tool.

Professor John Holmes (University of Sheffield; one of Boyd's supervisors) discussed pricing policies as a tool to reduce inequalities in alcohol harm, highlighting minimum unit pricing (MUP) as a particularly useful intervention. Holmes' research found that MUP targets the cheapest alcohol drank by the heaviest drinkers in lower SES groups, whilst having minimal impact on those of low SES drinking at moderate levels.

As an area for future research, Boyd noted that it would be useful to apply health inequality theory to explore differences in acute versus chronic alcohol harms, and she hopes researchers will more widely apply health inequality theory in their own work.

Watch this seminar

You can watch this seminar, and other recent webinars.

Forthcoming events

All 2021 *Alcohol Occasionals* are available for booking

The next will be a joint SHAAP/SARN/IAS event on 25th February 12.30-2pm GMT: *Exploring men's alcohol consumption in the context of becoming a father: A scoping review*, by Dr Elena Dimova. Book now

SHAAP Blog

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