



House of Commons
Health Committee

Government's Alcohol Strategy

Third Report of Session 2012–13

Volume II

Additional written evidence

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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Written evidence

Written evidence from Professor Robin Touquet (GAS 02)

EMERGENCY DEPARTMENTS

I highlight successful implementation of the above—having recently completed 25 year as A&E (Emergency Medicine) Consultant/Professor at St Mary’s Hospital, Paddington, Emergency Department (ED)—Imperial College Healthcare Trust—where ED work led to the inception of the Paddington Alcohol Test, together with ED based Alcohol Health Workers from 1994.

1. Brief Advice (BA) is relatively unthreatening for ED staff to implement as it takes only one to two minutes by definition; if longer it is no longer true Brief Advice. It is unstructured (NOT using any specific format)—giving simple feedback on “cause” (drinking alcohol) and “effect” (ED attendance), to stimulate reflection by the patient (“contemplating change”)—with the offer of further help from an Alcohol Health Worker (AHW)—who may be present in the ED at the time.

2. Brief Intervention (BI) is much longer, being structured (may be based on “FRAMES”), given by those trained to give it (and who are specifically paid to give BI, having the allocated time), ie by AHW’s (who may or may not be qualified RMN or SRN nurses: then Alcohol Nurse Specialists, ANS’s) and lasts 20–30 minutes (or longer). This should include, for the truly dependent drinker, arrangements for the patient to be followed up in the community (Patton R, 2011)

3. “Clinical Inertia” is “a reluctance to update practice”, and “NIMBYism” is “not my job”. The key point is ED doctors and nurses have a wariness of anything that they perceive to slow down patient through-put, because ED staff are under such pressures of time, space and staffing—remembering that the ED workload is both variable and unpredictable. Using the term “Screening” risks precipitating negative responses because screening—implying for every patient—will inevitably slow patient through-put. If clinicians muddle BA (one to two minutes) with BI (20–30 minutes) such that they perceive that they, and their staff, will have to spend in excess of say even five extra minutes with every patient, quite simply there will be great resistance to implementing even the simplest of “Early Identification and Brief Advice” (EIBA). However, if it is clearly understood that all that is expected is one to two minutes of BA for those presentations likely to be associated with alcohol misuse (ie fall, collapse, head injury, assault, accident), that there are readily available AHWs to be of stress-relieving support (and are the ONLY staff who enact BI), and vitally that as a consequence unscheduled alcohol-related re-attendance will be reduced—then negative attitudes by ED leaders will be changed to being positive. Hence why it is vital that BA (very short and unstructured) is differentiated from BI (Huntley et al, 2001; Huntley et al, 2004).

4. For ED staff and indeed patients it matters far less what basic questionnaire is used (eg PAT, FAST, AUDIT C or RAPS4), rather that question(s) are indeed actually asked about alcohol—this may be only one question eg SASQ, effective as SIPS has shown (www.sips.iop.kcl.ac.uk). What is used depends on what suits that particular ED. Key for successful implementation are Education, Audit and on-going Feed-back (together with BI from the AHW, forming the anagram “BEAF”) with support from ED senior doctors and nursing sisters themselves. It must be remembered that in the majority of ED’s junior doctors change (ie move to another job) every four months now—so it is constant and unending Education, Audit and Feed-back. ED senior support (Consultants, Nurses) is the pre-requisite for success, again as SIPS has shown (www.sips.iop.kcl.ac.uk).

5. With PAT, Paddington Alcohol Test—PAT(2009) being the latest edition—please note the following (Touquet, Brown WHO 2009):

- (a) *Patient Information Leaflet (PIL)*. PAT(2009) states: “Give alcohol advice leaflet to all PAT+ve patients, especially if they decline ANS appointment”. The cost effectiveness of this advice has been confirmed by SIPS ED research results (www.sips.iop.kcl.ac.uk). Together with PIL (Patient Information Leaflet)—as used in SIPS—feed-back is given, which is equivalent to Brief Advice—and which is what BA actually is—cause/effect relating to the precipitating unpleasant episode that necessitated the inconvenience of an ED attendance.
- (b) PAT(2009) is used “back-ended”, ie it is applied at the end of the consultation by the busy clinician who, hopefully by relieving pain, showing care and compassion etc, has generated “the gratitude factor”. The patient’s agenda (reason for attendance) is dealt with first.
- (c) It is applied by the specific clinician who has seen the patient, to emphasize cause and effect with the relationship emphasized (to generate “contemplation of change” by the patient).
- (d) It is applied using the word “routinely” (for all of “the top ten” presentations as shown on PAT) so it does not appear to the patient to be judgmental (Touquet & Brown. A&A, 2009).
- (e) It is focused—ie it is selective to be applied only to the top ten alcohol-related conditions (eg fall, collapse, head injury, assault, accident), unless alcohol misuse is suspected for other reasons. (Huntley et al 2001) The word screening (a public health term) is never used as this implies universal application of whatever questionnaire is used.

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- (f) An appointment with the AHW is offered within a maximum of 48 hours of ED attendance to make best use of the “Teachable Moment” for “Opportunistic Intervention” (Williams et al, 2006)—even better if in real time providing the patient is sober.
 - (g) The pay off for the busy Clinician is to reduce alcohol-related unscheduled re-attendance—important for those working in an ED for say years (ie ED seniors)—less so for those relatively transitory staff only working 4/12 in the department (Crawford et al, 2004).
 - (h) PAT is an evolving clinical and educative tool to facilitate change—it is much more than a simple questionnaire—see information printed on the back of PAT2009, including:—A. *History*. B. *Physical Signs of alcohol use*. C. *Resuscitation Room* requested Blood Alcohol Concentrations (BACs)—patients unable to speak. (Touquet & Brown. A&A, 2009).
 - (i) Senior support from both ED Consultants and ED Nursing Sisters is vital for success as SIPS has shown (www.sips.iop.kcl.ac.uk).
 - (j) Immediate availability of AHWs to help with difficult patients to relieve Clinicians’ stress is hugely helpful eg to prevent Wernicke’s or withdrawal (or both)—this can only happen if the AHW is a nurse. Thereby the ANS (Alcohol Nurse Specialist) can advise on Clinical Management so as to gain respect from the ED doctors in real time when ED staff are “*Harassed, Apprehensive, Lonely and Tired*”; anagram “*HALT*”. ED work can be very stressful, even frightening, for the junior doctor/nurse eg managing the drunk head injury. The AHW is the “stress-reliever”—hence the real advantage for AHW’s being RMN or SRN trained in order to help gain respect from clinicians, encouraging further support for implementing BA.
 - (k) It hugely helps if the AHW’s office is in the actual ED itself (for availability and profile), and if there is an over-night ED ward so that “drunks” can be seen, when sober, by the AHW in the morning before they goes home.
 - (l) All of the 20 years plus research (with >20 per-reviewed scientific papers) from St Mary’s Paddington has been pragmatic, by which is meant all of the initial data collection has been (without exception) by jobbing ED doctors and nurses in real time as part of their routine clinical care. Researchers have only been used for patient follow-up—hence, whilst it is only one site, it is truly translational with continuous Education, Audit, Feed-back—ie a lot of background on-going work. What has been achieved (and published) did not develop “over-night”—but was a long-term process that did catalyze attitudes towards drunk patients to become more positive. It was seen that something could be done and that over time it really did work (Huntley et al, 2004; Crawford et al, 2004).
 - (m) PAT is embedded in the ED clinical practice—*no consent* is needed to apply it (especially not written—this is very time consuming) as it is in the patients’ best interests to be asked about alcohol and to be given BA with the offer of an appointment with the AHW for BI as part of high standard clinical care.
 - (n) What is important is *Early* Identification of the Hazardous drinker before the patient becomes a Dependent Drinker (even before they have become a true harmful drinker), ie working to facilitate “contemplation of change” early on in the drinking career of the patient. Hence the importance of clinically relevant coding (Touquet & Harris, 2012).
 - (o) As part of feed-back *for the young* (who may well not understand that alcohol is actually a drug), the question should be asked, “Why make yourself vulnerable?”. The first effect pharmacologically of alcohol is to depress behaviour inhibitory centres. Advice should be given not to put one’s self in potentially vulnerable situations, eg “date-rape”, where nearly always alcohol is involved. With alcoholic amnesia it can be very difficult for the police to unravel what has actually happened.
 - (p) Once a patient has become dependent—“change” is so much more difficult to achieve, BA/BI being much less effective in isolation on their own. Here with dependency, on-going follow-up care in the community is vital for success. Once a patient in truly dependent, this dependency is for life—whether or not drinking—because the brain chemistry has become permanently altered such that if the abstinent dependent drinker goes back to drinking alcohol, they are right back where they started as a dependent drinker: craving for alcohol everyday (Touquet & Harris, 2012).

6. It would be a serious omission not to highlight that *ED Reception Staff* do have a key role to play of recording where “alcohol-related incidents” happen which precipitate ED attendance, followed by close liaison with the community (police and Council) to identify clubs/pubs where drinking is not properly controlled, with specific action then being taken—the key work of Professor Jonathan Shepherd, Cardiff has demonstrated the effectiveness of such.

CONCLUSION

Every Dependent Drinker was once a hazardous/harmful drinker, ie every drinker has to start somewhere—how quickly the drinker become dependent depends both on their genes (endogenous) and their environment (exogenous).

Hence the importance of *Early* Identification with Brief Advice (EIBA), before dependence develops, together with understanding of the roles of BA, BI, AHWs with the advantages of ANSs. (Price and Availability being the other two keys for reducing consumption.)

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May 2012

Written evidence from Miss Renate van Nijen (GAS 03)

SUMMARY

I am a Dutch-born writer and artist, currently residing in Spain. 12 years of living with an English alcohol-addicted partner. Holistic approach to the wide-spread and often denied problem of alcohol-abuse and/or alcoholism. Interviewed partners, mothers, children, friends of alcoholics, plus alcoholics themselves, and health workers in the field of recovery to show the human face behind alcoholism.

1. The increasing problem of alcohol abuse in modern society has been highlighted in many television programmes, newspapers and through other media.
2. As an ex-partner of an alcohol-addicted man, I am pleased wider attention is being paid to this subject. However, I feel an important part of the problem is being under-represented. The focus always seems to be on the “drinker” and how he or she is costing society a lot of money by placing additional burdens on, for example, the police force (to deal with anti-social, aggressive, etc. behaviour) and the health service (increased accident and emergency admissions). What about the larger—and mostly hidden—group of people affected by alcohol abuse such as partners, children, victims of alcohol-related crime?
3. Recent reports estimate three in five people will be negatively affected in their lives by alcohol abuse—either directly or indirectly. It is said that the life of one alcoholic will have an impact on the lives of at least six other people.
4. I’ve heard journalists and drink-industry representatives state that alcohol-abuse concerns only a “minor element” in today’s society. This is completely inaccurate, not to mention misleading, when the above groups are taken into account.
5. The medical world is increasingly concerned about the price this excess use of alcohol is exacting on tens of thousands of people, physically, and governments are worried about the future health costs for society as a whole. There is no easy answer and no magic bullet. Alcohol is a legal drug and it is difficult to imagine a world without it.
6. Responsible drinking—whatever that is—is recommended, but we are also made to feel boring if we don’t join in with a few glasses of wine when we meet up with friends. Mixed messages are to be found all over the media and the age at which people start excessive drinking seems to be getting younger and younger, with its related problems accelerating at an alarming rate.
7. The mixed message of society also creates a sense of shame in those affected by the disease of alcoholism. People would rather not talk about their own alcohol issues, ashamed to admit that they even have any. Erecting a façade of normality is typical among the family and friends of someone who is suffering from alcoholism. Nobody seems to understand, so why try to explain? Everybody seems to judge, so why invite criticism? The frequent result here is that people suffer in the privacy of their own homes. Children are forced to witness

awful and sometimes dangerous situations between their parents due to verbal or sometimes physical abuse and may sometimes become the object of abuse themselves.

8. Children, partners or other family members find themselves utterly isolated. The alcoholic seeks isolation because he or she feels it is impossible to deal not only with their own sense of worthlessness and be judged by others as well. The victims are frequently too scared and/or ashamed to seek help for themselves. Yet, there are ways out.

9. Recovering alcoholics, who have found such a way out of their addiction, often come together in meetings (where anonymity is guaranteed), which diminish this deadly isolation. In such situations, they are able to share their experiences with others who have been there and who fully empathise, and they can find this fellowship to be a powerful and comforting healing tool. They are now not alone. Their problems are not unique. The relief of realising this up-close-and-personal is immense, both for the alcoholic and their immediate family alike. But the necessary anonymity in this form of recovery process seems to confirm society's ignorance and denial. Modern society is in denial of the problem, just as those affected by alcoholism are often in denial of their situation.

10. Many visualise an alcoholic as a dishevelled homeless guy sleeping under a bridge or on a bench in the park. If only they knew the truth. It is hugely misunderstood as an illness and even "science" hasn't accepted that it might actually be a mental illness, like schizophrenia. In general, especially in Europe, it is not even regarded as a medical problem and, therefore, hardly any funds are made available to find a "medical solution".

11. I believe that it is possible to lift the veil of guilt and shame surrounding alcoholism by showing how healing can take place through understanding, compassion and kindness.

12. Having lived with an alcoholic myself for many years I know that the alcoholic is suffering and that inadvertently this suffering is also inflicted on others, usually the nearest and dearest. I strongly believe that alcoholism is an illness, but when we accept that alcoholism is an illness, we have only put a label on the problem. However, trying to understand what drives the human being behind a vague term like "an alcoholic", and getting an idea as to why addicts behave the way they do, could create a shift in the general attitude of denial by society.

13. Why do people affected by alcoholism feel ashamed and the need to cover up their problems, more often than not creating a situation of utter isolation? Society is sending out mixed messages. We do not approve of alcoholics who cannot control their drinking. They are regarded as weak, not part of civil society. At the same time, there is a culture of being made to feel guilty for not joining in the drinking. You are called a bore and, in general, people would argue that "one drink won't hurt".

14. I have first-hand experience of living with an alcohol-addicted partner and all the complexity this involves. The secrecy surrounding alcoholism in society as a whole, and the non-acceptance and judgemental attitudes of my family, friends and outsiders, have driven me to interview people who are in one way or another affected by over-consumption of alcohol. I have comprised their stories in a book called *Cheers, the hidden voices of alcoholism*—a compelling book, which shows the human face behind alcoholism.¹

15. In order to create a holistic perspective, I have interviewed not only partners, children, parents and friends of alcoholics, but also health workers in the field of addiction, and alcoholics themselves. In this book, I recount their remarkably candid experiences, openly, yet anonymously, revealing my own and their incredible stories of desperation and pain, but ultimately also of hope and escape.

16. It highlights the person/people behind the problem. This book will help to raise awareness of the growing problem of alcohol abuse; and help those affected by alcoholism to find a way to cope with—or, indeed, to discover a way out of—this widespread, yet frequently misunderstood, disease. Compassionately written, *Cheers* offers information about some of the many avenues of help currently available to those affected both directly and indirectly by alcoholism.

17. I believe alcoholism is the symptom of an intricate web of cause and effect. Layers of causes build up in an individual and erupt in the effect, which is the disease of alcoholism. The underlying cause is the emotion of fear. The individual's essential problem is one of fear and society's reaction to an individual's alcoholism compounds the problem by also being one of fear.

18. The individual fears loss, failure, loneliness, rejection, not being good enough, sadness, lack of security, not being loved and suffering. The effect of this fear is seen in anger, depression and despair. The individual, who lacks emotional awareness, will not be aware of these causes or of these effects. A society that lacks emotional awareness will react towards the alcoholic with harsh judgements, anger, despair and disdain.

19. In my book *Cheers*, I seek to address the negative effects that the lack of emotional awareness, judgements and reactions of society as a whole have on the disease of alcoholism.

20. It is my passion to show that alcoholics, and all those close to alcoholics, should be treated with compassion, love and kindness. I feel very strongly that without those positive and healing emotions the alcoholic cannot be healed and neither can those who are close to them, nor society as a whole. If a person is

¹ You can read the first three chapters of *Cheers*, via the following link: http://www.save-our-trees.org/books/renate_van_nijen/cheers/

drinking too much and society treats them with the same emotion that gave rise to the drinking problem in the first place, namely with fear, then the problem will be compounded and help will not be sought.

21. If the alcoholic is driven into denial, then those close to them will be too. Many skeletons in family cupboards are not mentioned because an alcoholic brings back too many emotions related to fear. That means children are not made aware of the dangers of alcohol or the potential genetic link to alcoholism that they may carry. Through society's denial, advertisers are not properly held to account and so the disease continues down the generations.

22. I want to bring the problem out of the cupboard so that everybody can discuss it, find out about it, dissect it and lay it to rest without harsh judgement. It is my aim, possibly through lectures and my book, to arouse a strong feeling of compassion in people so that the healing can begin:

"Cheers, the hidden voices of alcoholism" by Renate Van Nijen is published by Palcho Publications and printed and distributed via Lightning Source and is an amazing account of real life stories about the people in and around alcoholism. Each story offers a message of profound insight and ultimately of hope. It lifts the lid on alcoholism to reveal the person behind the alcoholic.

23. What has been interesting to me is that I had no problem finding interviewees for my book—in fact, once the word was out that I was writing it, many people volunteered to tell me their stories. It was clear that a group of people had emerged, who wanted to speak out, but had no outlet.

24. I would like to see the media, and society as a whole, explore the problem of alcoholism from the perspective of those indirectly affected by it as well. The experience of interviewing people affected by the problem showed me not only how having "a life consumed by alcoholism" can happen to anybody, but also how those indirectly affected by it feel they have no voice in today's society. It seems living with alcoholism and its effects tends to exile people into the shadows of society, ashamed and isolated, which (of course) doesn't make the problem go away. Rather it makes it worse—for the individual and for society as a whole.

25. I suggest that by concentrating only on the alcoholic's perspective, a valuable point is missing. Those indirectly affected by the behaviour of alcohol-abuse will also have an impact on the health system of society and on society as a whole. The number of people indirectly affected by alcoholism is far greater than those directly affected by it.

26. I'd be happy to contribute my experience (as a writer, and also as an ex-partner of an alcoholic) and help your researchers in any way I possibly can.

April 2012

**Written evidence from Redcar and Cleveland Adult Drug and Alcohol Joint Commissioning Group
(GAS 04)**

- The Government's Alcohol Strategy, released 23 March 2012, had been anticipated for some considerable time in a climate of increasing concern about the harmful effects that alcohol misuse has upon individuals and wider society.
- Whilst the Strategy and many of the proposals contained within it are welcomed, there is a distinct lack of ownership of the Strategy; it is a "Government Strategy" not a "National Strategy". Additionally there are no timescales relating to the desired outcomes which are outlined in the Strategy.
- The Strategy document is published by the Home Office and its contents is very much focused upon crime, disorder and licencing issues. These are clearly areas of importance. Our concern relates to the lack of a coherent contribution from the Department of Health relating to the reduction of alcohol related health harms, particularly alcohol related hospital admissions.
- The Strategy appears unfinished with mention of consultation required on no less than six important issues. At best the strategy reads as a list of "to do" enforcement style actions plans. We would have welcomed (and expected) proposals/actions relating directly to prevention and treatment strategies as present in our local area Alcohol Harm Reduction Strategy.
- An introduction of a minimum unit price (MUP) for alcohol is welcomed although the suggested minimum unit price of 40p is perhaps not enough, with evidential research indicating that 50p would deliver better reductions in harmful alcohol consumption amongst high risk groups. Additionally the proposed legislation to end multi-buy promotions is welcomed but not without questions as to why it is not intended to apply such a ban to the on-trade.
- The increased licencing powers relating to density of licenced premises and opening hours are welcomed and fit with the move towards allowing local authorities to address local licencing issues. These measures and the proposed late night levy do suggest a commitment towards making town centres a safer place to consume alcohol.
- The intention to pilot sobriety schemes is an interesting development, but once again the focus appears to be from a crime and community safety perspective. This is all well and good but these schemes cannot succeed in isolation. They need to part of a multi-agency approach incorporating a dedicated course of treatment and/or education to ensure that rehabilitation occurs alongside punishment.

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- The intention to introduce a wider choice of lower strength alcoholic drinks and the challenge to the drinks industry to with regards to production, sales and promotion are covered by the Government’s “Responsibility Deal” with the alcohol industry. However, we hold concerns that the self- regulation of these pledges by the alcohol industry is not sufficient and would be best served by a legislative frameworks and timescales to ensure progress is made. This view is supported by a number of prestigious bodies including Alcohol Concern, British Medical Association and the Royal College of Physicians who have withheld support for the “Responsibility Deal”.

1.1 The strategy document released 23 March 2012 is described as “The Government’s Alcohol Strategy”. The document reads very much like a political manifesto centred upon addressing the crime and disorder issues associated with alcohol misuse. Whilst accepting the earlier Government Alcohol Strategy (2004) and update (2007) were published by a previous administration; they were very much holistic documents which could be viewed as part of a “National Strategy” due to the strategic aims of:

- improving information and advice about alcohol use;
- increasing identification and treatment of alcohol problems;
- tackling alcohol related crime and disorder and improving services to victims; and
- working with the [alcohol] industry to tackle harms caused by alcohol.

1.2 Throughout the new strategy document there is a distinct lack of information in chart or graph form and there are no timescales applied to the six desired outcomes stated in paragraph 1.6 of the Strategy.

2.1 The Government’s Alcohol Strategy is published by the Home Office which perhaps explains the focus upon crime, disorder and licencing. There is a distinct lack of input from the Department of Health in the document and no health related annexes as supplementary material. With alcohol related hospital admissions in England rising unabated year on year and having broken one million admissions for the first time in 2011; it would appear at best misguided to have overlooked the need for a contribution relating to lower risk drinking and preventing alcohol related health harms.

2.2 Although published by the Home Office the strategy does not appear to fit into any of the existing Home Office structures. It appears to transcend a number of themes including licencing, anti-social behaviour and violence without a best fit. Additionally the document bears the name of the Prime Minister, yet he does not chair any of the groups to which the Alcohol Strategy relates.

3.1 Released some months later than its expected publication date, the Alcohol Strategy appears to be an “incomplete” document. The Strategy lacks action points and contains commitments to consult on important issues including:

- minimum unit pricing—setting the actual price per unit or whether it actually goes ahead?
- multi-buy promotions.
- mandatory codes.
- anti-fraud measures.
- health measures.
- PHSE (Personal, Health, Social and Economic) education in schools.

3.2 Until definitive indicators and timescales for implementation are in place the Strategy reads more like a “wish list” or a “to do list” and as such a refresh of the Strategy will be needed to provide responsible authorities with clear and coherent guidance.

4.1 The indication that the Government recognises the introduction of a Minimum Unit Price (MUP) for alcohol as a means of tackling alcohol related harm is well received by the Redcar and Cleveland Adult Drug and Alcohol Joint Commissioning Group which has over recent months explored the feasibility of a local MUP to address health harms in the borough. The Government’s statement of intent with regards to MUP effectively allows local authorities to press on with local MUP schemes. There is however the major issue regarding at what level MUP should be set, with the Government Alcohol Strategy indicating that 40p may well be the chosen unit price, but consultation will occur on this. The influential Independent Review of the Effects of Alcohol Pricing and Promotion (2008) conducted by the University of Sheffield suggests that a MUP of 50p would provide the greatest impact in reducing alcohol related health harms. As a result there is a slight disappointment that the Government did not made the suggestion of a 50p MUP ahead of the consultation.

4.2 The Government’s commitment to consult on legislation to prohibit multi buy promotions in the “off-trade” is welcomed, particularly in light of the evidence from Scotland which suggests that a similar prohibition is having the desired effect. There is however some disappointment that the Government has not seen fit to extend such proposed legislation to the “on-trade”; ostensibly on the grounds of the on-trade is a more regulated environment. Whilst it may be true that Mandatory Code for Alcohol has outlawed irresponsible drinks promotions such as “all you can drink” and “dentist chair” drinking games; it is still possible for the on-trade to offer heavily discounted drinks to patrons and this must surely been seen as less than responsible behaviour and potentially a contributory factor in town centre based anti-social behaviour.

5.1 The introduction of additional licencing powers for local authorities to have greater control over density of licenced premises and opening hours is welcomed and fits well within the localism agenda. Such powers will allow for identified problem premises to be dealt with in a co-ordinated and responsible manner and should promote safety and good management of licenced premises whilst reducing anti-social behaviour in the night time economy. The introduction of the night time levy will go some way towards meeting the often huge cost of policing the night time economy; but there is the potential for a perverse incentive. Licenced premises may be tempted to stay open longer or continue to serve individuals in a drunken state in a bid to increase revenue and cover the late night levy. Such permutations will require a great deal of thought on a local level.

6.1 The Government Alcohol Strategy proposes piloting sobriety schemes to deal with individuals who are engaged in alcohol related anti-social behaviour or alcohol related offending behaviour is innovative. It does however continue to demonstrate the emphasis upon crime and disorder which is a constant throughout the Strategy. Whilst accepting that there is a need to test the feasibility of sobriety schemes and the technology that is now available to enforce them; it would be short sighted to expect these schemes to be successful in isolation. It is to be hoped an education and/or treatment option will be developed and suggested as best practice to run alongside sobriety schemes. Without treatment and education sobriety schemes may serve only to usher individuals with alcohol problems towards other substance use and/or increased involvement with the Criminal Justice System. The combination of treatment/education/sobriety scheme would appear to be more holistic approach to addressing both the alcohol misuse and offending behaviour of individuals with alcohol identified as a criminogenic need.

7.1 The “Responsibility Deal” involving the alcohol industry is intended to “*foster a culture of responsible drinking which, which will help people to drink within guidelines*”. According to the strategy this will be achieved through pledges from the alcohol industry which include the introduction lower strength products. The anticipated benefits of the responsibility deal include improved public health, a reduction in crime and a practical demonstration that the alcohol industry is able to police itself without Government interference. Whilst the aims of the Responsibility Deal are admirable, it amounts to nothing more than a series of promises to change the status quo and is severely hamstrung by the lack of timescales and milestones to adhere to. The concerns about the effectiveness of the Responsibility Deal are perhaps best illustrated by the endorsements it has not received from respected expert groups including Alcohol Concern, British Medical Association and the Royal College of Physicians. In summary there does not appear to be sufficient confidence that the alcohol industry will make the much needed changes quickly enough; to use the analogy “*Turkey’s don’t vote for Christmas*” appears very apt in this instance and stresses the need for central government to be more demanding of the alcohol industry with regards to responsible promotion, marketing and sale of alcoholic drinks.

April 2012

Written evidence from Institute for Social Marketing, University of Stirling (GAS 05)

THE GOVERNMENT’S ALCOHOL STRATEGY: GAPS AND OPPORTUNITIES

- In March 2012 the UK government published an alcohol strategy that set out proposals to reduce excessive alcohol consumption and to deal with the consequences of this consumption.
- The strategy is ambitious in a number of respects but also contains a number of gaps. This short note identifies some of those gaps as well as areas where action set out in the strategy could be enhanced or expanded.
- Our comments are grouped around the 4 “ps” of marketing—price, product, place and promotion. The government’s strategy contains proposals in all four of these areas.

1. PRICE

The strategy contains two main proposals on price. The first is to consult on a minimum unit price for alcohol. This proposal follows Scotland and is to be welcomed. Key considerations are what level MUP will be set at—there is good evidence to suggest that 45 or 50p would be more effective than 40p, for example. How long the consultation will take and when possible changes will be introduced is also key. Secondly, the strategy commits to a consultation on a ban on multi-buy promotions in the off-trade. This is already in place in Scotland and should be adopted more widely—it is not clear why this requires a consultation.

2. PRODUCT

The strategy is weak on changes to the product. It commits to working with the Advertising Standards Authority and other bodies to “look at the rules and incentives that might inhibit the promotion of lower strength alcohol products”. The strategy is silent on labelling and health warnings, for example. Larger and clearer warning labels on bottles could provide drinkers with better information and contribute to changing drinking behaviour as is the case with warning labels on cigarette packaging, for example.

More fundamentally it says nothing about the relative appeal of products and the need control those that have a particular appeal for the young. In our view there is no justification for a product that is more popular

with children than adults. All new products should be subject to independent scrutiny to assess their appeal to young people and impact on public health before they are permitted onto the market.

3. PLACE

The strategy contains a number of proposals to promote better local action on alcohol, address issues around late night sales, outlet density, licensing and crime and justice measures, all of which are welcome. The strategy could have gone further in terms of proposals to ensure that sales in shops and supermarkets are limited to specific areas and specific times of the day, distinct from the sale of other products. For example, alcohol in supermarkets should be limited to particular areas where children are not permitted and that have separate entry points (ie turnstiles) and separate tills for purchases.

4. PROMOTION

The promotion of alcohol is extremely widespread and young people in particular are inundated by pro-drinking messages. This advertising has been shown to have a direct effect on both the age at which drinking starts and the amount consumed—reducing the former and increasing the latter. Despite this evidence, there are no proposals in the strategy to reduce the amount of alcohol advertising, or even to introduce a degree of independence into the regulatory process. Instead it is business as usual, with an industry driven focus on content regulation—and approach which lacks any evidence base and has been shown to fail. Nowhere is this complacency more apparent than with online advertising, which the strategy treats as a mere extension of current promotion. In reality it completely changes the landscape, with young people not just being marketed to, but being recruited as a peer to peer brand advocates, unwittingly feeding marketing campaigns with their personal details and generating their own promotional content. How, for example, can the current regime of content controls deal with this last phenomenon? And the talk in the strategy of better age restrictions on digital marketing is simply fanciful. Digital marketing has to be treated much more seriously.

The strategy also misrepresents the *Loi Evin* as a ban on advertising. It is nothing of the kind. Rather it is exactly the type of imaginative response to a major public health problem that the UK lacks, and it simply ensures that alcohol advertisers behave responsibly by a) restricting their messages to verifiable statements of fact b) making sure these messages only reach adults. If the Government could not bring themselves to learn from this excellent cross-channel experience, there were a number of intermediate steps they could and should have taken, including: prohibiting alcohol advertising on television before the watershed; limiting or prohibiting sponsorship of sport; and requiring health promotion messages to be screened before programmes or films promoting drinking.

5. SOCIAL MARKETING/HEALTH PROMOTION

The strategy also contains measures on information and education and on treatment but in both these areas the strategy is weak. On information and education, for example, there is a renewed commitment in the strategy to continue to work with the alcohol industry and its partners (ie Drinkaware) to provide the public with information on “safe” drinking whereas evidence from other related areas (such as tobacco) suggests that the producers of a harmful product should not be involved in designing or delivering public health messages. On treatment, there is an urgent need to ensure adequate implementation of existing NICE guidance on both brief interventions and treatment services and to make treatment more available and accessible. The Alcohol Health Alliance will be providing the Health Select Committee with a comprehensive critique of the strategy that will provide more detail on gaps in these areas.

6. INDEPENDENCE

We have used the word “independent” several times in our response. By this we mean independence from vested interest in the alcohol and advertising industries. None of the three bodies mentioned on numerous occasions in the strategy—Drinkaware Trust, the Portman Group and the ASA—pass this test of independence and this is much to be regretted.

May 2012

Written evidence from Balance, North East (GAS 06)

SUMMARY

- Balance welcomes The Government’s Alcohol Strategy (2012) and its acknowledgement of the harms associated with current levels of alcohol consumption in England.
- We particularly applauds the proposal of a minimum unit price for alcohol, and the recognition that affordability, as well as availability and marketing are all major factor in driving levels of excessive consumption and associated health harms.

- We are pleased that strategy acknowledges the link between alcohol advertising and consumption, especially aimed at young people, but feel the ongoing involvement of the alcohol industry in public health campaigns is an area of great concern—It is our belief that the alcohol industry should not shape policy; further the measures proposed in the strategy are not strong enough and too vague. We would welcome the introduction of a version of France's Loi Evin.
- Overall the strategy is thin on detail and targets and says nothing about resources; this is a particular concern for treatment providers.

OVERALL RESPONSE TO THE GOVERNMENT'S ALCOHOL STRATEGY

1. *Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role*

1.1 The strategy, published by the Home Office, is light on detail, particularly in relation to targets and outcomes.

1.2 It is skewed towards a "law and order" agenda with the Prime Minister setting the tone in his introduction.

1.3 The choice of language suggests that alcohol problems in society can be placed at the feet of the "young binge drinker"; the "irresponsible" and the "ignorant". It fails to set the problem in the right context, that of a population level issue which involves significant numbers of people drinking at levels of increasing and higher risk and one which affects everyone in the country either directly or indirectly.

1.4 DH ownership and contribution appears to be small. That being said we welcome support for Identification and Brief Advice (IBA) and Alcohol Liaison Nurses in hospitals. However, we support Alcohol Concern's response to the strategy in stating the need "to ensure sufficient resources can be made available for alcohol services which has long been underfunded, if we are to match the aspirations set out in the strategy."

2. *Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol*

2.1 Alcohol policy should be coordinated across the UK. In the North East we share many of the problems of alcohol harm with our neighbours and we should be following a similar path, one which is based on sound, scientific, independent evidence. We believe, in particular, the level at which minimum unit price is set should be coordinated across the jurisdictions.

3. *The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group*

3.1 While Balance welcomes the Government's recognition that the industry needs to do more, we don't believe it should be playing such a central role in helping to shape Government alcohol policy. We believe there is a fundamental conflict of interest when corporations with a legal obligation to maximise profits for shareholders are involved in shaping public health policy.

3.2 Further, the evidence to date does not suggest that the alcohol industry will deliver the changes needed to reduce alcohol harm unless those changes are supported by legislation. For example, the industry failed to deliver on its promise to include labelling information on 50% of its products under the last Government. What's more, to reduce alcohol harm we need to reduce the amount of alcohol consumed at a population level which goes against the industry's responsibility to deliver maximum shareholder value. While supporting the Responsibility Deal, many alcohol companies and its representative organisations are active in undermining the international evidence base.

3.3 We are concerned that the strategy appears to rely on organisations which are totally funded by the alcohol industry. For example, the Portman Group plays a role in overseeing alcohol marketing while at the same time it has been publicly undermining the well established and independent evidence base supporting minimum unit price (eg Henry Ashworth, Chief Executive: "...calling for Soviet Union style population controls cannot do anything but alienate the vast majority of people who already drink within Government guidelines").

4. *The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing*

4.1 Balance supports a minimum price per unit for alcohol as the best evidenced and most targeted way to address the problem of the affordability of alcohol (alcohol is 44% more affordable than it was in 1980).⁽¹⁾ The Sheffield study indicates that the introduction of minimum price would reduce consumption amongst harmful drinkers and young drinkers while having a minimal effect on those drinking within the guidelines.⁽²⁾

4.2 We welcome the bold step in committing to the introduction of a minimum unit price (MUP) for alcohol. However, many independent experts believe that an intended MUP of 40p per unit level to be too low.

4.3 The previous Chief Medical Officer called for an MUP at 50p, while Scotland is unlikely to introduce the measure below 45p and may go higher. A briefing paper released this month by the BMA Board of Science says “a minimum price for the sale of alcohol should be set at no less than 50p per unit, and this should be kept under review to ensure alcohol does not become more affordable over time.” Evidence from certain Canadian provinces which have MUP indicates that the measure should be regularly reviewed to maintain its effect.

4.4 Some have suggested that the introduction of MUP will lead to increased profits for the retail sector and in particular the large supermarkets. While the Scottish Government is looking to claw some of these back through the tax system, the strategy for England and Wales relies on the extra income from alcohol being used to reduce the price of other goods in store. We’d like to see how the Government propose to ensure this happens. The worst outcome would be that the profits are further used to increase the sophistication and reach of alcohol marketing.

4.5 A comprehensive analysis of 1003 sets of data from 112 studies, including information spanning two centuries and many countries, found a significant negative relationship between alcohol price and drinking.⁽³⁾

4.6 Should MUP be introduced at the level suggested by the previous Chief Medical Officer, namely at 50p, it would have the added advantage of closing the price differential between on and off licence premises. This would arguably protect small businessmen running community pubs as well as reducing the frequency of pre-loading.

4.7 In a survey carried out by Balance with 244 landlords across the North East, over half had seen a decline in business in the previous year; 72% saw customers arriving later due to pre-loading; 72% would welcome legislation to address cheap supermarket prices; and 81% would support the introduction of a minimum price in the North East.⁽⁴⁾

4.8 The North East public also supports action to address the affordability of alcohol. More people think supermarket alcohol prices are too cheap (35%) than too expensive (13%) and 56% said they would support the introduction of minimum price, an increase of 7% on the previous year. Support for minimum price increases if it is seen to address social problems, with 83% saying their support would increase if it addressed drunk and rowdy behaviour.⁽⁴⁾

4.9 The strategy includes the introduction of fiscal marks for beer, supply chain legislation, and a licensing scheme for wholesale alcohol dealers. These measures are currently the subject of an HMRC consultation and are an important area of work. In WHO Europe’s recent report *Alcohol in the European Union: Consumption, Harm and Policy Approaches* it says “the level of illegal trade and smuggling predominantly depends on the level of Government enforcement”.

5. *The effects of marketing on alcohol consumption, in particular in relation to children and young people*

5.1 Balance welcomes the recognition in the strategy of the role played by alcohol advertising and marketing in creating a pro-alcohol culture and in influencing young people to drink earlier and drink more. We especially welcome work to develop an effective online age verification system as alcohol companies increasingly move their advertising and marketing activity into the online arena.

5.2 Balance is concerned that the strategy does not contain sufficient specific proposals to reduce children’s exposure to alcohol advertising and marketing. Instead, it relies on working with a partially self regulatory system which is currently failing to protect our children and which, in the case of organisations such as The Portman Group, is totally funded by the alcohol industry.

5.3 Tinkering with the existing system won’t make a significant difference in terms of protecting our children. Balance would like an approach similar to that taken in France, whereby the promotion of alcohol would be restricted to media that adults use; at point of sale in licensed premises; at local producer events. Content would be restricted to verifiable factual statements such as alcoholic strength, composition, place of origin, means of production, and patterns of consumption and must carry explicit health information.

6. *The impact that current levels of alcohol consumption will have on the public’s health in the longer term*

6.1 The Office of National Statistics estimated that in the UK there were 8,664 alcohol-related deaths in 2009, which is more than double the 4,023 recorded during 1992.⁽⁶⁾ By way of a comparison 1,738 people died due to drug misuse in 2008.⁽⁷⁾

6.2 In its publication “reducing alcohol harm” the British Liver Trust states “The challenge of alcohol misuse is reaching epidemic proportions in the United Kingdom; with the average intake of alcohol rising steadily, NHS admissions from alcohol increasing”⁽⁸⁾ and cites the research that suggests that the current death toll from alcohol is equivalent to “a jumbo jet crashing every 17 days”.⁽⁹⁾

6.3 It is estimated that 80% of liver disease is directly related to alcohol and possibly around a quarter of the total attributable mortality. Liver disease is the fifth most common cause of death in England. However, the British Liver Trust warns that this prevalence is growing and “mortality from liver disease could overtake stroke and coronary heart disease as a cause of death within 10 to 20 years”.⁽⁷⁾

6.4 The British Liver Trust states that “there is unequivocal evidence of a relationship between alcohol consumption and liver disease” and goes on further to suggest that “liver death rates offer a good measure for the success of any alcohol policy”.⁽⁷⁾

7. *Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services*

8. *Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm*

8.1 The proposed health reforms will see the responsibility for alcohol services move from NHS to local government; this reconfiguration offers partnerships and Directors of Public Health an opportunity to develop coherent, robust alcohol-harm-reduction programmes across health, voluntary sectors; social care; police, judicial, and licensing authorities.

8.2 is essential that Joint Strategic Needs Assessments don’t just focus on anti-social behaviour or criminal justice agendas. Areas should provide a range of treatment options in line with NICE Guidelines. There are fundamental distinctions between drug and alcohol problems. These differences mean the recovery pathways for alcohol misuse may differ to that of drug misuse. There is a danger, following the focus of “recovery” set out in the 2010 Drug Strategy, that there is a narrowing of focus and loss of recognition of guidance on alcohol use disorders. We would concur with Alcohol Concern that sufficient resources should be made available for alcohol services, if we are to match the aspirations set out in the strategy.

9. *International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking, such as:*

9.1 Public health interventions such as education and information:

9.1.1 The strategy recognises the importance of cross-cutting approaches to tackling alcohol harm. In particular, the strategy talks about piloting advice in sexual health clinics and featuring alcohol in the Change4Life and wider youth marketing programmes. This is to be welcomed, while recognising that education, information and marketing campaigns can only ever be effective as part of a wider programme to address the social norms around alcohol.

9.1.2 In its report *Alcohol in the European Union*, WHO Europe says: “Information and education on the risks for alcohol and how to reduce them is needed for an educated population and for the development of individual capital, although as an isolated policy measure it will not reduce alcohol related harm”. It goes on to say that such activities “could be reframed to encourage and support consumer advocacy by providing information on how the public can influence alcohol policy”.

9.2 Reducing the strength of alcoholic beverages:

9.2.1 Steps to reducing the strength of alcoholic drinks, and labelling alcoholic beverages to warn of the harm of excess drinking are welcomed, but we question whether they should be left in the hands of the alcohol industry.

9.3 Raising the legal drinking age:

9.3.1 While we recognise the emerging evidence that alcohol can damage the developing brain until the early twenties, we believe that further work is required to educate the public about the dangers of alcohol to young people before such measures are considered.

9.4 Plain packaging and marketing bans:

9.4.1 Research shows children are drawn to brands with appealing packaging which is why packaging is used as a seductive marketing tool. Studies show that the younger people start drinking, the more likely they are to develop alcohol problems later in life.⁽¹⁰⁾ However, we believe that the greatest evidence for action on marketing currently lies elsewhere and we should start by introducing advertising restrictions similar to those found in France. We also believe this would receive greater public support. In our public perceptions survey 2011, 55% believed alcohol advertising targeted under 18s and 68% would support a ban on alcohol being advertised on television before 9pm.

9.4.2 Whilst Balance would welcome any new emerging international research findings, we would stress the importance of acknowledging and implementing what we already know to work. The World Health Organisation (WHO) recommendations: “Increasing the price of alcoholic beverages is one of the most effective interventions to reduce harmful use of alcohol”. The policy recommends raising taxes on alcohol, prohibiting promotional pricing and establishing minimum prices for alcoholic beverages.

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May 2012

Written evidence from The Salvation Army (GAS 08)

The Salvation Army is an international Christian church working in 125 countries worldwide. As a registered charity, The Salvation Army demonstrates its Christian principles through social action and is one of the largest, most diverse providers of social welfare in the world.

The Salvation Army welcomes the publication of the Government’s Alcohol Strategy. This is a welcome declaration of intent to seriously address the detrimental impact of alcohol on individuals, families and society and we look forward to actively contributing to the consultation process.

We have worked closely on the issue of Alcohol Policy including being closely involved in the legislative process in Scotland. The Salvation Army has given evidence to the Scottish Parliament on these vital issues. The Salvation Army has a long history of working with those whose lives are damaged by addictions, most notably to alcohol and drugs. We provide an extensive range of treatment services for those who are recovering from alcohol abuse.

The Committee has invited written submissions and has requested views on the following issues:

1. Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role.
2. Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol.
3. The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group.
4. The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing.
5. The effects of marketing on alcohol consumption, in particular in relation to children and young people.
6. The impact that current levels of alcohol consumption will have on the public’s health in the longer term.
7. Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services.
8. Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm.
9. International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking.

1. THE SALVATION ARMY’S RESPONSE TO SELECTED QUESTIONS

Historically, The Salvation Army has unashamedly expressed the view that excessive alcohol consumption has only a negative impact upon society and we have consistently sought to ameliorate this effect through programmes of intervention, particularly among the most marginalised populations. Sadly, our task has become increasingly difficult over recent years due to the exponential increase in alcohol outlets and the proliferation of stronger and cheaper products.

This, along with the “normalisation of intoxication” reflects an increased tolerance within society of alcohol use, the consequences of which are now all too evident and well documented. Although there is current concern

emanating from mortality, liver deaths and crime statistics there are wider issues relating to personal well-being and negative health behaviours, especially in the young, which will hopefully be addressed in the implementation of the alcohol strategy.

The Salvation Army warmly welcomes the Alcohol Strategy and the range of measures that it proposes in order to tackle harmful and hazardous drinking. Every day we see the consequences of excess alcohol consumption on the physical and mental health, careers, relationships and family lives of those we help. Many with alcohol problems have often exhausted the kindness of family and friends and have lost contact with their own children.

There is a huge alcohol related problem in this country. In 2010 we saw over a million alcohol related admissions to hospital. It is costing the NHS an estimated £2.7 billion every year. The number of alcohol related deaths has increased by 101% in the last 20 years.

2. COORDINATION OF POLICY ACROSS THE UK WITH THE DEVOLVED ADMINISTRATIONS, AND THE IMPACT OF PURSUING DIFFERENT APPROACHES TO ALCOHOL

We welcomed the recent move to introduce minimum pricing in Scotland and have given evidence to the Scottish Parliament.

The Health Secretary has introduced a Bill within the Scottish Parliament that looks to implement minimum pricing of alcohol. The price will be set through a formula related to the alcoholic strength. This will be announced during the bill. Whilst we strongly welcome this move we also urge them to set the price no lower than 50p per unit.

Scotland already has introduced a ban on quantity discounts and promotions in retail sales have been restricted, we welcome these moves.

We have also welcomed the Northern Ireland Executive's moves towards introducing a minimum unit price in Northern Ireland.

We feel that Westminster has been behind the curve on this vital issue and we hope that there will be effective co-ordination, for example in setting a broadly similar minimum price so that "alcohol tourism" does not result from these welcome UK wide measures.

3. THE ROLE OF THE ALCOHOL INDUSTRY IN ADDRESSING ALCOHOL-RELATED HEALTH PROBLEMS, INCLUDING THE RESPONSIBILITY DEAL, DRINKAWARE AND THE ROLE OF THE PORTMAN GROUP

We believe that raising awareness of the negative impact of alcohol use is important and should be prioritised.

Such a belief stands contrary to the current freedoms enjoyed by the industry in the unrestricted promoting of alcohol. We therefore would support an intention to extend the existing regulations to target irresponsible promotions. Promotional activities increase sales and often outweigh the responsibility message. Curtailing promotional activity and increasing the responsibility agenda is a crucial first step in addressing the current imbalance.

We would support proposals to introduce labelling but would prefer to see this as a mandatory requirement rather than a voluntary agreement.

4. THE EVIDENCE BASE FOR, AND ECONOMIC IMPACT OF, INTRODUCING A FIXED PRICE PER UNIT OF ALCOHOL OF 40p, INCLUDING THE IMPACTS ON MODERATE AND HARMFUL DRINKERS; EVIDENCE/ ARGUMENTS FOR SETTING A DIFFERENT UNIT PRICE; THE LEGAL COMPLEXITIES OF INTRODUCING FIXED PRICING

We acknowledge that the research by The School of Health and Related Research, University of Sheffield in 2008 and 2009 produced a convincing model measuring the potential impact of minimum alcohol pricing on a variety of population groups. We are encouraged by the intention of the Scottish Government to re-run the Sheffield Model to secure up-to date evidence in support of the minimum unit price.

There is a significant body of international research literature on the relationship between the price of alcohol and consumption levels.

"...price affects drinking of all types of beverages, and across the population of drinkers from light drinkers to heavy drinkers. We know of no other preventive intervention to reduce drinking that has the numbers of studies and consistency of effects seen in the literature on alcohol taxes and prices".

Wagenaar, A C, Salios, M J, Komoro, K A, *Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1,003 estimates from 112 studies*, *Addiction*, 104, 179–190, Society for the Study of Addiction, 2009.

The evidence suggests that consumers of alcohol increase their drinking when prices are low and decrease their consumption when prices rise. Therefore, public health can be further protected by increases in price.

The current research indicates that setting a level of 50p per unit would result in a significant reduction in alcohol related harms whilst ensuring that alcohol remains affordable for moderate drinkers.

There is a well documented link between this level of harm and the rising cost and availability of alcohol. Minimum pricing per unit is the most efficient, fair and effective way of tackling this problem.

Alcohol has become more affordable and more widely available. In 2010, alcohol was 44% more affordable than in 1980.

This rising availability can be partially explained through the growing price gap between on and off trade sales. In recent years the supermarkets have driven down the price of alcohol selling well below the cost of production.

As such The Salvation Army advocates the introduction of minimum pricing of alcohol at a minimum of 50p per unit.

Setting a basic 50p per unit price for alcohol would mean a can of lager could not cost less than £1, a pint could not be less than £1.50, a bottle of wine could not cost less than £4.50 and a 70cl bottle of spirits could not be less than £14.

This would result in:

1. Over 1,600 fewer hospital admissions in the first year and 97,900 fewer in 10 years;
2. 406 less deaths in the first year and 3,393 fewer in 10 years;
3. 10,000 fewer violent crimes; and
4. A saving of £66 million in health costs and £49.6 million in crime costs in the first year.

5. THE EFFECTS OF MARKETING ON ALCOHOL CONSUMPTION, IN PARTICULAR IN RELATION TO CHILDREN AND YOUNG PEOPLE

We would support interventions aimed to minimise the harm caused to children and young people by alcohol misuse. Accurate information about the physical, emotional and social impact of alcohol misuse should be embedded within our learning structures and young people should be encouraged to build up “personal resilience” to challenge the “cultural norm” of under-age drinking.

We would also suggest that “at risk” groups should be given particular attention and would encourage a more assertive approach to children who suffer through parental alcohol misuse. Early intervention in such groups can minimise the risk that such behaviour is replicated through the family system. Interventions should include easier and quicker access to specialist treatment for parents linked into structured therapeutic programmes that address family issues caused by the alcohol misuse.

We would also be encouraged by the development of “diversionary schemes” which promote alcohol-free alternatives for young people. Meaningful activity should be prioritised with strong role-model leadership in such schemes.

6. THE IMPACT THAT CURRENT LEVELS OF ALCOHOL CONSUMPTION WILL HAVE ON THE PUBLIC’S HEALTH IN THE LONGER TERM

A number of clients who use Salvation Army services have on-going alcohol related problems. As such The Salvation Army works closely with addiction referral services as well as providing six specialist detox centres in the UK. This is complimented by rehabilitation and support programmes to facilitate recovery and social integration.

The delivery of these services comes at a large monetary cost to the taxpayer and to charities such as The Salvation Army. However it is the cost of ruined lives that is incalculable.

9. International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking, such as:

- Public health interventions such as education and information;
- Reducing the strength of alcoholic beverages;
- Raising the legal drinking age; and
- Plain packaging and marketing bans.

The harmful use of alcohol is a global problem and the eyes of the world are on the UK as first the Scottish Government, then the Northern Ireland Executive, and now the UK Government in Westminster all look at radical measures to tackle alcohol misuse.

In Geneva on the 20 May last year the 193 Member States of the World Health Organization adopted in a consensus vote their eagerly awaited Global Strategy to Reduce the Harmful Use of Alcohol.

Addressing price and availability through legislation are consistently recognised as effective, public health interventions and we would strongly encourage Parliament to pursue these options.

CONCLUSION

The inclusion of a minimum unit price, as a whole population approach, is welcomed. Setting this at a level which has the effect required is, of course, vital to the success of this initiative. The proposed level of 40p, while laudable, is, in our opinion, too low. An entry level of 50p, supported by many who contribute to this debate, should be carefully considered. This opportunity to protect vulnerable lives and tackle the inter-generational misery caused by over consumption of alcohol should not be lost.

Minimum alcohol pricing is one measure to tackle harmful and hazardous drinking and we have offered the Government our support and expertise in seeks to address this problem. The Salvation Army will do all we can to provide, through our community and residential centres, support and help to those whose drinking detrimentally affects their daily lives and helps to minimise the damage that over indulgence of alcohol produces in our society.

The Salvation Army warmly thanks the Committee for the opportunity to respond to this inquiry.

May 2012

Written evidence from the Office of Fair Trading (GAS 09)

1. This short note responds to the Health Committee's inquiry into the Government's Alcohol Strategy, launched on 26 March 2012. The Office of Fair Trading (OFT) would like to provide evidence to the Committee on two elements of the Government's policy:

- proposals for a minimum price of alcohol; and
- possible voluntary industry agreements under the Responsibility Deal.

2. We are aware of the evidence demonstrating the harmful effects of excessive alcohol consumption and fully support the Government's desire to reduce that harm. The views expressed here are not in any way intended to challenge the Government's wider policy objectives. The OFT has a remit to comment solely on the competition and consumer aspects of Government policies.² We recognise that the Government must weigh any concerns relating to competition and consumers against its wider policy goals.

3. This document sets out:

- The background to the OFT's involvement in alcohol policy.
- The competition and consumer concerns about the proposal to introduce a minimum price for alcohol.
- A brief comment on the legal issues relating to minimum pricing.
- Brief comments on voluntary agreements and the Responsibility Deal.

4. The OFT has made a number of recent submissions to other Parliamentary inquiries in relation to alcohol policy in the UK:

- The OFT gave evidence to the 2009 Health Select Committee inquiry into alcohol policy.³ This included a written memorandum,⁴ and oral evidence to the Committee.⁵
- The OFT gave written and oral evidence to the 2010 Health and Sport Committee of the Scottish Parliament on the Alcohol etc. (Scotland) Bill (SP Bill 34).⁶
- In November 2011, the OFT made a short submission to the Scottish Select Committee inquiry into the Alcohol (Minimum Pricing) (Scotland) Bill.⁷

5. The comments below build on points we have raised publicly in these previous submissions.

BACKGROUND

6. The OFT is an independent, non-ministerial government department, with lead responsibility for enforcing competition and consumer law in the UK. Our mission is to make markets work well for consumers. Markets work well when businesses are in open, fair and vigorous competition with each other for the consumer's custom. We pursue our mission by:

- encouraging businesses to comply with competition and consumer law and to improve their trading practices through self-regulation;
- acting decisively to stop hardcore or flagrant offenders;

² Under section 7 of the Enterprise Act 2002 the OFT has the function of giving information and advice to Ministers and public authorities in relation to any of its functions.

³ <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/151/15102.htm>

⁴ <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/151/151we33.htm>

⁵ <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/151/09070208.htm>

⁶ www.oft.gov.uk/shared_of/consultations/alcohol-scotland-response.pdf; and www.scottish.parliament.uk/S4_HealthandSportCommittee/Inquiries/MIN53_Office_of_Fair_Trading.pdf

⁷ www.scottish.parliament.uk/S4_HealthandSportCommittee/Inquiries/MIN53_Office_of_Fair_Trading.pdf

- studying markets and recommending action where required; and
- empowering consumers with the knowledge and skills to make informed choices and get the best value from markets.

7. The OFT has a range of enforcement powers under different statutes to address competition concerns in markets. Of these, the Competition Act 1998 (CA98) is most relevant to the current discussions of alcohol policy.

8. The CA98 is designed to secure the benefits of competition—for example a level playing field for firms, lower prices and greater choice for consumers and economic growth. It does so by prohibiting certain types of anti-competitive behaviour (the Chapter I and Chapter II prohibitions). The OFT has strong powers to investigate businesses suspected of breaching the CA98 and to impose penalties on those that do.

POLICY CONCERNS ABOUT MINIMUM PRICING

9. We entirely appreciate and support the need for the Government to address alcohol misuse. However, we have reservations about the adoption of a minimum price as a way of achieving this. In particular, we are concerned about possible unintended consequences of setting a minimum price.

10. At its simplest, setting a minimum price would require retailers to charge more than they currently do for low cost alcohol. There is good evidence that this price increase would be likely to lead to some reduction in demand for alcohol, as the Government intends.

11. However the price increase is also likely to generate windfall gains for retailers, as predicted by recent independent modelling carried out by researchers at the University of Sheffield.⁸ Unlike an increase in tax, additional consumer spending on alcohol would go to private firms rather than to the Government.

12. The OFT is concerned that the unintended consequence of this increase in profit may be to give retailers an incentive to sell more, rather than less, low cost alcohol. Retailers would gain additional profit for every unit of low cost alcohol that they sold. At worst, such an incentive could dull the effectiveness of the minimum price in reducing alcohol sales.

13. More generally, the OFT is concerned about the long-term impact of minimum pricing restrictions on consumers and on productivity in the retail sector. International studies, including by the OECD, suggest that restrictions on retail prices, such as banning below cost selling, ultimately lead to lower productivity and worse outcomes for consumers.⁹ For example in France, between 1997 and 2002, food prices increased faster than general inflation—11.8% compared to 6%—in part because of retail price restrictions.¹⁰ In Ireland, it has been estimated that Irish families were paying €500 more per year for retail items in 2005 because of rules preventing below cost selling.¹¹

14. Taken in isolation, a minimum price for alcohol may not have a significant negative effect on productivity. However, the OFT is concerned that, by legitimising intervention to control prices in a competitive market, it will be harder for the Government to resist calls for similar measures in other parts of the retail sector in future. This could have significant long-term costs.

15. For these reasons, the OFT considers that a change in taxation would be preferable to imposing a minimum price, with less risk of creating unintended consequences.¹²

LEGAL ISSUES RELATING TO MINIMUM PRICING

16. One of the points frequently raised in discussion around the Government's alcohol policy is whether a minimum price would be compatible with competition law.

17. The OFT's view is that UK competition law does not prevent legislation to set a statutory minimum price for alcohol. The relevant part of the Competition Act 1998 applies to agreements or concerted practices between firms. Statutory legislation imposed unilaterally by Government does not create such an agreement.

18. The main concern from a UK competition law perspective would be that, in the process of agreeing a minimum price, the Government does not inadvertently encourage discussion between firms of commercial issues which could be incompatible with CA98, such as expected future prices or competitive strategies.

19. In this context, it is also important to distinguish between the current proposal for a statutory minimum price unilaterally imposed by Government, and the alternative of a voluntary agreement between retailers to agree prices (with or without Government encouragement). A voluntary agreement on price would almost certainly infringe CA98 and European competition law.

⁸ Most recent published research is available here—www.sheffield.ac.uk/polopoly_fs/1.150021!/file/scotlandupdatejan2012.pdf

⁹ www.oecd.org/dataoecd/13/30/36162664.pdf

¹⁰ Biscourp, P, Boutin, X, Vergé, T (2008), "The effects of retail regulation on prices: evidence from French data", INSEE-DESE Working Paper G2008/02, Paris France.

¹¹ www.tca.ie/images/uploaded/documents/s_05_006%20Groceries%20Order.pdf

¹² For more on the taxation option, see Written Evidence of the Office of Fair Trading (the OFT) to the Health and Sport Committee of the Scottish Parliament, 20 January 2010 (see web link at footnote 5).

20. There may be constraints on minimum pricing legislation arising from wider European law. For example, minimum pricing legislation may raise issues of compatibility with European free movement rules. The OFT does not have jurisdiction over these areas of law—enforcement takes place at the European level. The OFT understands that this is currently a live issue in relation to proposals for minimum alcohol in Scotland, and it is possible that there may be legal action which would clarify the position.

RESPONSIBILITY DEAL AND VOLUNTARY INDUSTRY AGREEMENTS

21. More widely, in order to try to reduce the harmful effects of excessive alcohol consumption there may be scope for retailers to make voluntary agreements on elements of their behaviour which do not relate to core parameters of competition such as prices or quantities. The Government’s “Responsibility Deal” is one such example, where retailers and producers are encouraged to sign up voluntarily to collective targets.

22. Voluntary industry agreements potentially fall within the scope of the Chapter 1 prohibition of the CA98. This prohibits agreements between undertakings which have as their object or effect the prevention, restriction or distortion of competition within the United Kingdom.

23. Whether any particular voluntary agreement is compatible with the CA98 depends on its specific details. However, the OFT is clear that retailers and producers should not use competition law as a blanket excuse for not engaging with Government on possible areas where agreements might be reached.

24. Some agreements may not restrict competition at all, or not do so in an appreciable manner. Even cooperation agreements that do have an appreciable impact on competition may benefit from an exemption. In broad terms, this will be the case where the agreement results in efficiencies and consumer benefits, the restrictions are indispensable to the obtaining of these benefits and competition is not eliminated.

25. There is a wealth of guidance material on the OFT and European Commission websites to help businesses assess whether collaboration would raise competition law problems. The Department of Business, Innovation and Skills has also published guidance that should be of assistance to businesses and policy makers.¹³

26. Although in general the law requires parties to “self-assess” whether any agreements they enter are consistent with CA98, if a collaboration proposal raises novel or unresolved issues the OFT can also issue a Short-form Opinion stating its view of the legal issues to assist parties’ self-assessment. The Short-form Opinion will be given on the basis of a statement of facts as to the nature and extent of the prospective agreement that has been agreed between the parties.¹⁴

27. There are also steps that the Government might sensibly take in approaching possible voluntary agreements. For example, engaging with firms on a bilateral basis will typically raise fewer competition concerns than having multi-lateral discussions.

SUMMARY

28. We hope that this note provides helpful input to the Committee’s inquiry. The OFT would be pleased to provide further information should the Committee require it.

May 2012

Written evidence from Alcohol Focus Scotland (GAS 10)

ABOUT ALCOHOL FOCUS SCOTLAND

Alcohol Focus Scotland (AFS) is Scotland’s national alcohol charity. We advocate for evidence-based policy interventions to reduce the burden of alcohol-related harm and we work to provide accurate and accessible information about alcohol to policy-makers, practitioners, the media, and the general public.

SUMMARY OF RESPONSE

- Alcohol Focus Scotland welcomes the Westminster Government’s Alcohol Strategy and the acknowledgement of the historically high levels of consumption and harm being experienced in the UK.
- Action is required at a number of different levels, but controls on affordability, availability and marketing are critical to reducing consumption and harm.
- Plans to introduce minimum unit pricing are particularly welcome as evidence shows a clear link between alcohol price, consumption and harm.
- Increasing the price of alcohol is one of the most effective and cost effective ways to reduce consumption and harm at a population level.
- Alcohol Focus Scotland calls on the government to significantly strengthen the strategy in relation to marketing.

¹³ <http://www.bis.gov.uk/files/file45711.pdf>

¹⁴ See www.offt.gov.uk/OFTwork/competition-act-and-cartels/short-form-opinions/, which sets out the OFT’s approach to Short-form Opinions and materials from a published Short-form Opinion.

- To protect children and young people from exposure to alcohol marketing, Alcohol Focus Scotland calls for greater regulation of social media.
- Alcohol Focus Scotland believes that the alcohol industry can be involved in the implementation of alcohol policy but should not be involved in the identification of public health goals given the obvious conflict of interest and the fact that their expertise is in producing and selling alcohol and not in protecting and improving public health.

1. INTRODUCTION

1.1 Over the last thirty years, a combination of deregulation, liberalisation of licensing laws and aggressive marketing has led to alcohol becoming more affordable and more available than at any time in recent history. This in turn has fuelled our consumption and as our consumption has increased, so too has the health and social harm caused by alcohol. One hundred people die every week from alcohol-related liver disease in England and Wales. Every year alcohol causes the admission of over a million people to hospital; is linked to 13,000 new cases of cancer and is associated with 1 in 4 deaths among young people aged 15 to 24.¹⁵

1.2 Alcohol Focus Scotland welcomes the analysis in the Strategy linking consumption levels with the ready availability of cheap alcohol and the fact that to date, industry needs and commercial advantages have been too frequently prioritised over community concerns.

1.3 Alcohol Focus Scotland further welcomes the recognition that “universal action” is required to address the underlying issues driving the increases in consumption and harm, as the international evidence shows that measures to control affordability, availability and marketing are amongst the most effective levers to reduce consumption.

1.4 Plans within the strategy to consult on the introduction of a health-related objective within alcohol licensing in England and Wales are welcome. Experience in Scotland shows that having a public health objective enshrined in licensing legislation enhances local licensing bodies’ powers to restrict availability on the grounds of protecting health.

1.5 However, Alcohol Focus Scotland has concerns that, by focusing heavily on binge drinking and crime and disorder, the strategy misses a critical opportunity to consider alcohol harm as primarily a public health issue affecting the whole population. With over a million alcohol-related hospital admissions in 2010–11¹⁶ and a 450%¹⁷ increase in liver cirrhosis rates in the last 30 years, the health harms caused by alcohol are being experienced by increasing numbers of people who would class themselves neither as “binge” nor “irresponsible” drinkers.

2. MINIMUM UNIT PRICING

2.1 The inclusion of minimum unit pricing in the Strategy provides an historic opportunity to put in place a policy measure that many leading health organisations including the World Health Organisation, the National Institute for Clinical Guidance and the Medical Royal Colleges believe will be effective in saving lives and reducing harm.

2.2 In addition to the health gains, effective alcohol policy can significantly reduce the costs to the public purse of alcohol-related harm. In 2003, alcohol harm was estimated to cost around £20bn each year and there is evidence to suggest that this cost has continued to rise.¹⁸ Much of this burden could be avoided if people drank less. There is extensive and robust evidence confirming that there is a consistent relationship between price and consumption (when the cost of alcohol goes down, people drink more and when the cost goes up, people drink less) and that the most effective and cost-effective way to reduce alcohol consumption in the population is controls on price and availability.¹⁹ Consequently, controls on price and availability have been identified by the World Health Organisation as one of the most effective measures that governments can implement to reduce the harm caused by alcohol: *“Of all alcohol policy measures, the evidence is strongest for the impact of alcohol prices as an incentive to reduce heavy drinking occasions and regular harmful drinking. The gains are greatest for younger and heavier drinkers and for the well-being of people exposed to the heavy drinking of others”*.²⁰

2.3 To date, the policy mechanism that has been used to increase the price of alcohol is taxation. More recently, minimum unit pricing (MUP) has emerged as a measure that would be complementary to duty increases and also more effective in targeting the cheapest alcohol products, which are often drunk by the most vulnerable groups in society. MUP has also come to the fore because in recent years, duty increases have not always been passed on to consumers. Some supermarkets have even advertised “tax busting prices” following

¹⁵ Health experts letter, Professor Sir Ian Gilmore et al, published in Telegraph, 13 December 2011.

¹⁶ Statistics on Alcohol: England, 2011, NHS Health and Social Care Information Centre, 2011.

¹⁷ Leon D, & McCambridge J, Liver cirrhosis mortality rates in Britain from 1950–2002, ONS 2001.

¹⁸ Meier P. Independent review of the effects of alcohol pricing and promotion: Part A: systematic reviews. University of Sheffield, 2008.

¹⁹ Wagenaar A C, Salois M J, Komro K A Effects of beverage alcohol taxes and prices on consumption: a systematic review and meta analysis of 1003 estimates from 112 studies. *Addiction*: 2009, 104.

²⁰ European Alcohol Action Plan 2012–2020: Implementing regional and global alcohol strategies, WHO Europe, 2011.

duty increases with the ten big supermarkets admitting to the Competition Commission that they use alcohol as a “loss leader” to drive footfall.²¹

2.4 As MUP is a relatively new policy measure, the estimates of the potential health gains come primarily from econometric modeling studies. Modeling is a recognised tool that is used regularly by governments to estimate the effects of new policies. For example, modeling was undertaken to estimate the effects of a minimum wage prior to adoption of the policy.

2.5 However, further evidence of the effect of minimum pricing is now available with the publication of an evaluation of minimum pricing schemes in two Canadian provinces in early 2012. The overall conclusion from the study was that “increases in minimum prices of alcoholic beverages can substantially reduce alcohol consumption” with minimum pricing reducing alcohol consumption by between 3% and 5% in the two provinces in which it was implemented.²²

2.6 A combination of the significant evidence base linking alcohol price, consumption and harm, the growing interest in implementing a pricing measure that specifically targets the cheapest products, and concerns that retailers don’t always pass on duty increases, has resulted in governments in a number of jurisdictions actively exploring MUP. In the Scotland, the Alcohol (Minimum Pricing) Bill (Scotland) is expected to be agreed by the Scottish Government by June 2012. Northern Ireland has recently consulted on the issue, Ministers in Wales have indicated their interest in implementing MUP and a number of local authorities in the North of England have sought to introduce MUP through local bye-laws. Internationally, governments actively considering MUP include the Republic of Ireland, Australia and New Zealand.

2.6 The price of alcohol provides a clear message about where alcohol is positioned in the “culture” of a society. The “culture” that we have created today is one of low cost and easy availability of alcohol. History teaches us that this culture of access and excess is one that has developed over a relatively recent period of time. During the first half of the 20th century, drinking to excess was almost entirely unknown as the conclusion from the Royal Commission on Licensing in 1931 demonstrates. At that time there were significant controls on the price and availability of alcohol. These have been steadily eroded over the last forty years as successive governments have embarked on a process of deregulation and liberalisation. Successful changes in culture in areas such as smoking, seat belt use and drink driving have come about through a combination of regulation, enforcement and public information. Without action on price, any other measures to reduce consumption and harm will be swimming against a very powerful tide. If we want to change “culture” then price is a very good place to start.

Ban on multi-buy discounts

2.7 Experience in Scotland shows that to ensure maximum effectiveness, the ban on multi-buy discounts should be implemented alongside minimum pricing and across the UK. A ban on multi-buy discounts came into force in Scotland on 1st October 2011 with the implementation of the Alcohol etc. (Scotland) Act 2010. During the first weekend of the new legislation being implemented, a number of the major supermarkets sought to undermine the spirit of the Act by encouraging online purchasing of alcohol from distribution centres in England.²³

2.8 Moreover, many of the major supermarkets slashed their prices when the ban came into effect in Scotland. The Grocer magazine published figures which showed that whilst supermarket multi-buys had disappeared, the number of products on price reduction promotions in the first four weeks following the ban period rocketed from 753 to 1,178.²⁴ Whilst legal, these practices call into question the large supermarkets’ claims to be responsible retailers and reinforce the case for a ban on multi-buy discounts to be introduced in conjunction with minimum unit pricing.

3. MARKETING

3.1 The alcohol industry spends £800million each year in the UK marketing their products.²⁵ Young people are particularly vulnerable to alcohol harm with evidence linking regular heavy drinking in adolescence with impaired brain development.²⁶ Evidence also confirms that alcohol marketing increases the likelihood that young people will start to use alcohol, and to drink more if they are already drinking.²⁷ There is a particular concern about social media which is heavily used by children and young people and is largely unregulated.

²¹ Pricing Practices Working Paper, Competition Commission, 2007. Part of the “emerging thinking” in the Groceries Market Inquiry. www.competition-commission.gov.uk

²² Does minimum pricing reduce alcohol consumption? The experience of a Canadian province. T Stockwell, et al. *Addiction*, May 2012.

²³ In Focus, Alcohol Focus Scotland, October 2011.

²⁴ The Grocer, November 2011. <http://www.thegrocer.co.uk/topics/health/scottish-beer-sales-fall-as-multibuy-ban-bites/224565.article>.

²⁵ Alcohol Harm Reduction Project: Interim analytical report, Prime Minister’s Strategy Unit (2003).

²⁶ Tarpert S F and Brown S A ((1999) Neuropsychological correlates of adolescent substance abuse: Four year outcomes, *Journal of the International Neuropsychological Society* 6: 481–493.

²⁷ Anderson P, de Bruijn A, Angus K, Gordon R and Hastings G (2009b) Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies. *Alcohol and Alcoholism* 44: 229–243.

3.2 The Health Select Committee reported in 2010 that the current regulatory framework for alcohol marketing was inadequate.²⁸ The current controls which are in place to limit children's exposure to alcohol marketing are clearly failing with a study funded by the Medical Research Council showing that 96% of 13 year olds in the UK were aware of alcohol advertising and on average had come across it in more than five different media.²⁹

3.3 Of the £800million spend on alcohol marketing, it is critical to note that around £550million of this is spent on football sponsorship, promotions, music festivals and online marketing and promotions³⁰ where the potential exposure of children is even more problematic.

3.4 Indeed in 2007, the alcohol industry increased its marketing spend on social media by 70%.³¹ This has worrying implications with regards to the exposure of children and young people to alcohol marketing when you consider the growing presence of alcohol companies on social networking sites such as Facebook and Twitter. Research from Ofcom has shown that almost half (49%) of children aged between 8 and 17 years old who use the internet have set up their own profile on a social networking site.³²

3.5 In September 2011, Diageo struck a multi-billion dollar deal with Facebook, which makes Smirnoff, according to its producer Diageo, "the number one beverage alcohol brand on Facebook worldwide". Diageo report that Facebook activity in the US has increased sales by 20%. This online activity is only set to increase, as the company boasts of training 950 marketers to build social media capabilities to generate "significant returns on investment".

3.6 Although Facebook argues that pages set up by alcohol advertisers are "age-gated" and only accessible to those over 18, these "age-gates" are far from infallible and can be bypassed simply by inputting a fake birth-date. Perhaps most worrying is that Facebook accounts are hidden from parents, providing companies with a direct and uncensored communications channel to children and young people.

3.7 Importantly, children and young people are not just at the mercy of "official" marketing. Fans of alcohol products are increasingly becoming brand advocates by setting up fan pages and passing alcohol adverts between themselves, further normalising consumption and increasing pressure on young people to drink and drink more.

3.8 Alcohol Focus Scotland believes that the implementation of a UK adapted *Loi Evin* would provide a good starting point to begin to protect children and young people from alcohol marketing. This framework provides guidance on marketing practices and how best to ensure children and young people are protected from an exposure that poses a risk to their health and wellbeing. The *Loi Evin* has been upheld by the European Court of Justice which found the measure to be proportionate, effective and consistent with the Treaty of Rome.³³

3.9 However the area which requires most urgent and robust action is online marketing. It is of grave concern therefore that the strategy proposes the extension of the ASA's powers and work with the alcohol industry in relation to age verification as the key actions required to address this area of concern.

3.10 Alcohol Focus Scotland do not believe that the ASA have the specialist expertise required to tackle this new and expanding area of marketing and instead calls for a ban on advertising on social media sites, where the alcohol industry has guaranteed exposure to children and young people.

3.11 Further Alcohol Focus Scotland calls for an independent body, with no representation from the alcohol industry, to monitor children and young people exposure to alcohol marketing. This independent body should give particular and urgent attention to ensuring online, digital and social media is adequately regulated and monitored.

4. THE ROLE OF THE ALCOHOL INDUSTRY

4.1 When considering the role of the alcohol industry in the development of alcohol policy, the following statement from the 2010 report by the House of Commons Health Committee on alcohol should be considered: "*It is time the Government listened more to the [Chief Medical Officer] and the President of the [Royal College of Physicians] and less to the drinks and retail industry. If everyone drank responsibly the alcohol industry might lose about 40% of its sales and some estimates are higher. In formulating its alcohol strategy, the Government must be more sceptical about the industry's claims that it is in favour of responsible drinking*".³⁴

4.2 Whilst the strategy acknowledges that "industry needs and commercial advantages have too frequently been prioritised over community concerns", Alcohol Focus Scotland has concerns about the emphasis that the

²⁸ Health Committee, First Report of Session 2009–10, *Alcohol*, House of Commons 151-I. 2010.

²⁹ Ibid.

³⁰ Ofcom, ASA, Neilson Media. *Young People and Alcohol Advertising: An investigation of alcohol advertising following changes to the Advertising Code*, 2006.

³¹ James, L (2008) *Winners and losers of the next UK media downturn*, World Advertising Research Centre.

³² Ofcom (2008) *Social Networking: A quantitative and qualitative research report into attitudes, behaviours and use*, p 5 <http://stakeholders.ofcom.org.uk/binaries/research/media-literacy/report1.pdf>

³³ *Commission of the European Communities v the French Republic*, Case C-262/02 (Court of Justice of the European Communities) March 11, 2004.

³⁴ Health Committee, First Report of Session 2009–10, *Alcohol*, House of Commons 151-I. 2010.

strategy gives to the involvement of the alcohol industry in relation to the development of alcohol policy and self regulation.

4.2 The World Health Organisation has considered the extent to which governments must be mindful of the issue of conflict of interest between public health and commercial vested interests. The fifty-three Member States of the World Health Organisation's European Region endorsed the European Alcohol Action Plan in September 2011 which included a clear statement on conflicts of interest:

The Regional Office will strengthen its processes of consultation and collaboration with NGOs and relevant professional bodies that are free of conflict of interest with the public health interest....guided by the principles that public policies and interventions to prevent and reduce alcohol-related harm should be guided and formulated by public health interests and based on clear public health goals and the best available evidence.³⁵

4.3 Alcohol Focus Scotland further notes the view that it is an "ethical responsibility of the entire industry—alcohol retailers, alcohol producers and both the on-trade and off-trade—to promote, market, advertise and sell their products in a responsible way". It is of significant concern however, that the strategy has reinforced the role of self-regulation given that the evidence indicates that this is ineffective.³⁶ In keeping with the guidance summarised above, Alcohol Focus Scotland is of the view that whilst commercial vested interests can be involved in the *implementation* of alcohol policy, their involvement should be confined to areas which pertain specifically to their role as producers and retailers of alcoholic beverages. For example—labeling and server training. They should not be involved in the identification of public health goals to inform alcohol policy given the obvious conflict of interest and the fact that their expertise is in producing and selling alcohol and not in protecting and improving public health.

May 2012

Written evidence from the Scotch Whisky Association (GAS 11)

SUMMARY

- The focus of the Government's Alcohol Strategy should be on reducing irresponsible drinking and the number of people drinking excessively. Alcohol policy requires an appropriate balance between regulatory, self-regulatory and non-regulatory measures.
- Industry is part of the solution to tackling alcohol-related harm. However, the importance of personal responsibility should be stressed in any strategy.
- Alcohol products are marketed responsibly in the UK.
- The Scotch Whisky Association opposes minimum unit pricing (MUP):
 - There is no strong evidence that MUP as a policy will reduce alcohol-related harm. It will not reduce the number of hazardous and harmful drinkers.
 - EU jurisprudence is clear, minimum pricing has invariably been ruled illegal. It is contrary to EU Single Market rules and international trade law.
 - Minimum pricing will damage the Scotch Whisky industry in the long term. If brought into law it will establish, for the first time, a barrier of trade on health grounds that will be used by other administrations against Scotch Whisky overseas.
- Scotch Whisky is one of the UK's leading export earners. Its reputation is built on strong brands. Plain packaging would not be in the interest of the balance of trade.

INTRODUCTION

1. The Scotch Whisky Association (SWA) is the trade association representing over 90% of the industry; members include distillers, blenders, and bottlers. The UK market is the industry's 3rd largest market in terms of volume and is often viewed by Governments in key export markets as a guide to how they should regulate Scotch Whisky.

2. The SWA welcomes the opportunity to provide evidence to the Committee's Inquiry and the opportunity to discuss our submission in more detail with the Committee.

3. Scotch Whisky accounts for nearly 25% of the UK's total food and drink exports. Export figures for 2011 show that Scotch Whisky earns £134 every second for the UK balance of payments. The value of exports in 2011 £4.2 billion, an increase of 23% on 2010.

4. The industry employs 10,300 workers directly with another 35,000 jobs across the UK supported by the industry. The industry has invested some £1 billion in its production and manufacturing capacity over the last

³⁵ *World Health Organisation Regional Committee for Europe, European action plan to reduce the harmful use of alcohol 2012–2020, Baku, Azerbaijan, WHO Regional Office for Europe 2011.*

³⁶ KPMG. Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks. Home Office, 2008.

four years. Scotch Whisky sales in the UK contribute between £600 million to £700 million annually in excise duty.³⁷ There are also significant additional tax receipts from VAT, National Insurance, and Corporation Tax.

5. The SWA recognises the need to address alcohol misuse. We are firmly committed to playing our part to reduce alcohol-related harm, promoting a culture where responsible alcohol consumption is the accepted norm and misuse is minimised.

6. We welcome the focus of the Strategy being on irresponsible drinking and reducing the number of people drinking to excess. Alcohol consumption in the UK has fallen by 13% since 2004.³⁸ Weekly consumption has decreased from 14.3 units to 11.5 units. A decline has been seen for both men and women. There has also been decline in the number of men and women drinking above the weekly guidelines. Between 2005 and 2010 for men it fell from 31% to 26% and for women from 21% to 17%.³⁹

Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role

7. Tackling alcohol misuse is an issue that cuts across many Government departments. Any alcohol strategy requires a cross-Government approach. Clear and effective co-ordination across all departments with regular reviews of progress against established outcomes is essential. What is important is that the outcomes of the strategy are delivered.

The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group

8. The alcohol industry is an important and equal stakeholder in tackling alcohol-related harm. We welcome recognition of the role of industry in the Government's Alcohol Strategy. The SWA supports a partnership approach with Government and all stakeholders. We consider this to be the most effective way to reduce alcohol-related harm. Such an approach breaks down barriers between the various stakeholders, fosters co-operation and allows the different stakeholder groups to share their experiences and build on best practice.

9. Many SWA members are Responsibility Deal Partners, funding contributors to Drinkaware and members of the Portman Group or signatories to its Code of Practice.

10. Government sets alcohol policy; the Responsibility Deal is part of that policy and industry's role, as well as other Responsibility Deal partners is implementation of that policy.

11. The SWA has been a Responsibility Deal partner from the launch of the Deal in March 2011. The Responsibility Deal provides the right framework to engage, co-ordinate and focus industry action. It is additional to other company national and local activity to promote responsible consumption.

The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing

12. The SWA is opposed to minimum unit pricing (MUP). We are unconvinced it will effectively tackle alcohol misuse. Minimum pricing will fundamentally damage the Scotch Whisky industry at home and abroad with negative consequences for the wider economy. The industry believes minimum pricing to be the most serious threat to its future international competitiveness.

13. The ECJ has invariably ruled that minimum pricing is illegal. It will also cause a number of negative unintended consequences.

Effectiveness

14. The case for minimum pricing relies heavily on the commissioned "Sheffield" modelling. The Scottish Government commissioned Sheffield modelling has been updated twice. At each up-date the effectiveness of MUP was diminished.

15. The latest Sheffield report⁴⁰ commissioned showed those drinking most heavily would have to spend less than the price of one pint of beer a week more if MUP was introduced. These drinkers are the least likely to change their drinking patterns and behaviour.

16. The Sheffield report has three categories of drinker—moderate, hazardous and harmful. The report assesses moderate consumers as drinking on average 6 units per week. This does not reflect government weekly drinking guidelines, which are 21 units for men, 14 units for women. All drinkers within a category are assumed to hold the same characteristics. No assessment is made for age, gender, ethnicity, social grouping or

³⁷ HMRC Spirits Bulletin.

³⁸ BBPA, New figures show UK alcohol consumption down again in 2011, 11 March 2012.

³⁹ ONS, General Lifestyle Survey 2010, March 2012.

⁴⁰ University of Sheffield: Model-Based Appraisal of Alcohol Minimum Pricing and Off-Licensed Trade Discount Bans in Scotland Using the Sheffield Alcohol Policy Model (v2): Second Update Based on Newly Available Data. January 2012.

different drinking patterns. It is assumed that all hazardous and harmful drinkers buy on price alone, which is clearly not the case.

17. There is no strong evidence as to the effectiveness of minimum pricing as a policy to reduce alcohol-related harm⁴¹. Claims that it is a targeted measure having greatest impact on problem drinkers with limited impact on moderate drinkers have been rejected by an Institute for Fiscal Studies⁴² report finding that MUP will hit responsible drinkers and, in particular, those on lower incomes at a time when household budgets are already under extreme pressure.

18. Although the Sheffield modelling work shows precise numbers on a range of potential impacts, nowhere does it state the reduction in the actual number of hazardous and harmful drinkers that would be achieved. In fact the proportion of hazardous and harmful drinkers would appear to remain unchanged.

19. The Sheffield modelling work suggested there would be a reduction in harms as a result of consumption within one year of MUP being introduced. Consumption has been decreasing in the UK since 2004, but we have seen an increase in alcohol-related hospital admissions and little change in alcohol-related deaths in England. The model therefore does not appear to reflect the real world.

20. In relation to binge drinking in younger people 18–24 year olds, Sheffield researchers in evidence to the Scottish Parliament confirmed MUP will have less impact on this group and the model does not address binge drinking.⁴³

21. Tackling alcohol misuse will take concerted effort over many years. It should be based on a multi-component approach, involving all relevant stakeholders targeting those drinking heavily and inappropriately. Targeting hazardous and harmful drinkers offers the greatest opportunity to reduce harm. Reducing the number of hazardous and harmful drinkers will reduce per capita consumption; we have no issue with that outcome. Reducing consumption without significantly reducing the number of heavy drinkers, while undermining a major industry and its contribution to the economy, is a policy option that undermines the national economic interest.

Legality

22. Concerns over the legality of introducing a minimum pricing regime have never been addressed, despite the clear jurisprudence of the European Court of Justice.

23. From responses provided in Parliament the UK Government clearly has legal advice questioning the legality of MUP. Evidence given by Anne Milton, Public Health Minister, to the Commons Science and Technology Committee stated that the UK Government has legal advice which indicates that MUP is “probably illegal”. Chloe Smith, Chief Economic Secretary to the Treasury stated in debate on 14 December 2011 in relation to minimum unit pricing “we believe that it could be incompatible with article 34 of the treaty of the functioning of the European Union”.

24. A legal opinion on minimum pricing⁴⁴ for the Swiss Government also clearly states that minimum pricing would breach its EU/EEA obligations and that a health exemption would not be likely to succeed.

25. Even campaigners for minimum pricing have written they are not convinced of the legality.⁴⁵

26. The Scottish Government has said it expects a legal challenge to its minimum pricing plans. It has been reticent to open up its Bill to scrutiny by notifying it to the European Commission.

27. Minimum pricing is a barrier to the free movement of goods. It is likely to breach the EU Treaty (Article 34), and World Trade Organisation rules (GATT Art.III). These rules have allowed the Scotch Whisky industry to challenge protectionism in global markets with a resultant increase in exports underpinning future industry success. Scotch Whisky accounts for around 25% of UK food and drink exports. If Government action undermined EU and WTO rules, the precedent set would be used by third countries to protect their local alcohol industry. The knock-on effect would be hugely damaging for Scotch Whisky and the wider economy.

28. The precedent of a home grown trade barrier would adversely affect exports of premium brands. Attempts to open up new markets would be stalled. Stopping attempts by Chile to re-introduce non-WTO compatible discrimination against Scotch Whisky would be much more difficult. At home, value brands and supermarket own label products favoured by those on lower incomes would see immediate price rises. Companies specialising in this sector fear a significant loss of business, leading to job losses and closures.

29. All price fixing measures distort the market. We believe MUP will significantly distort the UK market. Any additional profits that may result from any increase in prices due to MUP will be retained by retailers, and not passed back to producers. We note the strategy recognises the net benefit that will accrue to retailers and state the Government will work with them to provide better value to customers in other areas. There is no explanation as to how or if this could work.

⁴¹ Babor et al, Alcohol: No Ordinary Commodity, 2nd Edition, Oxford University Press 2010.

⁴² Alcohol Pricing and Taxation Policies, IFS Briefing Note NB 124, 2011.

⁴³ Health and Sports Committee, Stage 1 report, March 2012.

⁴⁴ Professor Dr A Epiney et al, On the Compatibility of a Legal Minimum Price for Alcohol with the Free Trade Agreement Switzerland-EU and Economic Freedom. Legal Opinion on Behalf of the Swiss Alcohol Board, October 2009.

⁴⁵ B Baumberg, P Anderson, Health, Alcohol and EU law. European Journal of Public Health, Vol. 18, No. 4, 392 -298.

Unintended consequences

30. There is no consideration of the impact of minimum pricing on cross border sales, illicit supply, organised crime and fraud in the Sheffield Report.

31. Markets with over stringent control policies see a greater incidence of fraud, illicit sales, cross-border shopping and increased use Internet sales all of which could see the Government's strategy outcomes being undermined.

Alternative

32. The SWA supports the introduction of a ban on sales below tax based duty plus VAT. This measure if linked to duty reform where alcohol is taxed at the same rate across all drinks, according to alcohol content would be equitable and transparent. Taxing all drinks at the same rate according to alcohol content would underpin the message that it is the amount of alcohol consumed rather than the type of drink chosen that matters. This would introduce a legal "floor price" mechanism and, unlike MUP, would generate revenue for the Exchequer. The Institute of Fiscal Studies reaches the same conclusion in its report published in 2011.⁴⁶ Estimates of the benefit of tax equivalence for the Government are that it would generate an additional £1 billion in alcohol tax receipts.

The effects of marketing on alcohol consumption, in particular in relation to children and young people

33. The figures on underage drinking are showing promising trends. The proportion of pupils who drank alcohol in the last week fell from 26% in 2001 to 13% in 2010. Also, the proportion of 11–15 year olds who had never drunk alcohol increased from 39% in 2003 to 55% in 2010.⁴⁷

34. Alcohol marketing in the UK is comprehensively controlled. The current legislative framework, along with effective self-regulation ensures that alcohol marketing does not target young people under the legal purchase age.

35. The SWA Code of Practice for the Responsible Marketing and Promotion of Scotch Whisky is supported by an independent complaints panel. The Code includes a range of sanctions, which include fines and removing a company ultimately from membership.

36. The scientific literature on the influence of advertising on alcohol consumption is extensive and mostly contradictory. Econometric and cross-sectional studies have failed to show a clear causal relationship between marketing and expenditure and any indicator of harmful drinking. Where an association has been found in a small number of longitudinal studies⁴⁸ it is very weak and does not make a compelling case that advertising causes harmful drinking.

37. Many countries that impose the most severe restrictions on advertising and marketing continue to have problematic drinking patterns.⁴⁹ Studies have shown the principal influences shaping drinking patterns in young people are parents, family and peers.⁵⁰ Recent research from Drinkaware has indicated that parents are the largest providers of alcohol to children.

International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking

38. The Committee raises a number of issues. We would make the following points:

- The Government's Alcohol Strategy is consistent with the approach endorsed by the World Health Organisation global strategy; the focus should be on reducing the harmful use of alcohol, not consumption *per se*.
- There is a broad range of evidence-based targeted measures for tackling alcohol-related harm and reducing harmful drinking. Not all these measure require a regulatory approach: alcohol brief interventions, multi-component community based programmes, social norms and parenting support programmes, such as, strengthening families. Education and information campaigns are an essential part of any alcohol strategy, a point recognised by all stakeholders.
- Plain packaging is rightly not included in the strategy. There is no evidence such a measure would have any impact on reducing harmful drinking. A move to plain packaging is contrary to UK economic interests. Scotch Whisky is one of the UK's leading export industries, an iconic brand built on quality and tradition. Its success has been achieved by strong international brands. Undermining these brands would harm the UK economy and balance of trade.

May 2012

⁴⁶ IFS Briefing Note NB 124, 2011.

⁴⁷ NHS Information Centre, Smoking, drinking, and drug use among young people in England 2010, July 2011.

⁴⁸ Smith & Foxcroft 2009, BMC Public Health 9: 15.

⁴⁹ Martinic & Alexander 2008, Swimming with crocodiles: The culture of extreme drinking Routledge: 186- 191.

⁵⁰ Donovan 2004, Journal of Adolescent Health 35(6): 529.

Written evidence from Heineken (GAS 12)

SUMMARY

- HEINEKEN is the UK's leading beer and cider producer and the name behind drinks brands such as Foster's, Strongbow, Kronenbourg 1664, Bulmers, John Smith's and Heineken®. We also own circa 1,400 pubs and directly employ 2,400 people in our UK business, operating from sites in London, Edinburgh, Manchester, Tadcaster and Herefordshire.
- As a responsible alcohol producer, Heineken believes it has an important role to play in tackling alcohol misuse and encouraging people to drink responsibly. We want our products to be made, sold and enjoyed responsibly.
- Alcohol consumption in the UK has declined in recent years and the majority of people drink responsibly. Alcohol policy should be targeted at the minority who misuse alcohol.
- Alcohol-related policy measures should be necessary, evidence-based and proportionate.
- We believe that the most effective way to promote responsible drinking is not through Government action in isolation but through a partnership approach involving Government, industry and NGOs. Industry has a role to play in this as it can reach consumers in ways that the Government cannot.
- Our commitment to working with Government and NGOs can be demonstrated through the pledges we made under the Public Health Responsibility Deal. This includes our individual commitments to:
 - remove 100 million units from the market each year from 2013 by lowering the abv of a major brand ; and
 - improve unit awareness by introducing 11 million unit labelled glasses into the on trade.
- There is no evidence that minimum unit pricing will reduce alcohol misuse. It will affect all consumers regardless of whether they contribute to alcohol harm.
- There is uncertainty on the legality of minimum pricing and whether the policy will be implemented. We agree with the Government's view that there is not any evidence to suggest a ban on alcohol advertising would be a proportionate response.
- We welcome the Government's intention to look at the current barriers to promoting low strength products.

1. INTRODUCTION

1.1. HEINEKEN welcomes the opportunity to respond to this call for evidence.

1.2. HEINEKEN is the UK's leading beer and cider producer and the name behind drinks brands such as Foster's, Strongbow, Kronenbourg 1664, Bulmers, John Smith's and Heineken®. We also own circa 1,400 pubs and directly employ 2,400 people in our UK business, operating from sites in London, Edinburgh, Manchester, Tadcaster and Herefordshire.

2. GENERAL COMMENTS

2.1. We recognise the need to tackle alcohol misuse. We also believe that moderate alcohol consumption can be part of a healthy lifestyle. Recent Government data shows that:

- UK Consumption has fallen in recent years. HMRC duty clearance data show that consumption per head has fallen by 13% since 2004. The ONS General Lifestyle Survey shows that average consumption in the UK has fallen by 20% between 2005 and 2010.
- Binge drinking continues to decline. The ONS General Lifestyle Survey shows that the proportion of men drinking more than 8 units on their heaviest drinking day in a week fell from 23% in 2005 to 19% in 2010. Women drinking more than 6 units were 15% in 2005 and 13% in 2010.

2.2. We believe that alcohol misuse is a complex set of issues, not one single problem, that should be tackled by targeting at the groups of problem drinkers—be it underage drinking, town centre disorder or chronic alcohol misuse.

3. RESPONSIBILITY WITHIN GOVERNMENT FOR ALCOHOL POLICY

3.1. The question of which Government Department should have responsibility for alcohol policy is not a matter for industry. Different Departments will necessarily have responsibilities for different elements of alcohol policy and the alcohol industry. However, it is important that Government policy is proportionate and based a strong, robust evidence base.

4. THE COORDINATION OF ALCOHOL POLICY ACROSS THE UK

4.1. We are a UK wide business and as far as possible it is preferable and more efficient to work within a UK wide regulatory framework.

5. THE ALCOHOL INDUSTRY'S ROLE IN ADDRESSING ALCOHOL-RELATED HEALTH PROBLEMS

5.1. As a responsible alcohol producer, Heineken believes it has an important role to play in tackling alcohol misuse and encouraging people to drink responsibly. We want our products to be made, sold and enjoyed responsibly.

5.2. We believe that the most effective way to promote responsible drinking is not through Government action in isolation but through a partnership approach involving government, industry and NGOs.

5.3. Industry has much to contribute to such a partnership as it can reach consumers in ways which government cannot. For example:

- Following HEINEKEN's takeover of Scottish and Newcastle, one of the first things we did was delist White Lightening in March 2010. We followed this by delisting Strongbow Black in November 2010.

5.4. HEINEKEN has been an active partner in the Responsibility Deal and has signed up to all of the alcohol pledges. The full list of general Responsibility Deal pledges can be found here (<http://responsibilitydeal.dh.gov.uk/pledges/>). Some highlights include:

- Encouraging better consumer education of the harms of alcohol by (i) supporting Drinkaware and (ii) providing information on unit labelling alongside the CMO guidance on alcohol consumption on our packaging;
- Supporting local authority partnerships with the policy, local agencies and retailers by providing £150 million to Best Bar None and £70 million to Community Alcohol Partnerships; and
- On alcohol advertising near schools, HEINEKEN goes further than the Responsibility Deal pledge and work with our agencies to ensure that no advertisement for our brands is placed within 200 metres of a school.

5.5. In addition to the general alcohol pledges that the alcohol industry made as part of the Responsibility Deal, HEINEKEN made two further pledges as an individual business:

- Remove 100 million units of alcohol from the UK market each year through lowering the abv of a major brand by 2013.
- Improving unit awareness amongst UK consumers by providing 11 million unit labelled glasses to the on trade.

6. MINIMUM UNIT PRICING

6.1. HEINEKEN is opposed to a policy of minimum unit pricing both in principle and in practice.

6.2. There is no evidence that minimum pricing will reduce harmful drinking—It assumes a link between price and reducing harm that is not supported by the evidence:

- Since 2004, there has been a 13% reduction in alcohol consumption in the UK, but no decrease in alcohol harm or alcohol related hospital admissions. If getting the whole population to drink less worked as a theory, we should be seeing the benefits now.
- At an evidence hearing to the Health Select Committee on 17 April 2012, Dr John Holmes of the Sheffield Alcohol Research Group said “... *young binge drinkers do not buy as much cheap alcohol as older people simply because they tend to drink more of their alcohol in the on trade, which is largely not sold at prices which will be affected by this policy*”.

6.3. Minimum pricing affects everyone—Evidence suggests that the heaviest and most harmful drinkers are the least responsive to price changes. This means that higher prices will penalise moderate drinkers whilst having little impact on those whose behaviour we want to change- harmful drinkers. Minimum pricing is also regressive, hitting those on lowest incomes the hardest and assumes that higher price alcohol is not misused.

6.4. Minimum pricing will have an impact on UK investment and employment—There is uncertainty on the legality of minimum pricing and whether the policy will be implemented. This will have a significant impact on investment decisions in the UK market. By announcing minimum pricing without definitive legal advice, the Government has put the industry in a position of uncertainty. This uncertainty will have an impact on investment decisions in the UK market.

6.5. The brands most likely to be affected will be domestically produced beers and ciders—which are more likely to be sold in the UK market. As a business we tend to only import premium products which attract a premium price. Domestically produced products support more jobs but are more reliant on UK demand and investment.

6.6. We believe Government should focus on targeted interventions for different types of alcohol misuse, be that under-age drinking, town centre disorder or long-term chronic drinking. Each problem is different and therefore the solution is different.

7. THE EFFECTS OF MARKETING ON ALCOHOL CONSUMPTION

7.1. We agree with the Government's view that there is not any evidence to suggest a ban on alcohol advertising would be a proportionate response.

7.2. The UK already has some of the strictest restrictions on alcohol advertising and marketing in the world. The industry's self-regulation through the Portman Group Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks works to ensure that products do not encourage irresponsible consumption or appeal to children. Alongside this, the Advertising Standards Authority enforces strict standards in all "paid for" space such as television and radio.

8. EDUCATION AND INFORMATION

8.1. We believe that better education to help people make sensible choices about their consumption is very important. In recent years there have been concerted alcohol education and information campaigns by government, industry and NGOs and evidence suggests this is having an impact. HEINEKEN has played a part of this by:

- Providing support to Drinkaware, the alcohol education charity. This includes financial support and support in kind by including Drinkaware branding on our packaging, print advertising and TV end frame advertising.
- Providing unit-labelled packaging for our brands and supplying 11 million unit-labelled glasses to our on-trade customers.
- Integrated responsible drinking campaign as part of our sponsorship of the John Smith's Grand National.

8.2. Recent cases studies show that consumer education is an effective measure.

8.3. The Drinkaware "Why let the Good Times Go Bad" campaign challenges the acceptability and desirability of drunkenness among young adults. Independent research among 18–24 year olds shows that after seeing the Drinkaware "Why let good times go bad?" campaign, 56% claimed it made them consider drinking differently and 80% claimed to have adopted at least one of the campaign's tips to help them moderate their drinking.

9. REDUCING THE ABV OF ALCOHOLIC BEVERAGES

9.1. HEINEKEN was the first company, in 2011, to make a public pledge to remove 100 million units of alcohol from the UK market each year through lowering the abv of a major brand by 2013 as part of the Responsibility Deal.

9.2. We have also worked with the industry on the collective Responsibility Deal pledge announced in March by the whole alcohol industry to remove more than 1 billion units of alcohol by 2015.

9.3. We welcome the statement in the alcohol strategy that the Government will work with the Advertising Standards Authority and other bodies to look at the rules and incentives that inhibit the development of lower strength products.

Plain packaging

9.4. The Government is currently consulting on the issue of plain packaging for tobacco. To consider this in relation to alcohol products therefore effectively equates drinking with smoking, which we utterly reject. Smoking is harmful in any quantity, whereas moderate alcohol consumption can be part of a healthy lifestyle.

May 2012

Written evidence from Quaker Action on Alcohol and Drugs (GAS 13)

Quaker Action on Alcohol and Drugs (QAAD) is a listed group of the Religious Society of Friends (Quakers). QAAD is an independent national charity that has a concern with the use and misuse of alcohol and other drugs, legal, illegal and prescribed, and with gambling. QAAD does not represent the Religious Society of Friends as a whole, but the views we express are grounded in our Quaker principles. We present evidence-based arguments that prevention and treatment save society's resources, but our values are also that people affected by alcohol problems deserve support in their own right.

QAAD offers prevention and information services for Quakers and contributes to public policy discussions. Trustees give their time to QAAD freely, and bring voluntary and statutory experience from settings that include prevention, a variety of treatment and support interventions, medical services, and criminal justice. Like any other group, we have in our number people who have been personally affected by alcohol problems.

1. EXECUTIVE SUMMARY

1.1. We warmly welcome many aspects of the new Alcohol Strategy, particularly its willingness to address current consumption. We support the view advocated by Professor Ian Gilmore in oral evidence, that population level consumption is high in historical terms, and that this is related to the high level of alcohol problems experienced by individuals in our society.

1.2. We welcome minimum pricing per unit as a key preventative and harm-reduction measure. We hope the opportunity will be taken to set this at an effective level. We would like to see a rate of 50p, which would give substantial health benefits and set a prevention framework for the future.

1.3. We also welcome the measures that strengthen the ability of local areas to deal with alcohol problems and the measures to reduce alcohol content via the Responsibility deal.

1.4. Public health messages will continue to have limited effects if there is such an imbalance with resources put into advertising by the industry. Consideration should be given to tightening advertising, and moving towards the restrictions seen in France and Norway.

1.5. If a total ban on advertising appears too great a step, other measures for which there is a reasonable evidence-base can be taken more quickly. These include a ban on pre-watershed advertising of alcohol, advertising at PG films, and ceasing other forms of marketing and sponsorship that are directly seen by children.

1.6. Only 6% of those in need receive services, and in some areas, residential treatment for the most severely affected people is already not available. New arrangements for local commissioning under the aegis of Public Health England have yet to be finalised, but on recent figures the average PCT spend on alcohol treatment was £600,000—0.1% of budget. Robust arrangements are needed to ensure that those needing services get access to the full range of support.

1.7. The only alcohol indicator in the proposed Public Health Outcomes Framework relates to hospital admissions, but this is wholly insufficient to ensure that commissioning covers the range of alcohol-related need. Developing further indicators (using advice from the NTA and possibly Alcohol Concern) is one possible approach that could usefully be explored. More simply, providing evidence of appropriate access to the major types/tiers of service (from brief advice through to residential or hospital treatments) could be placed as a requirement on commissioning bodies. Appropriate, needs-related funding formulae, and ring-fenced budgets should be part of this, recognising that alcohol problems are most acute amongst those suffering from other forms of disadvantage.

SPECIFIC ISSUES

2. Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role

We believe that alcohol policy in general is best located in the Department of Health. This is not only because the majority of services are based or commissioned from there, but because those suffering from alcohol problems *will* develop significant health problems over time. We also think a health focus would be helpful to families and close others, who can be deeply affected and suffer their own health problems as a result. However, the prime consideration is that the Strategy should be well integrated, and deliver progress for individuals across the many government department areas involved.

3. Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol

31. It would be highly desirable for minimum pricing rates to be as close as possible in order to prevent policies being undermined, particularly in border areas. In other respects we welcome the fact that the Alcohol Strategy is considering adding public health as a licensing objective, as it is in Scotland. The convergence of approach to a preventative rather than a reactive framework is the most important factor.

4. The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group

4.1. The industry has an important role, as the strategy outlines. Some Drinkaware initiatives have been useful (website self-monitoring, for example). The increase in lower alcohol drinks that has been agreed through the Responsibility Deal is welcome, particularly as regards reducing the alcohol content of wine, which is one of the factors underlying increased unit consumption by women. However, there is a limit on how far the industry can be expected voluntarily to promote practices that risk adverse effects on profitability. Legislators and government departments have a wider public health remit; this entails a leadership role, which needs to be exercised.

5. *The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing*

5.1. The Committee is well aware of the peer-reviewed ScHARR report and its findings. Whilst up-dates are always desirable (like those recently undertaken by ScHARR for the Scottish government), this remains the most authoritative work on which to base policy.

5.2. We believe 50p should be the minimum unit price, and have extracted the following figures from the ScHARR report to illustrate the case for this.⁵¹

	<i>40 per unit 1 year benefits</i>	<i>40 per unit 10 year benefits</i>	<i>50p per unit 1 year benefits</i>	<i>50p per unit 10 year benefits</i>
Hospital admissions	6,300 fewer	40,800	16,400 fewer	97,900 fewer
Deaths	157 fewer	1,381 fewer	406 fewer	3,393
Violent crimes	3,200 fewer		10,300 fewer	
Total consumption	-2.6%		-6.9%	
Reduction in 11–18 year old drinkers (all)	4%		7.3%	
Reduction among 18–24 year old “hazardous” drinkers	0.7%		3%	
Direct public costs (?millions)	-353.9	-3,284	-739.7	-7,426

If figures were updated there may be some variation, but it is apparent that substantially higher benefits accrue when the minimum unit price is higher.

5.3. A weighty argument is the stronger impact that 50p per unit would have on young hazardous drinkers, who are one of the groups that consume cheaper alcohol. A recent qualitative and quantitative study of 15–16 year olds bears out the importance of this:

“Results suggest a strong relationship between consumption of cheaper alcohol products and increased proportions of respondents reporting violence when drunk, alcohol-related regretted sex and drinking in public places”.⁵²

Aside from immediate damage in terms of these problems and acute manifestations like hospital admissions, early drinking patterns tend to follow through into later life—so this consideration is really critical.

5.4. As regards lighter or moderate drinkers, the economic costs of 50p per unit would be relatively light (less than £20 per annum). Much has been made of the effects of minimum pricing on poorer people, but those in the most deprived groups are actually more likely not to drink at all: in a recent study only 33% of households on the lowest income band purchased alcohol in the last week, as opposed to 70% in the highest.⁵³ However, if they do drink, men in the most deprived areas are five times as likely to die of an alcohol-related illness as those in the most affluent areas, and women are three times as likely. Effective minimum pricing would thus help the poorest groups.

5.5. Focusing only on the price a person pays to buy alcohol also disregards the costs they pay in taxation for the NHS, and for criminal justice services. The overall costs of alcohol harms are estimated to be three times the amounts raised in revenue duty⁵⁴—and the environmental ill-effects of alcohol problems are felt particularly strongly in less affluent areas.

6. *The effects of marketing on alcohol consumption, in particular in relation to children and young people*

6.1. International studies indicate that marketing and advertising do affect children and minors. Two recent reviews concluded:

“Longitudinal studies consistently suggest that exposure to media and commercial communications on alcohol is associated with the likelihood that adolescents will start to drink alcohol, and with increased drinking amongst baseline drinkers. Based on the strength of this association, the consistency of findings across numerous observational studies, temporality of exposure and drinking behaviours observed, dose-response relationships, as well as the theoretical plausibility regarding the impact of media exposure and

⁵¹ Brennan, A. et al. (2009) “Modelling the Potential Impact of Pricing and Promotion Policies for Alcohol in England: Results from the Sheffield Alcohol Policy Model Version 2008 (1–1)”, *Independent review of the effect of Alcohol Pricing and Promotion: Part B* pages 126, 133, 139, 144.

⁵² Bellis, M. Philips-Howard Et Al (2009) Teenage drinking, alcohol availability and pricing: a cross-sectional study of risk and protective factors for alcohol-related harms in school children. *BMC Public Health*.

⁵³ Ludbrook, A (2010) Purchasing Patterns for low price off sales of alcohol: evidence from the expenditure and food survey.

⁵⁴ Ludbrook, A (2009) Minimum Pricing of Alcohol. *Health Econ.* 18: 1357–1360 (2009).

commercial communications, we conclude that alcohol advertising and promotion increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol”.⁵⁵

“exposure to alcohol advertising in young people influences their subsequent drinking behaviour”.⁵⁶

“The SchHARR study reported that “There is some evidence to suggest that bans have an additive effect when accompanied by other measures within a general environment of restrictive measures”.

6.2. More generally for adults, public health messages are likely continue to have limited effects if there is such an imbalance with resources put into advertising by the industry. We believe consideration should be given to tightening advertising and moving towards the restrictions seen in France and Norway.

A recent WHO report states that:

“There is some evidence and experience that the self regulation of commercial marketing of alcohol does not prevent the kind of marketing that has an impact on younger people, particularly when it is not backed up by a legal framework and effective sanctions”.⁵⁷

6.3. If a total ban on advertising appears too great a step, other measures for which there is a reasonable evidence-base could be taken more quickly. These include a ban on pre-watershed advertising of alcohol, advertising at PG films, and ceasing other forms of marketing and sponsorship that are directly seen by children.

7. Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services;

Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm.

7.1. There have been insufficient resources devoted to alcohol services. Alcohol Concern published findings in 2010 that the average PCT spend on alcohol treatment was £600,000—only 0.1% of budget⁵⁸ markedly less than drugs. This is regrettable from a human point of view and does not make sense in terms of resources—it is estimated that every £1 spent on services saves £5 in medical, welfare and criminal justice costs.⁵⁹ At times of stringency, services risk being cut further. This is a particular issue for those for the most severely affected people, because services for them tend to be more expensive. However, this is the group that can show some of the most substantial gains in terms of contributing to society as well as regaining a stable, satisfactory personal quality of life.

7.2. The Strategy is at its weakest in addressing the long-standing problem of resourcing. We have linked concerns that austerity and the new commissioning structures could deepen rather than ameliorate some of these problems, in particular, regarding high needs or marginalised groups. The National Treatment Agency will be transferring its functions to Public Health England and states in its Action Plan 2012–13 that it will “*help support residential providers respond to the demands of the payment by outcomes operating environment, and challenge the minority of local areas who deny their population access to effective residential provision.*” Consortia or health areas that may not perceive themselves as having a strong need for the full range of services should nevertheless make them available to their local populations.

7.3. Adolescents with high needs are another significant group, as are those suffering from dual diagnosis. Often these groups need access to other related services, such as supported housing, as indeed do those with less severe problems. All of these require linked resourcing across departments both locally and nationally.

7.4. The only indicator in the proposed Public Health Outcomes Framework seems to relate to hospital admissions, but this is wholly insufficient to ensure that commissioning covers the range of alcohol-related need. Developing further indicators (using advice from the NTA and possibly Alcohol Concern) is one possible approach that could usefully be explored. More simply, providing evidence of appropriate access to the major types/tiers of service (from brief advice through to residential or hospital treatments) could be placed as a requirement on commissioning bodies.

7.5. However, it is also apparent that some areas of the country (often the poorest) have the highest need in terms of alcohol problems. National funding formulas need to take account of this. Ring-fenced resources (which appear likely to go) may be the best way to ensure that alcohol services are developed, or at least not eroded.

⁵⁵ Anderson P, de Bruijn A, Angus K, Gordon R, Hastings G. (2009) Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol Alcohol*. 2009 May-Jun; 44(3):229–43.

⁵⁶ Smith, L, and Foxcroft, D. (2009) The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. *BMC Public Health* 2009, 9:51.

⁵⁷ World Health Organization for Europe (2009) “Evidence for the Effectiveness and Cost-effectiveness of interventions to reduce alcohol-related harm” pages http://www.euro.who.int/__data/assets/pdf_file/0020/43319/E92823.pdf

⁵⁸ Alcohol Concern (2010) Investing in Alcohol Treatments: reducing costs and saving lives London: Alcohol Concern.

⁵⁹ Raistrick, D Heather, N Godfrey, C (2006) Review of the effectiveness of treatment for alcohol problems London: National Treatment Agency of Substance Misuse.

8. *International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking*

8.1. As has already been illustrated, social inequality influences how alcohol problems are distributed and experienced. Addressing this across government is the most fundamental contribution that can be made.

8.2. At a specific level there are some promising initiatives such as the “Preventure” project, which develops resilience in young people in a way that responds to their own personality characteristics.⁶⁰

- Public health interventions such as education and information;
- Reducing the strength of alcoholic beverages;
- Raising the legal drinking age; and
- Plain packaging and marketing bans.

8.3. The WHO for Europe publication notes the evidence that public health campaigns alone have a limited impact, and states:

“Providing information and education is important to raise awareness and impart knowledge, but, particularly in an environment in which many competing messages are received in the form of marketing and social norms supporting drinking, and in which alcohol is readily accessible, do not lead to sustained changes in alcohol-related behaviour”.⁶¹

Further:

“Consideration could be given to regulating and limiting the content and volume of commercial communications on alcohol, ranging from a Europe-wide roll-out of the principles of the French Evin Law to a ban on all forms of commercial communications that appeal to children and adolescents. Statutory regulation of commercial communications seems to be more effective than self-regulation in limiting inappropriate exposure of commercial communications to young people”.

The wide promotion of alcohol is a fundamental problem, and the evidence suggests that educational approaches need to be given a basis in statute and integrated with wider policies if they are to be effective. We welcomed the private members Bill to tackle advertising in 2011 and regret that this did not come to fruition. We wonder if a Committee devoted to this specific subject would be a useful way forward.

8.4. Enforcement of the existing age restrictions may be the most useful approach. The WHO European report states:

“There is consistent evidence that maintaining and raising minimum purchasing ages for alcohol can reduce alcohol-related harm, provided that they are enforced”.

8.5. We would support any tax measures that promote lower alcohol drinks, and believe that fine bandings would be helpful in reducing alcohol content.

We welcome many features of the Alcohol Strategy and hope the Committee’s work will enhance those areas that could usefully be developed.

May 2012

Written evidence from the British Retail Consortium (GAS 14)

1.0 INTRODUCTION

1.1 The British Retail Consortium (BRC) is the trade association of the retail sector and is the authoritative voice of the industry. The BRC brings together the whole range of retailers across the UK, from independents to large multiples and department stores, selling a wide selection of products through centre of town, out of town, rural and online stores.

1.2 Our membership includes all the major food retailers, who between them account for over 90% of the UK’s grocery sales, including alcohol. Representing our role as responsible retailers we are actively involved in delivering and commenting on alcohol policy.

1.3 Alcohol sales are an important element of a supermarket’s turnover, typically about 10%, but it is not the only product we sell and we are actively involved in a wide range of public health issues such as obesity and tobacco cessation.

1.4 Our members agree with the outcomes set out in 1.6 of the alcohol strategy and have been working for a number of years to change the culture of consumption in the UK. We particularly support the comment in 5.1 that ultimately, individuals need to take control and change their behaviours. Retailers are working with their customers to help them achieve that change.

⁶⁰ Conrod, P. Castellanos-Ryan, N. Strang, (2010) Brief, Personality-Targeted Coping Skills Interventions and Survival as a Non-Drug User Over a 2-Year Period During Adolescence. *Arch Gen Psychiatry*. 2010;67(1):85–93 <http://www.actiononaddiction.org.uk/Documents/Adventure-study-results.aspx>

⁶¹ World Health Organization for Europe (2009) “Evidence for the Effectiveness and Cost-effectiveness of interventions to reduce alcohol-related harm”.

1.5 It is worth remembering that sales and consumption of alcohol from the off trade is different to the on trade. We know, for example, that the vast majority of alcohol is purchased as part of a wider shop with food and that alcohol can be bought in larger amounts for consumption over a long period or shared with others; simply offering consumers value on their purchase does not mean they will exceed sensible drinking limits, a point we reinforce through comprehensive labelling and advice.

1.6 Finally to clarify, we are retailers not health experts, which is reflected in our response and we have answered those parts of the terms of reference most relevant to us. Our overall approach, which is reflected in the submission, is we expect all policy to be based on sound evidence.

1.7 The key points in our submission are:

- Retailers have a clear role, alongside other groups, in helping encourage responsible consumption.
- The best way to meet the challenge is by changing our drinking culture.
- The most effective way to change culture is through information and education.
- The majority of our members (with the exception of Waitrose and other retailers) believe controls on pricing and promotion are not the most effective tools and can impact on responsible drinkers, who make up the vast majority of drinkers.

2.0 RETAILERS AS RESPONSIBLE SELLERS

2.1 Our members recognise the responsibility which is attached to the right to sell alcohol and have been at the forefront of the delivery of policies to tackle alcohol abuse and change the culture of drinking in the UK. They are continuing to lead the alcohol industry in preventing sales to underage customers, reinforcing the Government's health advice on recommended drinking limits and supporting the work of the Drinkaware Trust.

2.2 Our members are putting resources into these various initiatives, as we believe the best way to tackle the issue is by ensuring a permanent change in the UK's relationship with alcohol which is only achieved by changing culture.

2.3 On underage sales, BRC members have led the industry by forming with members of the Wine and Spirit Trade Association (WSTA) and the Retail of Alcohol Standards Group (RASG) to agree common, effective methods to prevent sales. This led to the Challenge 21 and then Challenge 25 which has become established practice across the industry reduced illegal sales and changed the culture amongst younger, legal drinkers who now expect to carry ID and be challenged.

2.4 RASG also led to the development of Community Alcohol Partnerships (CAPs) which are local collaborations of retailers, police, local authorities and schools and are successfully tackling not only underage drinking but also low level disturbances.

2.5 Our members have also been extremely active, working with health departments throughout the UK to tackle health issues, reinforcing sensible drinking limits and raising awareness of the problems of excessive consumption. BRC members rolled out the UK health department's alcohol health label on all their own brand products by the end of 2010, well in advance of the rest of the alcohol industry which is yet to complete this. They have reinforced the on pack label through dedicated in store campaigns.

2.6 We have also been the most active sector in the DH Public Health Responsibility Deal. BRC members are supporting all the relevant alcohol pledges, the continued rollout of CAPs, the health label, support for the Drinkaware Trust and most recently, contributing to the removal of 1bn units of alcohol from the market.

2.7 The continued support for the Drinkaware Trust is important to BRC members. The Trust's work, overseen by independent experts, to target key parts of society is a key method of harnessing industry's resources in a responsible and progressive way. Retailers make a large contribution through their promotion of campaigns in store as well as contributing financially directly to the Trust.

3.0 WHO IS RESPONSIBLE FOR ALCOHOL POLICY WITHIN GOVERNMENT

3.1 Our experience in recent years is an increasing focus on tighter regulation, particularly through changes to the licensing laws in the UK, and less focus on public health education. Extensive legislative time has been taken to increase penalties for illegal sales, amend the way licences are awarded, alter the hours when stores can trade and create additional taxation from alcohol sales but less emphasis to tackle individuals directly, through improved education in schools or challenging public health campaigns.

3.2 This approach was highlighted in the recent launch of the alcohol strategy. The Government chose to tailor its comments to the media on minimum pricing and promotions but there was little mention of the 1bn unit reduction which was launched the same day as a new pledge under the Responsibility Deal. It was clear the emphasis was on regulation and not the delivery of policy through voluntary initiatives.

3.3 Our members have invested resources in initiatives such as Drinkaware Trust and clear labelling as we believe helping consumers to understand drinking limits and tailor consumption accordingly is the way to change culture and achieve long term change, particularly working with the next generation of drinkers. The problem appears to be that the political expediency of being seen to do something takes precedence over a

consistent public health campaign that would span several Parliaments and whose results will not be seen for a number of years.

4.0 COORDINATION OF ALCOHOL POLICY ACROSS THE UK

4.1 Our experience is not favourable of coordination between Governments or health departments on alcohol policy. Whilst all are actively tackling alcohol issues there are nuances in the approach which are leading to different regulations and policy across the UK and at different timescales. An inconsistent approach to regulation is challenging and burdensome for our members that operate on a UK basis.

4.2 Different approaches to regulation can prove counter-productive due to intra UK trade. Regulation on promotions in one devolved administration can lead to an increase in trade with a neighbouring country where the same regulations do not apply. Similarly, we could have the situation where countries have different levels of minimum pricing again leading to an increase in cross border trade.

4.3 We are also not convinced that all the measures are driven by evidence. Scotland, for example, introduced a Public Health Levy which was simply a tax on larger supermarkets that sell alcohol and tobacco with no justification of why it should be size limited and no plans on how the revenue would be used to improve public health.

4.4 We believe a more coordinated approach would increase the impact on consumers and by sharing resources increase the evidence base. The initiatives our members are engaged in are used throughout the UK ensuring a consistent message on health consumption and recognising consumers move around and increasingly use the internet to order goods.

5.0 THE ROLE OF THE ALCOHOL INDUSTRY IN ADDRESSING HEALTH PROBLEMS

5.1 Our members believe alcohol sellers have a responsibility in playing a full role in helping customers make healthier choices. This involves clear information on units of alcohol linked to official drinking guidelines, the promotion of a range of alternative alcohol and non alcoholic drinks and contributing towards targeted education campaigns through Drinkaware. Retailers are not, however, the only ones who can drive change, that will also depend on the role of Government, other parts of the alcohol industry and importantly individuals, taking responsibility for their own drinking and the role they have in influencing others.

5.2 The Responsibility Deal has given an increased emphasis to the role industry can play and brought a wider section of the industry together to work collaboratively. We have been disappointed that some health groups have chosen not to engage with the process, our belief is there was a poor understanding of what could and could not be delivered through it and that public health initiatives must be given time to work. We feel, however, the change of emphasis in the alcohol strategy towards regulation on how alcohol can be sold and promoted severely restricts the opportunity for further pledges from the retail sector.

5.3 Generally our view is there has been a good improvement in collaboration throughout the alcohol industry in recent years to tackle alcohol issues. This is demonstrated by the wide membership of the Responsibility Deal and the support for the Portman Code and the work of the Drinkaware Trust.

6.0 THE EVIDENCE BASE FOR INTRODUCING A MINIMUM PRICE PER UNIT OF 40p

6.1 The majority of our members (with the exception of Tesco, Co-op, Waitrose and Spar) oppose the introduction of minimum pricing believing the more effective method is to change the culture of drinking through information and education, which would avoid penalising the vast majority of the population who drink within the Government's health guidelines. Those other members listed above would be prepared to consider minimum pricing, alongside other measures if there was evidence to support its use.

6.2 Minimum pricing could also lead to a shift in product choice. For example, it could have a significant impact on own brand products which could be removed from the market as they would be uncompetitive against established branded products. This reduces competition, affects own brand producers and less consumer choice.

6.3 We believe clear information for consumers, combined with proven, targeted campaigns aimed at parents and drinkers will change the culture of alcohol. We acknowledge that consumption levels have been high but are encouraged that the trend in recent years is for falling consumption generally and a reduction in those exceeding health guidelines. We believe this trend will continue as education continues, particularly with parents and children, where the data on later take up and lower consumption of alcohol by children is encouraging.

6.4 The General Lifestyle Survey 2010 published this March provides evidence of the small but steady decline in consumption and also reinforces the point that the vast majority of the population, who already drink responsibly would be penalised by a minimum price. It showed only 17% of women (21% in 2005) and 26% of men (31% in 2005) reported drinking more than the weekly guidelines of 14 units for women and 21 for men. This means the vast majority of the population drink within weekly guideline limits.

6.5 The Lifestyle Survey also suggests that a minimum price would have little impact in tackling the problem of excessive consumption amongst higher income consumers. The group comprising managerial and

professional households reported more frequent and heavier consumption than those in the manual household group. We know the “hidden drinker” is a major concern, but we believe this group would be much less susceptible to the impact of minimum pricing.

7.0 THE EFFECTS OF MARKETING ON ALCOHOL CONSUMPTION, IN PARTICULAR IN RELATION TO CHILDREN AND YOUNG PEOPLE

7.1 Our members’ marketing of alcohol is aimed at adult consumers who, in almost all cases, buy alcohol alongside other grocery items. Whilst we accept that marketing is designed to increase purchases it is not designed to increase consumption, as it can be purchased over a long period and shared with friends within responsible drinking guidelines. It is also factual, giving information on prices and offers, in no way designed to be attractive to children.

7.2 All our members are supporters of the Portman Code which ensures that in store promotion of products themselves is not inappropriate and could appeal to children and will remove products where they are found to be in breach of the Code.

8.0 PUBLIC HEALTH INTERVENTIONS SUCH AS EDUCATION AND INFORMATION

8.1 Our members support the use of education and information, both to help existing drinkers consume responsibly and also to influence the approach of the next generation of drinkers. As well as making clear information available on sensible drinking limits our members have given support to the independent Drinkaware Trust to develop targeted campaigns. Our members have ensured the Trust’s campaigns are effective and impactful and believe continuing support will drive cultural change.

8.2 We believe it is important to ensure consistent messaging on drinking is given through all available routes to reinforce them. For example, universal use of the DH health label, on all products and in the on trade will drive home the need to understand the units in different drinks and sensible consumption limits, in a similar way to the Challenge 25 campaign which is so effective in preventing underage sales.

8.3 We also believe there is a responsibility on Government to consider its role in education and challenging parents to ensure children are not exposed to irresponsible behaviour and are introduced to alcohol in a responsible manner.

9.0 REDUCING THE STRENGTH OF ALCOHOLIC BEVERAGES

9.1 Our members fully support the Responsibility Deal pledge on reducing the units of alcohol in the market by 1bn by reducing the strengths of their own brand products and promoting lower strength branded products. We believe the wider availability of lower strength products and a reduction in the strength of well known brands will help consumers subtly reduce their consumption without them noticing the difference.

9.2 We are already seeing an increase in sales of lower strength products and expect this trend to continue as members support the Responsibility Deal pledge.

10.0 RAISING THE LEGAL DRINKING AGE

10.1 We don’t believe a change is necessary and believe consistent messages on consumption by younger people would be a more effective target. Retailers have successfully driven down sales to underage customers through the Challenge 25 policy. We know, however, from research that parents and older peers continue to supply alcohol to younger people and feel there should be more attention on the irresponsibility of proxy buying and more pressure on parents to ensure they are not ignoring advice on sensible consumption by young people.

11.0 PLAIN PACKAGING AND MARKETING BANS

11.1 We do not support plain packaging and have concerns this could lead to an increase in fraud. We feel a better answer is to ensure all alcohol products, wherever they are sold, have the full DH health label to reinforce unit awareness and sensible drinking limits.

11.2 We do not support marketing bans as our members simply use these to give consumers information on pricing and promotions which may drive purchasing patterns but are not proven to drive excessive consumption.

Written evidence from the Royal College of Anaesthetists (GAS 15)

INTRODUCTION

The Royal College of Anaesthetists is a member of the Alcohol Alliance and supports their views on alcohol-related issues.

Two key issues for anaesthetists are:

- (a) Dealing with the effects of the acute overconsumption alcohol in relation to binge drinking and motor vehicle collisions. During some nights on call, and particularly at weekends, over 90% of the patients being anaesthetised in emergency theatres would not be there but for the harmful overconsumption of alcohol. This might be following personal harmful consumption or that of someone else resulting in violent injuries from glass or knives. This uses up valuable NHS resources and reduces the anaesthetic services capacity to deal with other surgical emergencies whose treatment can sometimes be delayed as a consequence. Reduction of permitted alcohol level for driving should help this, see paragraph 9.
- (b) Anaesthetising and treating patients on Intensive Care Units or in Pain Clinics may be more complex because of comorbidities produced by the long term harmful consumption of alcohol. Such comorbidities eg liver failure increases mortality risk for these patients, prolongs their length of stay and increases the amount of resources the NHS has to devote to them compared to other patients.

The Royal College of Anaesthetists has recently contributed to the Academy of Royal Medical Colleges working party to agree core competencies for dealing with alcohol related issues. These are being incorporated into the FRCA curriculum.

RESPONSE TO QUESTIONS ON CALL FOR EVIDENCE

1. Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role

This College would not have a preference as to who is responsible within government other than it be the Department which can most reliably and effectively implement the alcohol strategy and start to address the very serious problems that the population now faces.

2. Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol

Ideally this will be coordinated across all the devolved administrations and implemented in the same way. Different approaches would confuse the public about the important and sometimes difficult messages to be conveyed and in the border areas lead to problems such as used to occur with differing Welsh/English licensing hours.

3. The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group

The alcohol industry should be involved in addressing alcohol-related problems. The Responsibility Deal seems fine on paper but removing 1 billion units over 10 years is a small part of the market. It will be interesting to see if this is actually achieved voluntarily as: reducing the strengths of their brands, reducing the volume of their products, and curtailing irresponsible marketing innovations is exactly the opposite of what they have been doing in the for the last 30 years. Indeed as the Government Alcohol Strategy says—consumption in the UK used to be the lowest in Europe, therefore the UK was the nation with the best potential of market growth and was specifically targeted with very successful marketing campaigns and lobbying for beneficial changes in legislation on licensing hours etc. As a result, alcohol consumption increased and after a lag death rates of from cirrhosis have gone from below average to some of the worst in Europe.

4. The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing

This College fully supports a minimum price per unit of alcohol. We are also persuaded by the evidence of University of Sheffield and others that 50p will be better. This is a measure that should be effective in reducing alcohol consumption at home and reducing the consumption of even moderate drinkers will also produce health benefits over time. A uniform UK national policy for a minimum price would be ideal. In the absence of this some large urban, conurbations in the North of England and Midlands are considering their own regional minimum pricing measures; it would be better to be a UK wide initiative.

5. *The effects of marketing on alcohol consumption, in particular in relation to children and young people*

One of the reasons for the large increase in alcohol consumption in the last 30 years has been the effectiveness of its marketing particularly in relation to young people. Regulation should be tightened up with consideration of banning it in the broadcast mediums and removing promotion at sporting activities.

Drinking should not be a feature of films classified 12.

6. *The impact that current levels of alcohol consumption will have on the public's health in the longer term*

Current levels of alcohol consumption underpin further increases in liver disease etc. for the health service to deal with in the coming years.

7. *Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services*

The full results of current levels of alcohol consumption have yet to be seen and increased investment in the relevant areas of the NHS and social care will be needed over the coming years.

The impact of harmful alcohol consumption on anaesthetic emergency services might be worthy of a study funded by the NHS to determine the exact extent and commitment of resources to this activity.

8. *Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm*

This is too early to tell but the Health and Well-Being Boards may have an important developing role in this area.

9. International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking, such as:

- Public health interventions such as education and information;
- Reducing the strength of alcoholic beverages;
- Raising the legal drinking age; and
- Plain packaging and marketing bans.

We would add—the permitted blood alcohol concentration for driving should be reduced as a matter of urgency. Great Britain and Ireland are the only countries in Europe with a limit of 80mg per 100ml, a number are 50mg per 100ml and we are persuaded that levels of 0 mg per 100ml would be best. Six countries in Europe and 17 in the world have Zero as their limit. We note the government is currently tightening up on the rules for driving under the influence of other drugs, with UK pedestrian death rates being highly unsatisfactory this will be an opportunity to send a coordinated message that anyone wishing to drive a car should never do so with their judgement and reflexes impaired.

Tightening up on the driving limit will also create further downward pressure on alcohol consumption levels in a particularly significant group.

May 2012

Written evidence from the Royal College of Physicians (GAS 17)

ABOUT THE ROYAL COLLEGE OF PHYSICIANS

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. The RCP undertakes a range of public health-related activity, including on the social determinants of health, obesity, tobacco and alcohol. As an independent body representing over 27,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

The RCP notes that the British Society of Gastroenterology are submitting a separate response to this consultation, which will provide additional information.

1. SUMMARY

The RCP endorses the Alcohol Health Alliance UK's (AHA) response to this inquiry and supports the AHA's comments and recommendations regarding the strategy. In summary:

- The RCP welcomes *The Government's Alcohol Strategy* and its acknowledgement of the harms associated with current levels of alcohol consumption in England.
- The RCP supports the strategy's clear commitments to address areas such as pricing and licensing and particularly welcomes the commitment to introduce a minimum unit price for alcohol.

- However the RCP is concerned about the limited commitments in other areas of the strategy, particularly in relation to restricting alcohol marketing and investing in a range of patient-focused treatment services.
- The RCP welcome initiatives that address specific sections of the population, however the RCP is calling for additional investment in services to address the significant proportion of the population who regularly drink at or above published guidelines over a sustained period of time, which can lead or contribute to a range of chronic diseases.
- A strong national framework, underpinned by effective governance, quality research and evaluation, will be essential in supporting local authorities and clinical commissioning groups to deliver effective services for their communities in the new public health system.

2. RELATIONSHIP BETWEEN PRICE AND CONSUMPTION

2.1 The RCP strongly supports the government's commitment to introduce a minimum price on alcohol in England and Wales. This step acknowledges the clear relationship between price and the consumption of alcohol and associated harms, which is supported by substantial and robust evidence and modelling.^{1,2,3,4,5}

2.2 Modelling conducted by the University of Sheffield found that increasing levels of minimum pricing show substantial increases in effectiveness. The RCP supports the introduction of a minimum unit price of at least 50p per unit, which the modelling suggests would reduce total alcohol consumption by 6.7%, saving around 20,000 hospital admissions in the first year and 97,000 a year once the policy has been in place for ten years. This would result in direct costs saved in relation to health, crime and workplace impacts in England of £7.6 billion over ten years.⁵

2.3 The RCP also strongly supports the proposed ban on multi-buy promotions in the off-trade, in addition to the introduction of a minimum unit price. The University of Sheffield modelling shows that increasing restrictions in off-trade discounting (ie through multibuys) will result in a reduction on overall consumption equivalent to that of a 40p minimum unit price.⁵

3. ADDRESSING MARKETING AND ADVERTISING

3.1 Evidence shows that exposure to alcohol marketing encourages children to drink at an earlier age and in greater quantities than they otherwise would. The Science Committee of the European Alcohol and Health Forum concluded in 2009 that "alcohol marketing increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol".⁶

3.2 While the government's strategy recognises the link between marketing and consumption, the actions outlined focus on working within the current structures and do not go far enough to curb children's exposure to alcohol advertising.

3.3 The RCP supports a UK adapted version of the French framework, the *Loi Evin*. The *Loi Evin* model provides a simple framework that can offer clarity on what marketing practices can and cannot be implemented whilst ensuring that children and young people are protected from an exposure that poses a risk to their health and wellbeing.

4. THE ROLE OF THE ALCOHOL INDUSTRY

4.1 The RCP welcomes the acknowledgement in the strategy that "industry needs and commercial advantages have too frequently been prioritised over community concerns".⁷ However the RCP remains concerned that the strategy reinforces existing roles and structures for industry involvement.

4.2 In line with the World Health Organisation recommendations, while we believe business must play a part and have the opportunity to engage with health issues, health experts must lead on setting policy priorities.⁸ Although businesses have a role to play in implementing and supporting public health initiatives it is not the place or responsibility of business to define public health policy or to be responsible for public health information, as in many cases this is in direct conflict with their interests and responsibilities to their shareholders and employees.

4.3 The RCP did not sign up to the Responsibility Deal due to a range of concerns, particularly around the alcohol pledges. The RCP continues to engage critically with the Responsibility Deal, and in particular is calling for independent monitoring and evaluation of the pledges and wants to ensure there is a clear timetable for reviewing progress and detail of the action that will be taken if outcomes are not achieved.

5. GREATER INVESTMENT IN EFFECTIVE SERVICES

5.1 There is a clear need to provide care for a large and growing group of patients with alcohol-related health problems. Presently a lack of coordinated action means that care is imperfect and spending is poorly targeted and ineffective, very few hospitals have dedicated alcohol services and only 5.7% of dependent or harmful drinkers access treatment, compared to 67% of dependent or harmful drug users.⁹

5.2 The RCP welcomes the strategy's actions relating to specific concerns such as those related to under 18 Accident and Emergency admissions and the rehabilitation of offenders. The strategy also acknowledges the benefits of early intervention and treatment services, but offers few commitments in this area.

5.3 The RCP is calling for additional investment in strategies and services to address the significant proportion of the population who regularly drink at or above published guidelines over a sustained period of time, which can lead or contribute to a range of chronic conditions such as liver disease, heart disease and cancer.

5.4 The RCP is calling for the full implementation of the NICE guidelines relating to alcohol dependence, which provide an excellent, evidenced-based guide to effective intervention, treatment and referral systems that involve a wide range of health professionals.^{1,2}

5.5 The RCP recommends that there should be a multidisciplinary "alcohol care team", a seven day alcohol specialist nurse service and an "assertive outreach alcohol service" in every district hospital. Transitions between teams and services should be quick and seamless in order to increase the efficiency and cost effectiveness of the service.¹⁰

6. A NATIONAL FRAMEWORK TO SUPPORT LOCALLY-DRIVEN PUBLIC HEALTH

6.1 The RCP believes there is potential to work more closely with local authorities to drive change and innovation, and deliver services targeted to the needs of local communities. However, with the changes to the public health system come risks that must be mitigated. These include: unjustifiable variation, piecemeal and fragmented service provision, an absence of quality evaluation metrics, and a lack of information sharing and best practice.

6.2 A national service framework on alcohol, which could be adapted to local needs, would be an effective way of keeping costs down, sharing best practice and getting the best value for money. A framework could be led by a dedicated alcohol team within Public Health England, with established experts leading the research work at the highest level, setting out principles for action, rather than prescriptive plans. The RCP recommends that an expert, influential and independent director of public health—supported by robust data analysis and outcome monitoring systems—will be essential.

7. COORDINATION OF ALCOHOL POLICY

7.1 Policies relating to alcohol fall under a broad range of governmental departments. There is therefore a particularly strong case for a cross-departmental unit on alcohol, and the RCP suggests that such a unit could be led by the Chief Medical Officer—reporting to the Home Affairs (Public Health) Cabinet Sub-committee.

7.2 A cross-governmental alcohol unit could maximise the impact of the different strands of the government's strategy and ensure there is rigorous evaluation applied to all aspects of the strategy. The unit would also be well placed to coordinate policy with the devolved administrations. Greater consistency around policies relating to the price, availability and promotion of alcohol will be important in ensuring success across the UK.

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³ WHO Expert Committee on Problems Related to Alcohol Consumption. Second report/WHO expert committee on problems related to alcohol consumption. WHO technical report series; no. 944. Geneva: World Health Organization, 2007.

⁴ Wagenaar A. C., Salois M. J., Komro K. A. Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction* 2009; 104: 179–90.

⁵ Purhouse, R et al, 2009. Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group.

⁶ Anderson P, C. D. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet* , 2009: 373:2234–46.

⁷ Home Office, The government's alcohol strategy. 2012:3.

⁸ World Health Organization. The World health report 2002: reducing risks, promoting healthy life. Geneva: WHO, 2002.

⁹ Department of Health. Alcohol needs assessment research project (ANARP). London:Department of Health, 2004.

¹⁰ The British Society of Gastroenterology and the Royal Bolton Hospital NHS Foundation Trust . Alcohol care teams: to reduce acute hospital admissions and improve quality of care. London:NHS Evidence, 2011.

May 2012

**Written evidence from the National Society for the Prevention of Cruelty to Children (NSPCC)
(GAS 18)**

SUMMARY

- There are a significant proportion of children living with alcohol misusing parents who, as a result, are at an increased risk of abuse or neglect.
- The Government’s alcohol strategy does recognise the need to identify and support problem drinkers who are also parents. However, the NSPCC believes there should be a greater focus on the impact of alcohol misuse on children. Implementation of the strategy provides a key opportunity to ensure the risks to children of parental alcohol misuse are addressed and families are better supported.
- Given the framework of the Health Select Committee’s inquiry into the Government’s alcohol strategy, this submission highlights the need for public services and interventions to recognise the needs of entire families, and to ensure a joined up approach to adult and children’s services. This will better protect children from harm and support parents’ understanding of the harmful effects of alcohol misuse on their children, ultimately helping them to control their drinking.

THE IMPACT OF ALCOHOL MISUSE ON CHILDREN

1. It is estimated that between 780,000 and 1.3 million children in England aged under 16 have parents whose drinking is classified as harmful or dependent.⁶² Around 79,000 babies under one year old in England have a parent who is a harmful drinker, which is equivalent to 93,500 babies in the UK. And around 26,000 babies under one year old in England have a parent who is a dependent drinker, which is equivalent to 31,000 across the UK.⁶³ Furthermore, parental alcohol misuse is present in a number of cases of child abuse and neglect. Evidence shows that it was present in 22% of Serious Case Reviews in England from 2007–09.⁶⁴

2. When parents misuse alcohol, it can impact upon children physically, mentally and emotionally, the effects of which can be both severe and long lasting. It can also have a profound effect on parenting as parents who misuse alcohol are less likely to be able to look after their children or develop healthy relationships with them and other family members. These vulnerable children can be left struggling to cope with complex problems that become difficult to solve.

3. Babies, given their total dependence, are particularly vulnerable to abuse and neglect if their parents are drinking excessively. Furthermore, damage can start before the baby is born as research indicates that alcohol is one of the most powerful and dangerous neurotoxins that can affect brain development during pregnancy.^{65,66}

What the implementation of the Government’s alcohol strategy needs to address

4. The Government’s alcohol strategy quite rightly aims to tackle problem drinking and focuses largely on the public face of alcohol misuse including crime, violence and antisocial behaviour. The NSPCC welcomes the Government’s recognition in the Strategy that a significant proportion of adults in alcohol treatment are parents with childcare responsibilities. However, we believe that parental alcohol misuse and the impact it has on children in the family should be considered more fully in order to ensure it addressed effectively and all family members receive the necessary support.

5. Both children and their parents living in these difficult situations need help and support to tackle their problems. Too often, adult alcohol services focus on the needs of the problem drinker rather than treat parents as parents and recognise the needs of their children. Families have been seen as an adjunct to their treatment and services for family members or family units in their own right are not widely available.

6. Therefore, there is a clear need to develop treatment services which meet the needs of the whole family, as this approach is more likely to succeed in supporting children and other non-drinkers in the household. Interventions need to focus on parenting. For example, whenever adults are in touch with primary, acute or specialist services because of alcohol misuse, they should be asked if they are a parent so that any risks to their children are identified and dealt with and they can be supported in this role. This would include parents automatically being offered parenting support, and children being offered practical and emotional support to deal with the impact of alcohol misuse on their lives. This may be particularly powerful where parents have young babies and may be more open to change.

⁶² Prime Minister’s Strategy Unit (2003) Alcohol Harm Reduction Project—Interim Analytical Report.

⁶³ Manning, V. (2011) Estimate of the numbers of infants (under the age of one year) living with substance misusing parents, NSPCC.

⁶⁴ Marian Brandon, Sue Bailey and Pippa Belderson (2010) Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007–2009, Department for Education.

⁶⁵ National Scientific Council on the Developing Child (2006), *Early exposure to toxic substances damages brain architecture*.

⁶⁶ Welch-Caerre, E. (2005) “The neurodevelopmental consequences of prenatal alcohol exposure,” *Advances in neonatal care*, 5(4).

7. It is important to appreciate that treatment that includes consideration of the whole family can also be more successful for the drinker. For example, a parent returning to a family after detoxification is more likely to maintain abstinence or controlled drinking if it has been possible to address their whole environment and change some of the factors that may have contributed to alcohol misuse in the first place, such as family relationships and stress in parenting.

8. In order to protect children we need to find ways of detecting and helping them at an earlier stage, and fully understand the nature and extent of the problem. When local authorities and health services undertake Joint Strategic Needs Assessments these should include data on the number of children affected in their area by parental alcohol misuse to enable them to commission services to support these families, in order for there to be sufficient support available to parents drinking excessively.

9. Pregnancy is also a key opportunity to give support to help mothers reduce problem drinking. While the Government's strategy does highlight the risk of foetal alcohol spectrum disorders, targeted public education must also highlight that alcohol use in pregnancy is also associated with miscarriage, early labour and still births,⁶⁷ and find further ways to reach out and influence these mothers. Midwives, health visitors and others still struggle to identify and treat pregnant women who are drinking too much, therefore improved screening is needed to identify mothers who are drinking too much for the safety of their baby. The NSPCC has also identified the development of a rigorous framework and tools for pre-birth risk assessments as a key intervention in order to identify the level of anticipated risk and determine how it can be successfully managed, and we are currently planning to develop a new service in this area.

NSPCC SERVICES SUPPORTING FAMILIES AFFECTED BY ALCOHOL MISUSE

10. The NSPCC has developed the following innovative services to provide the support we believe these families need:

- Family Alcohol Service: Our multi-disciplinary team works with parents to help them understand how their drinking affects their children, and helps children overcome the harm caused where one or both of their parents are drinking. Families with children 12 years old or under are allocated an NSPCC children's worker and an adult alcohol worker. The aim of the service is to prevent family breakdown through early intervention and by bridging the gap between adult treatment and childcare services. Parents are offered advice, guidance, treatment and information on how to stop drinking and become safer parents, and children are provided with services such as individual therapy and support groups.
- Family Environment: Drug Using Parents (FEDUP): This new service works with children between five and 11 years old. NSPCC practitioners lead groups of up to five children, some of whom are subject to local agency child protection plans, over ten weekly sessions. The practitioners enable and support children to talk about their feelings, particularly in relation to family life and living with adults who are substance users. The groups give children a safe space and mutual support to build self-esteem. Throughout the duration of the work, if the NSPCC believes children are not safe then appropriate action will be taken to ensure the child's safety and well-being. Through an eight week individual plan of work, practitioners also help the parents understand how their addictions affect their children and discuss with them ways in which they might change their behaviour.
- Parents Under Pressure: Originally developed in Brisbane, Australia, this is an intensive home visiting programme which supports alcohol and drug misusing parents to build parenting skills and develop safe and caring relationships with their babies. NSPCC workers visit the homes of alcoholic or drug-using parents who have babies under two years old on a weekly basis. The parents can phone the workers for emergency support outside the home visits. The programme teams work alongside other agencies involved with the family, including local children's services, drug and alcohol teams, mental health agencies, GPs and other local health services.

The above services are being delivered as part of the NSPCC's strategy to prioritise certain types of abuse and the most vulnerable children. We are pioneering 27 new programmes of work within our priority areas, building on knowledge we have gathered from around the world, and we want to share our learning and expertise in order to show what works and promote the most effective interventions. We would be more than willing to organise a visit to our services for members of the Health Select Committee.

ABOUT THE NSPCC

The National Society for the Prevention of Cruelty to Children (NSPCC) aims to end cruelty to children in the UK by fighting for their rights, listening to them, helping them and making them safe.

We share our experience with governments and organisations working with children so together we improve the protection of children and we challenge those who will not learn and change. We campaign for better laws and we educate and inform the public to improve understanding about child abuse.

⁶⁷ Sher J. (2010), *Ten Facts about Foetal Alcohol Harm*, Children in Scotland.

Our services include the NSPCC Helpline, for adults worried about a child, and ChildLine, the UK's free, confidential helpline for children and young people.

May 2012

Written evidence from the British Liver Trust (GAS 19)

1. The British Liver Trust is the only liver related charity for adults in the UK—it offers information and support for the millions who are at risk of liver disease, including the ever increasing numbers of people with, and affected by alcohol related liver disease.⁶⁸ (www.britishlivertrust.org.uk)

1.1 Along with the Alcohol Health Alliance (AHA) the British Liver Trust welcomes The Government's Alcohol Strategy (2012) and its acknowledgement of the harms associated with current levels of alcohol consumption in England.

1.2 The British Liver Trust is an executive member of the AHA; we have contributed to the AHA's comprehensive response to this consultation and fully support all of the comments made. In addition to the AHA's response the British Liver Trust would also like to add.

2. As quoted within the strategy "In the UK, there has been a 25% increase in liver disease between 2001 and 2009" and that alcohol is the major contributor—to address this as effectively as possible the British Liver Trust wants the Government to commit to:

- improved awareness and prevention campaigns;
- improved screening;
- early intervention;
- continuing care and support;
- equitable access to the most appropriate treatments; and
- effective palliative and supportive care when needed.

2.1 It is unfortunate that despite this strategy reporting that a liver disease strategy has recently been published this is not the case and it would undoubtedly be useful to have one as soon as possible.

3. With particular reference to greater investment in effective interventions the British Liver Trust would like the government to commit to improving access to and provision of a dedicated alcohol services with full liver health screening and appropriate care, treatment and support where needed for those with, and affected by, alcohol related liver disease.

3.1 The British Liver Trust is very concerned by the lack of actions and investment to address the significant proportion of the population who regularly drink at or above published guidelines over a long period of time, which can lead to chronic liver disease conditions.

4. Re: Early diagnosis and treatment of alcohol use disorders.

4.1 To complement a Quality and Outcomes Framework for GPs to record the alcohol intake of their patients and to give brief advice where indicated the British Liver Trust would recommend that the full extent of any potential health harm is assessed including full liver health screening and a stepped programme of further intervention implemented when needed.

5. RE: Secondary care services.

5.1 *As well as the recommended 7 day Alcohol Specialist Nurse Service and Assertive Outreach Alcohol Service* the British liver trust would like the strategy to commit to developing fully holistic care teams for people from early diagnosis to effective palliative and supportive care so the full extent of their holistic needs are met.

May 2012

Written evidence from Crime Reduction Initiatives (GAS 20)

BACKGROUND

CRI is a health and social care charity that works with individuals, families and communities across England and Wales who are affected by alcohol, drugs, crime, homelessness, domestic abuse, and antisocial behaviour. Our projects, delivered in communities and prisons, encourage and empower people to take control of their lives and motivate them to find solutions to their problems.

⁶⁸ <http://www.britishlivertrust.org.uk>

EXECUTIVE SUMMARY

Aspects of the Government's Alcohol Strategy are positive. However, it is too focused on policies like minimum pricing, and it is undermined by its failure to expand alcohol treatment provision.

CRI is also concerned that the Alcohol Strategy is weighted disproportionately to issues of youth drinking and the associated links to crime and disorder, while giving little attention to the wider public health issues associated with widespread alcohol misuse. Notably, the Government should give more attention to problematic alcohol misuse amongst the workforce, which has a significant negative economic impact and would be best addressed by a health lead approach involving employers at every stage.

Central to CRI's response to this inquiry is the firm belief that the only effective method of stopping individuals from misusing alcohol is high quality early intervention and treatment. Therefore, it is essential that government retains financial and political support for education and treatment services, and that it constantly strives to integrate these services with the criminal justice, health, and education systems.

CONTENTS

1. Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role

1.1. The Department of Health should take the lead on issues related to alcohol policy, ensuring a focus on treatment and intervention. The Ministry of Justice and the Home Office also have roles to play, but only when there is an overt criminality or antisocial behaviour link.

1.2. The involvement of different departments at Whitehall level can work well, so long as there is effective coordination and communication. For example, Drug Intervention Programmes were devised by the Home Office but they are successfully commissioned alongside drug treatment services.

1.3. The real issue that effects the implementation of any alcohol strategy is integration at a local level, to ensure that local recovery services are providing a full range of interventions that effectively address the complex needs of individuals. It is incredibly important that, for example, local services for alcohol treatment/intervention and antisocial behaviour are commissioned together, but it matters less which departments the money for those services comes from.

1.4. Local integration between alcohol and antisocial behaviour services is all the more important since it has been estimated that issues related to drugs and alcohol cause up to 50% of crime, and DirectGov has shown that in 2007–8 more than a million crimes involved alcohol in some way.

2. Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol

2.1. A degree of flexibility in the delivery of alcohol services allows for innovation, and there are strong arguments to suggest that slightly different approaches to alcohol might work in different areas.

2.2. However, in a context where administrations are devolved, and also across different Local Authorities, it is vital that certain standards and expectations are maintained. Commissioning frameworks, compliance standards and expectations must remain consistent from the top level to the local level.

2.3. The upcoming transfer of responsibilities to Public Health England will see funding for alcohol treatment pooled with other public health funding streams, and CRI has concerns about the security of funding for alcohol treatment services under this new structure. With the ringfence being removed, alcohol services will have to compete with 16 other public health priorities. This could see alcohol treatment cut in favour of other services, and could potentially be affected by local political motives.

2.4. Therefore, while there should be some room for local prioritisation, there must be nationally defined firm guidance on the minimum expectations of investment in locally available alcohol treatment and recovery services, in order to avoid creating a postcode lottery, and to avoid the potential for worsening public health and crime.

3. The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group

3.1. External pressure would have far more of an impact on the alcohol industry than self regulation. That said, the alcohol industry has a role to play. CRI would like to see industry bodies like the Portman Group investing in education and treatment provision.

4. The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing

4.1. Minimum pricing alone would not be an effective strategy for reducing alcohol consumption, as CRI has seen that the most harmful drinkers among its service users would not be deterred by a higher price of

alcohol; they would sacrifice food, clothing, and rent payments to be able to maintain their alcohol consumption.

4.2. There is also a significant section of the population—higher net worth individuals, who tend to drink more expensive forms of alcohol—who misuse alcohol but will not be affected by a minimum price.

4.3. However, alongside increased investment in treatment and education a minimum price will have a significant role to play.

5. The impact that current levels of alcohol consumption will have on the public's health in the longer term

5.1. Current levels of alcohol consumption are a public health time bomb. A binge-drinking culture has shaped harmful drinking habits within an entire generation. Unlike other European countries, people in Britain drink too many units of alcohol in short periods of time.

5.2. However, the Government's strategy focuses on highly visible problematic drinkers who indulge in antisocial behaviour, when this is not the only form of alcohol misuse.

5.3. There is a wider need to reinforce public health and prevention messages. There is a large sector of society where people drink far more than they should, but would not be affected by the kind of minimum price being proposed, as they already drink more highly priced alcohol.

5.4. Different approaches are required for different sectors of society. Investment in education, intervention and treatment for young people is vital, in order to address problem drinking early on at a stage when addiction tends to be less entrenched, so there are greater opportunities to assist people to get their lives back on track.

5.5. On a wider scale, less visible alcohol misuse—for example, people who regularly drink excessively in their own homes—has a significant impact on the economy through worklessness or working days missed through alcohol related sickness. In order to improve public health, large employers should be encouraged to invest in treatment as part of their health provision.

5.6. The Government should also consider replicating the strong and effective awareness campaigns which were deployed against tobacco harm in the context of alcohol harm.

5.7. In order to most successfully reduce harmful drinking, alcohol misuse must be considered in its wider context. Family relationships, homelessness, unemployment, mental health issues and drug misuse all play a part, and services that address these needs must not be commissioned separately.

6. Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services

6.1. Alcohol services are underfunded. Public investment per alcohol drinker is minimal compared to public investment per drug user when the stark reality is that problematic drinking is about twenty times as prevalent as illicit drug use. However, the response should not be to re-direct funds away from drug treatment services toward alcohol treatment services as this would merely dilute the impact of services in fighting both types of addictions.

6.2. In order to generate long term savings for the NHS, there is a need for more funding for both alcohol and drug treatment and intervention services.

6.3. The need for investment in hepatology services could be minimised by investing in prevention work. Investing in education and early intervention would be cost effective and would have a greater impact in terms of public health than investing in crisis intervention.

7. Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm

7.1. As outlined in 2.3 and 2.4, CRI is concerned by the fact that Public Health England will see the adult Pooled Treatment Budget combined with other public health funding streams, effectively removing the ringfence for alcohol treatment services and allowing for alcohol agendas to be dropped in some areas. In order to allow for improvements to public health, investment must be maintained in alcohol services.

8. International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking

8.1. Public health interventions such as education and information:

CRI believes that early intervention through public health education and information is absolutely key to reducing alcohol consumption and harmful drinking.

8.2. Reducing the strength of alcoholic beverages:

Some alcoholic products, such as super-strength lagers and ciders, are almost exclusively consumed by problematic drinkers, and therefore reducing the strength could have some impact; however, this would not form a solution, and would only be of any use alongside investment in treatment and

intervention. As outlined above, the most problematic drinkers will simply buy more—if necessary, sacrificing food and other necessities—in order to feed their addiction.

8.3. Raising the legal drinking age:

Such a measure is unlikely to have any impact.

8.4. Plain packaging and marketing bans:

As has been seen with cigarettes, restrictions on marketing and widespread public health education can be effective in reducing consumption, and the government should explore the potential impact of a similar approach to alcohol.

May 2012

Written evidence from the Association of Convenience Stores (GAS 21)

1. ACS (the Association of Convenience Stores) welcomes the opportunity to submit evidence to this important Inquiry. ACS represents 33,500 local shops across the UK, the majority of which hold alcohol licenses and would be affected by the measures outlined in the Government's Alcohol Strategy.

2. Convenience stores recognise they have a significant role to play in helping to tackle alcohol misuse and are strong supporters of the Government's Responsibility Deal. ACS also engages with Government on matters of national alcohol policy. Our aim is to ensure that measures are implemented only where there is clear evidence that they are necessary and any new regulation is developed to minimise the cost and disruption on local shop businesses.

3. In the evidence below ACS views on the following issues are set out:

- The role of retail and the alcohol industry in addressing alcohol-related health problems.
- Minimum unit pricing and a ban on multi-buy promotions.
- Additional measures to tackle alcohol misuse.
- Responsibility for alcohol policy within Government.
- Coordination of policy across the UK with the devolved administrations.

THE ROLE OF RETAIL AND THE ALCOHOL INDUSTRY IN ADDRESSING ALCOHOL-RELATED HEALTH PROBLEMS

The role of local shops

4. ACS represents over 33,500 local shops across the United Kingdom. Alcohol is an important part of a convenience stores range accounting for on average just over 12% of the sales.⁶⁹ Selling alcohol comes with a significant amount of responsibility and a range of compliance requirements. It is also a product with which errors in compliance or negligence come with severe consequences for a business or even lead to criminal prosecutions for individuals.

5. Preventing underage drinking is the most important concern for local shops; both in terms of the risk of underage sales taking place and the consequences of underage drinking for the individual and the community.

6. Local shop owners and their staff represent a frontline against access to alcohol for these young people. A recent survey of ACS members demonstrated that more than a quarter of retailers have to refuse age restricted sales more than ten times per week.⁷⁰

Responsible Retailing Initiatives

7. There have been significant improvements in the performance of off licence retailers in preventing underage sales in the past ten years. There is no sense that this is a problem that has been solved, but the following important initiatives have had a vital role to play:

- *Challenge 25*—an industry wide approach to age verification policies and customer communication.
- *Proof of Age Standards Scheme*—providing a hallmark for proof of age card schemes and tackle fake ID.
- *CitizenCard*—the not for profit, commercial proof of age card that has issued more than a million cards over more than 10 years.
- *Community Alcohol Partnerships*—a new approach to preventing and dealing with the effects of underage drinking in communities. Invariably achieving better outcomes than previous enforcement focused strategies.

⁶⁹ Average taken from IGD Convenience Retailing 2011—it is important to note that this percentage will vary significantly based on store location, business profile and other factors.

⁷⁰ ACS Voice of Local Shops Survey May 2012.

- *The Portman Group*—ACS supports the enforcement of the Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks.

8. These schemes have been accompanied by a wealth of local, corporate and individual initiatives that have made a significant difference to access to alcohol from shops. We must, however, continue to focus on attention in two areas:

- (i) retailers have still to improve their performance in preventing access to alcohol. Current indications that success in complying with internal age verification policies is at an off-trade average of 78%.⁷¹ This can still be improved.
- (ii) young people get alcohol from a number of routes not all related to buying it themselves. The single most likely course of alcohol for a young person is to be given it by someone else; this can be older peers or even parents.

9. The reality is that in order to prevent young people developing harmful behaviours related to alcohol at a young age we need a holistic approach. The very best example of communities tackling the problem this way is the Community Alcohol Partnership.

Responsibility Deal

10. Retailers and the alcohol industry are very aware of the importance of tackling alcohol misuse. Retailers want to be seen as part of the solution, not part of the problem, when it comes to tackling these issues. As a result, retailers have been working alongside suppliers and manufacturers to support the Government's Responsibility Deal, in addition to the initiatives outlined above.

11. ACS supports the Responsibility Deal; we believe that it is right in principle for Government, health experts and the trade to work together to achieve common objectives that reduce the harm of alcohol in society.

12. ACS has made several commitments:

- to take forward the Community Alcohol Partnerships initiative. Having made the commitment we have since trebled our funding contribution and have been focused on helping the CAP initiative achieve its aims of rolling out more schemes across the UK; and in particular ensuring that CAPS involve the smallest businesses in their work.
- to promote the "how many units in your drink" co-ordinated point of sale campaign to our members. The co-ordinated message is designed to achieve a similar awareness among consumers as the "Challenge 25" messaging, and was supported by the majority of symbol groups, representing over 15,000 stores nationwide.
- to play our part in the industry commitment to remove one billion units of alcohol from the UK alcohol market by the end of 2015. This commitment was made by 10 companies that either run shops or supply shops in the convenience market.

13. We believe that the Deal is a strong basis for achieving outcomes. Given the focus on outcomes, it is in our view a quicker and more effective route to achieve change than policy or legislative intervention.

MINIMUM UNIT PRICING AND MULTI-BUY PROMOTIONS BAN

14. The Prime Minister has made clear the Government's position on minimum unit pricing (MUP) for alcohol. We therefore expect MUP to be in force in England and Wales in the foreseeable future. ACS' main concern is that these new rules are implemented in a way that is clear, consistent and legal.

15. Nonetheless ACS does not believe that evidence for MUP is conclusive. We are concerned about the view expressed in the Alcohol Strategy that MUP will have a significant impact on binge drinking and associated anti-social behaviour. Our understanding of the evidence employed by MUP advocates is that it is as a measure targeted at reducing alcohol consumption on a population-wide basis and as a consequence will bear down on the health harms associated with alcohol rather than anti-social behaviour issues primarily associated with 18–24 year old binge drinkers in the night time economy.

16. We are concerned that the introduction of MUP, especially if brought in at too high a cost, will have its biggest effect on the consumption behaviour of average responsible consumers. With alcohol less affordable, results are likely to be either:

- (i) Responsible drinkers may consume the same amount but spend a higher proportion of their disposable income thereby affecting their quality of life and wider spending in retail; or
- (ii) Responsible consumers may buy less alcohol, which has a negative consequence for businesses and jobs in all parts of the alcohol industry.

17. There are possible non-strategy related benefits to a policy of MUP. Small stores have suffered in competitive terms from the effects of the assertive discounting practices of the major supermarkets. The introduction of MUP may have the potential to shift consumers from buying large quantities of alcohol infrequently from the supermarket to more frequent purchases of smaller quantities and this could benefit

⁷¹ Figures based on more than 20,000 'tests' carried out by Serve Legal <http://www.servelegal.co.uk/>

smaller format stores. Any benefits, however, would be dependent on the level at which MUP was set and the mechanism chosen to implement it.

18. In addition to minimum unit pricing, the Government's Alcohol Strategy also set out plans to introduce a ban on multi-buy promotions. A similar ban was introduced in Scotland and prohibits stores from selling a multi-pack of alcohol products for less than the value of each individual item. For example, if a can of lager cost £1.20, a four pack of the same lager in the same size containers could not cost less than £4.80.

19. ACS believes that this policy, if brought in in conjunction with MUP, would amount to an unnecessary additional burden on retailers. We believe the Committee should recommend that this proposal is removed for the following reasons:

- MUP will have the effect of removing the types of multi-buy supermarket promotions that have been the particular focus of concern from the market, rendering this additional rule and associated bureaucracy superfluous.
- Experience from Scotland shows that restricting promotions can actually make alcohol more affordable for problem drinkers. For example, rather than a person needing £12 to buy three bottles of wine, they can buy one for £4, when the actual single unit cost would have been £5.
- For smaller businesses the use of promotional mechanics is an important way of communicating value to customers in a market dominated by large retailers.

ADDITIONAL MEASURES TO TACKLE ALCOHOL MISUSE

Licensing objectives

20. The Alcohol Strategy also includes proposals to introduce a new public health licensing objective to allow local authorities to take account of local density of premises and hours of sale. ACS has concerns over the introduction of this measure, in particular over the potential to restrict the number of alcohol licenses in the off trade on public health grounds.

21. A report published by Alcohol Concern in September 2011 titled "One on Every Corner" claimed there was a positive link between the density of off-licensed premises and harm from alcohol in underage drinkers. However, ACS believes the findings of this report are an unsound basis for Government policy, as the report failed to show any direct causal link between the density of off licences and the prevalence of harmful drinking amongst young people; the report excluded evidence gathered in London, which did not fit the conclusions drawn by the report; and study failed to take into account on-trade density. This assumes that alcohol harm is linked to off-trade only, rather than total provision of alcohol.

22. There is also no evidence to explain definitively the correlation between demand and the number of off trade licenses. It is just as likely that the number of off-licenses increases due to existing demand in an area, rather than being the reason for higher rates of consumption.

23. In addition to concerns over the evidence base, the introduction of this policy could lead to significant barriers to new entrants and investment in the sector, especially as a barrier to small businesses. If the number of licenses were to be restricted as a result of this policy, larger businesses are more likely to have the resources to meet any addition administrative or legal hurdles needed to obtain an alcohol license.

Additional licensing changes

24. Given the significant burden of new policy interventions already committed in the Alcohol Strategy, ACS urges the Committee not to recommend further measures that constitute a further burden on business.

25. The measures newly announced or reiterated in the Alcohol Strategy include:

- The introduction of Early Morning Restriction Orders (EMROs) in October 2012—to enable local areas to restrict alcohol sales late at night if they are causing problems.
- The introduction of a late night levy from October 2012—to allow local authorities to charge premises that sell alcohol after 12am.
- More powers for Local Authorities to instigate a review of licenses or revoke them.
- Extended powers to increase use of cumulative impact policies—to make it easier for Councils to refuse new licences on the grounds of over provision.

26. It is important that those involved in alcohol health-related policy are aware of these measures and the cumulative impact on retailers of all of the measures outlined in the Alcohol Strategy. ACS has made separate submissions to the Home Office on these measures, which we would be happy to make available.

RESPONSIBILITY FOR ALCOHOL POLICY WITHIN GOVERNMENT

27. The Committee's call for evidence also raised a number of questions around overall responsibility and co-ordination of alcohol policy across. ACS engages with Home Office and Department of Health officials in relation to alcohol and licensing policy. The potential issues around the consumption and sale of alcohol clearly

have significance for both public health and crime and disorder, so it is right that these two Departments are involved and work closely together on key issues.

28. ACS does not have a view on which department in Government should have an ascendency, but it is absolutely clear that policy must represent the balanced view of Government as a whole. This includes important considerations that fall within the remit of HM Treasury, the Department for Business, Innovation & Skills, the Department for Environment, Food and Rural Affairs, and the Department for Education.

COORDINATION OF POLICY ACROSS THE UK WITH THE DEVOLVED ADMINISTRATIONS

29. ACS would welcome a more joined up approach to the implementation of policy across the UK, where possible inconsistency between jurisdictions places a significant additional burden on businesses.

30. We recognise that there are differences in the challenges faced in different parts of the country, most notably between Scotland and the rest of the United Kingdom. However, where decision makers in different jurisdictions are pursuing policies or legislation of very similar form they should work together as this has cross cutting economic benefits.

May 2012

Written evidence from Sport and Recreation Alliance (GAS 22)

SUMMARY

- Sponsorship is worth approximately £2.8 billion to the sports industry in the UK every year.⁷²
- Over £300 million comes from alcohol sponsorship⁷³ to sport. This creates investment in facilities, stadia, player development, regional structures, tournaments, etc.
- Approximately £50 million of which goes directly to grassroots sports.⁷⁴
- National Governing Bodies of sports are non-profit organisations; surpluses are reinvested into their grassroots. Generating income through sponsorship is key to their business models and to grassroots sport.
- Grassroots clubs average just £1,000 surplus every year.⁷⁵ Many rely on bar takings and sponsorship deals.
- The evidence connecting marketing to consumption is inconclusive and we ask the committee to ensure recommendations are proportionate and evidence based.
- We believe that self-regulation by the industry is a proportionate approach to sport sponsorship, however we would like to see sports rights owners directly involved in reviewing codes.

INTRODUCTION

1. The Sport and Recreation Alliance is the national alliance of governing and representative bodies of sport and recreation in the UK. Our 320 members represent 150,000 clubs across the country and some 8 million regular participants. The Alliance exists to promote the role of sport and recreation in healthy and active lifestyles, to encourage a policy and regulatory environment in which sport from grassroots through to elite level can flourish. Our membership stretches from organisations such as the England and Wales Cricket Board and the FA to Ultimate Frisbee and the Ramblers.

2. The sport sector welcomes the opportunity to respond to the Health Committee's inquiry. As only certain elements of the consultation are relevant to sport, the response concentrates on those specific areas. Namely:

- The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group.
- The effects of marketing on alcohol consumption, in particular in relation to children and young people.
- Plain packaging and marketing bans.

The response also puts into context why alcohol sponsorship is so important to sport.

THE VALUE OF SPONSORSHIP AND ALCOHOL SPONSORSHIP TO SPORT

3. According to the European Commission's report on sustainable financing of sport in Europe, sponsorship is one of the key funders of sport. The 2012 study (data from 2008) shows that sport receives more funds from sponsorship in the UK than from central Government.

⁷² European Commission commissioned report (2012) Study on the funding of grassroots sports in the EU.

⁷³ European Commission commissioned report (2012) Study on the funding of grassroots sports in the EU and percentage of sponsorship from alcohol as in Ipsos Mori, cited in BMA, *Under the Influence* (November 2009).

⁷⁴ *Ibid.*

⁷⁵ Sport and Recreation Alliance (2011) Sports Club Survey.

<i>Revenue from (2008):</i>	<i>Million €</i>	<i>Share of total</i>	<i>€ per capita</i>
General Government	4,105.6	13.1	66.6
of which:			
— Central Government :	2,334.2	7.4	37.9
— Ministry in charge of sport	279.5	0.9	4.5
— Other governmental entities	2,054.8	6.5	33.4
— Local authorities	1,771.4	5.6	21.0
Private stakeholders	27,315.0	86.9	443.4
of which:			
— Household's expenditure on sport	23,813.7	75.9	386.6
— Companies (sponsoring, donations, others,...)	3,158.8	10.1	51.3
— Revenue from media rights	342.5	1.1	5.6
Total revenue	31,420.6	100	509.2

Source: European Commission commissioned report (2012) Study on the funding of grassroots sports in the EU.

4. Alcohol sponsorship is believed to account for approximately 12% of sports sponsorship.⁷⁶ More importantly for the sustainability of sport in the UK, the European Commission study estimates that approximately 15% of sponsorship directly benefits grassroots sport, meaning a boost from alcohol sponsorship to the UK grassroots estimated at around £50 million.

5. Indeed 30% of grassroots clubs in the UK have sponsorship arrangement netting the average club with sponsorship just over £2,500 per year.⁷⁷ When we compare this to the average club surplus of just over £1,000, we can see the importance of sponsorship to grassroots sport.

6. Individual clubs often have sponsorship deals with local breweries and such community sponsorship programmes should be considered differently to mass marketing and should not be forgotten in this debate. One example of such sponsorship programmes is Ripon RFC which has the longest running commercial sponsorship of a rugby club in the country through its partnership with T&R Theakstons, in Masham. The brewer's association with the club goes back to the early 50s.

7. Local leagues also benefit from alcohol sponsorship for example Shepherd Neame are major sponsors of rugby in Kent, Essex and Sussex being the sponsors of the Kent Metropolitan Leagues and the Kent Cup. Their contribution is used to support the Essex leagues, the County Senior Cups (Senior, Intermediate and Shield) as well as, and the Senior and U20's XV's who take part in the unsponsored RFU County Championships. They also source their products at some of these events as well as the County dinner.

8. Not only is direct sponsorship important for grassroots, but many national governing bodies of sport and professional clubs also use their alcohol sponsorship to fund grassroots projects, for example, Carlsberg is the FA's Official Referees Partner and it lends considerable support to the recruitment and retention of referees at grassroots level in England.⁷⁸

9. Sports charities also benefit from their work with alcohol companies. For example, a proportion of each pint of Lord's Taverners Ale made by Marston's Beer goes directly to the Lord's Taverners. The Lord's Taverners is a charity which supports young people, particularly those with special needs, enjoy cricket and sport. They support grass roots cricket in the UK and have raised over £30million for schools and clubs.

SPORT AND RESPONSIBLE DRINKING

10. Self-regulation has proved effective in sports sponsorship for some time and the sport sector is keen to ensure our products are only associated with brands that promote responsible drinking. Sports often have policies and clauses in their sponsorship contracts designed to encourage responsible promotion. For example, the RFU require reasonable prominent references to responsible drinking and prescribes minimum standards for match days such as:

- (i) A four pint rule in that no customer can be served more than four pints at any one time
- (ii) Bottled water prices are low to allow and encourage non-alcoholic refreshment
- (iii) Becks Vier is served which, with an alcohol content of 4%, is at the low end amongst premium lagers
- (iv) Bar staff training programmes are designed to challenge those that may be under 21. There is a responsible alcohol management test that every member of bar staff must pass with 100%.
- (v) No alcohol offers or happy hours.

⁷⁶ Ipsos Mori, cited in BMA, *Under the Influence* (November 2009). The alcohol industry was the second sponsor of sport from 2003 -2006, accounting for 11.6% of the overall sports sponsorship market. Only the financial services sector had a larger share (19.2%).

⁷⁷ Sport and Recreation Alliance (2011) Sports Club Survey.

⁷⁸ The FA.

- (vi) At the London Sevens, for example, drinkers and families are separated so as to prevent drinkers disrupting non-drinkers.

THE RELATIONSHIP BETWEEN ALCOHOL AND CONSUMPTION

11. Alcohol marketing is designed to grab a greater proportion of the market share, not to increase alcohol consumption. Econometric studies examining the relationship between marketing expenditure and consumption have shown no or only slight correlation.⁷⁹ Meanwhile the European Commission report “Alcohol in Europe” also highlighted the inconclusive nature of researching stating that “research on the effects of sponsorship is limited, and much more is needed”.⁸⁰

12. Removing sports sponsorship will not lead to an overnight change in drinking patterns, and people would still be influenced by alcohol marketing in other ways. Sponsorship is only one part of the marketing communications mix,⁸¹ which also includes TV advertising, merchandise, internet presence, electronic communications and positive marketing.

13. Due to the importance of alcohol sponsorship to the sports industry we request that any policy recommendations be clearly based in evidence and that further research is carried out if required.

Should sports sponsorship by drinks companies be banned?

14. Currently sponsorship (excluding TV programme sponsorship) is regulated through the Portman Group’s Code. Sponsorship can only be undertaken if at least 75% of the audience or participants are aged over 18.⁸²

15. Furthermore, the Portman Group’s Code now prevents drinks companies from putting their logos on children’s replica shirts. Although there was no evidence to link this marketing with under-age drinking, drinks companies were concerned about the negative perception surrounding their logos appearing on children’s shirts.⁸³

16. We believe that self-regulation by the industry is a proportionate approach to sport sponsorship, however we would like to see sports rights owners directly involved in reviewing the code to ensure that best practice sport solutions are considered.

CONCLUSION

17. Sport relies on sponsorship for a large proportion of its funding and this is true of both grassroots and professional sport. A high proportion of this sponsorship comes from alcoholic brands. The evidence connecting marketing to consumption is inconclusive and we ask the committee to ensure recommendations are proportionate and evidence based. Self-regulation has proved effective in this area for some time and the sport sector is keen to ensure our products are only associated with brands that promote responsible drinking. The sector would welcome being further involved in the creation of any guidance and self-regulation and ask for the sports team at DCMS be consulted when the Government considers its recommendations.

May 2012

Written evidence from the British Horseracing Authority (GAS 23)

I am writing on behalf of the British Horseracing Authority (BHA), the Governing and Regulatory body for the sport of horseracing in Britain, as well as on behalf of the wider British Racing industry to highlight both the importance of alcohol sponsorship to our sport’s funding and infrastructure and also the efforts we go to alongside such sponsorship to promote safe and responsible drinking.

The BHA recognises the importance of a responsible alcohol policy and Government having a strategy in this area, but urges the Committee make recommendations that are proportionate and take full account of their potential implications.

By way of introduction, British Horseracing is the second most popular sport in Britain in terms of attendance, with a record 6.15 million visitors to racecourses last year. There are 60 racecourses in Britain, ranging from those that host some of the nation’s biggest sporting events to far smaller local tracks that have strong and historic links to their local communities. These racecourses, coupled with the thoroughbred training and breeding industry across the country, generate an annual economic impact of some £3.5 billion and account for 100,000 direct and indirect full-time jobs, a significant proportion of which are in the rural economy.

Companies both large and small which produce alcoholic products sponsor races across the country—from blue chip sponsorships such as the John Smith’s Grand National Meeting at Aintree, the biggest race in terms

⁷⁹ Portman Group, Alcohol marketing and its regulation in the UK: A briefing note.

⁸⁰ Anderson and Baumberg (2006) Alcohol in Europe: A public health perspective (for the European Commission (p277)).

⁸¹ Hutton (1996).

⁸² Portman Group, Alcohol marketing and its regulation in the UK: A briefing note.

⁸³ *Ibid.*

of betting turnover and TV viewership each year in the UK, to smaller breweries entering deals with their local racecourses.

This funding stream is increasingly important for our sport given the recent downturn in the wider economy and the flaws—currently being tackled by Government—within our central funding stream, the Horserace Betting Levy, which has fallen by some 30% in recent years. Accordingly, any moves to restrict certain forms of marketing and sponsorship would have a damaging effect on the sport, and the economy overall, at a critical time.

British Horseracing, and the drinks companies that sponsor within it, are well aware of our corporate social responsibility, and take appropriate steps to promote a responsible drinking message. Drinkaware references are prominent within all relevant raceday marketing literature, and in this regard we would also draw a parallel to our responsibilities and strong track record in promoting a responsible gambling message to our consumers, and our links with Gamcare. Racecourses are safe and family-friendly environments—under 16s go free to the vast majority of fixtures—and our popularity with a wide range of ages and social groups has been earned by making sure we never neglect our responsibilities in this area.

By way of example, at last month's John Smith's Grand National Meeting at Aintree—as outlined above one of the major sporting and social events in the country, with over 150,000 attendees—each day's race programme had prominent adverts from both the racecourse and sponsor promoting responsible drinking and making clear where soft drinks were available. Further, on Grand National day itself, Aintree racecourse and John Smith's provided free water to racegoers and broadcast messages promoting responsible drinking on the big and CCTV screens throughout the venue.

The Racing industry acknowledges the importance of an alcohol policy which protects younger and vulnerable citizens and is not seen to glamorize drinking; the industry and our sponsors have worked closely to ensure that these products are promoted responsibly. We are committed to self-regulation and to continue working with the relevant sponsors and the Portman Group in promoting this message. Therefore, we believe that a blanket ban on alcohol sponsorship, would be disproportionate and not evidence-based.

We would be happy to provide further information and/or statistics regarding the importance of alcohol sponsorship to the Racing industry if the Committee would find it useful as part of their deliberations. I would like to thank the Committee for providing the BHA with the opportunity to represent the Racing industry's perspective on this important issue through this call for evidence and shall follow the Committee's inquiry proceedings with interest.

May 2012

Written evidence from the Baptist Union of Great Britain, the Methodist Church and the United Reformed Church (GAS 24)

1. The Baptist Union of Great Britain, the Methodist Church and the United Reformed Church are three of the largest Free Church denominations in Britain, representing around half a million Christians.
2. Our churches have extensive experience of working with those who suffer harm as a result of alcohol abuse and of contributing to the policy debate around alcohol. As a result, we wrote to the Prime Minister in January, together with the Church of England, Christian Nightlife Initiative, Street Angels and others, to express our view of the urgency of implementing a robust minimum unit price for alcohol.
3. This policy engagement is rooted our local involvement: faith groups have a strong local knowledge of the effects of alcohol misuse, and many of our churches provide counselling and other forms of support for problem drinkers.

SUMMARY

4. The main points we wish to emphasise are:
 - It is welcome that, after some years of supporting research, the Government has acknowledged the need for a minimum unit price. But it is important that the right price is chosen. Studies have suggested that 40p is about the lowest value to make minimum unit pricing worth implementing.
 - If the drinks industry's desire to have a sunset clause inserted in the legislation is granted, it is important that the trial period is sufficiently long, and that the price adopted is high enough to show the effect of minimum unit pricing clearly. This would suggest a price nearer to 50p than 40p.
 - In addition, if a minimum unit price of 45p is established for Scotland at the same time as Northern Ireland and the Republic of Ireland are agreeing a cross-border alcohol strategy, it would be logical for the price for England and Wales to be 45p or more.

- Alcohol misuse is primarily a health issue. The Department of Health should have the central role in alcohol policy, coordinating work of other involved bodies in Whitehall including the Home Office and the Department of Communities and Local Government. However, our denominations are clear that, whichever Government departments are responsible, policy should be informed by evidence-based research and guided by medical experts, as well as communities' understanding of alcohol-related harm.

RESPONSIBILITY FOR ALCOHOL POLICY

5. The Department of Health should have the prime responsibility for alcohol policy making in England and Wales (alcohol policy being devolved in Northern Ireland and Scotland). This is because the harm, particularly the physical harm caused experienced by problem drinkers, relates directly to consumption patterns. The health harms of alcohol misuse are its most serious effects; in addition, medical research is best means of gathering and analysing the data which can reveal what incentives will dissuade people from drinking too much of alcohol that is too strong.

6. To achieve this goal, it is important that the Department of Health maintains close relationships with medical experts, so that important research like that of the University of Sheffield's School of Health and Related Research (scHARR) is understood and incorporated in a timely manner.

7. However, it is clear that the Department of Health will need to work closely with the Home Office in partnership with police forces across the UK. Alcohol-related violence and disorder cost England and Wales £13 billion and the cost to society as a whole has been estimated at £17-£22 billion.⁸⁴

8. Certain regions, and certain areas within regions, suffer disproportionately from problem drinking. It is important that communities are empowered to adapt price, licensing or advertising to their local context. For this reason, measures in the Alcohol Strategy including the Late-Night Levy and early-morning Restriction Orders are encouraging: we wish to see the Government continue its work to embody its localism agenda in alcohol policy. But it is also vital that local medical statistics are available and our so that communities to understand the nature and scale of problem drinking in their areas.

DEVOLVED ADMINISTRATIONS

9. Setting the correct minimum unit price is crucial to the success of the Alcohol Strategy. This likewise relies on coordination between the prices of alcohol in the UK's nations. This may not necessarily lead to the same unit price throughout the four nations, but the prices chosen should not lead to distortions based on local economic conditions, problem drinking or factors that might lead to cross-border trade.

THE ROLE OF THE ALCOHOL INDUSTRY

10. We recognise that the drinks industry has a key role. While many churches historically promoted temperance, that stance was associated with the excessive social harm caused by alcohol misuse at that time, and our three denominations are not "anti-drink".

11. However it is regrettable that some parts of the alcohol industry seem to have chosen to dismiss the extremely solid, measured and even-handed research conducted by scHARR as well as various studies showing the links between alcohol price, consumption and harm. Our denominations would hope to see the drinks industry fulfil its potential in understanding, then supporting, recommendations based on medical research supporting the development of a culture of social responsibility associated with alcohol. This should build on the Responsibility Deal but go much further.

12. Observation of the way that medical advice has been undervalued during the health debate in recent years has led to perceptions that the interests of the alcohol industry have had a disproportionate effect on alcohol policy making. The industry has the potential to contribute to socially responsible alcohol consumption, but it should not be able to influence or determine alcohol policy as such, which is fundamentally a medical and social issue.

A MINIMUM PRICE PER UNIT OF ALCOHOL

13. The most comprehensive UK-wide research of the likely results of introducing minimum unit pricing at different prices remains scHARR's research of 2008. No comparable national study has been released subsequently, though the 2009 Scotland-specific survey contains data relevant for the debate around a 45p minimum price.

14. The misleading and inaccurate suggestion that such studies are "just modelling" and do not count as evidence for minimum pricing has rightly been rejected by health and research experts. The **in principle** case for minimum price has been made successfully and accepted by those competent to judge the research. However it is likely that the scHARR figures need to be updated.

⁸⁴ <http://www.alcoholconcern.org.uk/assets/files/PressAndMedia/state.of.the.nation.pdf>

15. The figures used by Government as initial context for the Strategy differ from some previously suggested. Recent research argues that a unit price of 40p would save 170 lives in the first year, rising to 900 a year over a 10 year period.⁸⁵ While these health gains would be enough to justify a 40p unit price, other studies have suggested different outcomes, but it is clear from the scHARR study that the health benefits of a 50p unit price were substantially higher. 40p is around the lowest minimum unit price that should be considered and 50p should be given lengthy consideration.

16. To avoid unhelpful controversy around figures, it would be useful to have upper and lower limits for the expected results on health, accidents, crime and all other relevant variables, for different categories of drinker.

17. Nonetheless, previous research strongly suggested that 40p is approximately the lowest figure that would justify minimum unit pricing as opposed to other possible policies. While basing policy proposals on the absolute lower limit is useful, there are reasons for suggesting that nearer 50p would be better.

- Scotland is discussing 45p and it would seem sensible that England and Wales should price alcohol equally or higher, rather than lower
- The danger of a 40p price is that it will not make a sufficient difference to current pricing to make the case for minimum unit pricing one way or the other. This would be disastrous as all agree that it will be important to review the results of this policy
- An article recently published in the British Medical Journal suggested that while a 40p minimum unit price would lead to 1,149 fewer alcohol-related deaths and 38,900 fewer hospital admissions, a 50p minimum price would double these beneficial results with around 2000 fewer deaths and 80,000 fewer hospital admissions.⁸⁶

18. It has often been alleged that minimum unit pricing would be illegal under European competition law. The case has yet to be tried in a court of law, and there is little evidence for the claim. In any case, the nation's health needs must take precedence of concerns around unresolved points of law. The legal challenge must be faced once it is understood that minimum unit pricing is a vital element in the Alcohol Strategy

THE EFFECTS OF MARKETING UPON ALCOHOL CONSUMPTION

19. The Alcohol Strategy contains a commitment to work with the Portman Group to ensure that brands which contravene advertising protocols are taken off the market. This is encouraging, especially as marketing targeted at young people has been implicated as a significant cause of problem drinking. But there are wider concerns:

- problem drinking is a cause of parental neglect of children, as mentioned in the letter written by a coalition of churches and charities to the Prime Minister in January 2012;⁸⁷ and
- in some respects, alcohol advertising may not only influence but also reflect elements of the UK's drink culture which need to be addressed—to focus on solely on advertising rather than the deeper question of the role alcohol plays in our society would risk treating symptoms rather than root causes.

LONGER TERM IMPACTS

20. In February 2012, leading medical experts predicted over 200,000 preventable deaths over the next 20 years as a result of alcohol misuse. Binge drinking and the role of alcohol in obesity are also significant public health issues.

21. To meet this challenge and build on the joined-up approach that the Alcohol Strategy implies, it is important that the concept of the public's health is expanded to include a stronger emphasis on harder to quantify harm including mental health, career and wellbeing.

IMPACT ON NHS CARE

22. Historically, some professionals in the substance abuse field have felt that drug treatment was significantly better resourced than alcohol treatment—perhaps because of law enforcement priorities. Yet current levels of drinking and problem drinking suggest the need to recognise that, from a rational and medical perspective, alcohol is itself a drug, but one that happens to be legal and traditional. Thus, as the Alcohol Strategy is implemented it will be important to ensure that alcohol treatment is adequately funded and that the social stigma or sense that problem drinking is primarily an individual moral failing is combated.

23. We hope that these brief comments will assist you in your inquiry.

May 2012

⁸⁵ <http://ranzetta.typepad.com/files/minimum-pricing-2012-national-strategy-infographic.pdf>

⁸⁶ Summary at: <http://info.cancerresearchuk.org/news/archive/cancernews/2012-04-17-Minimum-alcohol-pricing-would-cut-deaths-and-hospital-admissions>

⁸⁷ <http://www.jointpublicissues.org.uk/alcohol/Churches%20Alcohol%20Letter%20To%20Prime%20Minister%20Jan%202012.pdf>

Written evidence from the Advertising Standards Authority (GAS 25)

1. INTRODUCTION

1.1 This evidence is provided on behalf of the Advertising Standards Authority (ASA) and Committees of Advertising Practice, CAP and BCAP (the ASA system).

1.2 The ASA is the UK's independent regulator for ensuring that advertising in all media is legal, decent, honest and truthful, for the benefit of consumers, business and society. The system is both self-regulatory and co-regulatory.

1.3 The ASA administers the UK Advertising Codes which are written and maintained by two industry bodies, the Committee of Advertising Practice (CAP) and the Broadcast Committee of Advertising Practice (BCAP).⁸⁸

1.4 The ASA system recognises the important role that advertising regulation has to play in ensuring that advertisements are responsible and do not encourage or condone irresponsible drinking. We have consistently worked hard to achieve this, as we will demonstrate through this submission.

1.5 This submission provides:

- Our initial view on the Alcohol Strategy.
- A brief overview of the UK advertising regulatory system and how the rules are developed.
- An outline of the rules governing alcohol advertising, and recent examples of where these rules have been applied.
- An analysis of the evidence base underpinning the alcohol advertising rules.
- A summary of recent developments in alcohol advertising regulation.

1.6 The ASA would be prepared to give oral evidence to the Committee or provide further written information on request.

2. THE ALCOHOL STRATEGY

2.1 As this submission will show, the UK's alcohol advertising rules are extremely robust, having been subject to significant regulatory scrutiny in recent years in response to societal concerns about irresponsible and harmful drinking.

2.2 The Government's latest Alcohol Strategy includes three commitments that are directly relevant to our work:

- We will work with the ASA and Ofcom to examine ways to ensure that adverts promoting alcohol are not shown during programmes of high appeal to young people.
- We will work with the ASA to ensure the full and vigorous application of ASA powers to online and social media.
- We will also work with the ASA and other relevant bodies to look at the rules and incentives that might inhibit the promotion of lower strength alcohol products and the encouragement of responsible drinking behaviours.

2.3 Two of these recommendations could have significant policy implications on the way alcohol ads are regulated. Our consideration of these recommendations will be undertaken in line with widely accepted better regulation principles.

2.4 We welcome the opportunity to explore these matters with Government. Whilst it is too early to provide the Committee with detailed responses at this time, this submission will, where relevant, outline some initial thoughts.

3. OVERVIEW OF THE ASA SYSTEM

3.1 The Advertising Codes are written and maintained by two industry committees, CAP and BCAP. The ASA is the independent body responsible for administering the Codes.

3.2 As well as handling complaints, the ASA also pro-actively monitors ads on TV, radio and on the internet, across both national and local media, to make sure standards are being maintained.

3.3 March 2011 marked a major step forward for advertising regulation when the advertising industry significantly extended the ASA's remit to cover companies own marketing communications on their own websites and social media.

3.4 A year on, the remit extension has been, to date, successful and has already had some notable successes in removing inappropriate alcohol advertising (Cell Drinks, see 4.11).

3.5 The ASA is 50 years old this year, and is widely viewed as an example of a best-practice self-regulator:

⁸⁸ www.cap.org.uk

“The Government recognises the ASA as a highly successful model of both self and co-regulation; and that the UK’s advertising regulatory system is well respected and seen as a gold standard worldwide.”⁸⁹

3.6 The ASA is an integral part of the alcohol regulatory system. Our role is distinct from that of The Portman Group,⁹⁰ which regulates the naming, packaging and promotion of alcoholic drinks, as well as drinks sponsorship.

3.7 More comprehensive information about the ASA system can be found in **Annex A** and on our website at www.asa.org.uk.

3.8 How the Advertising Codes are developed

- 3.8.1 CAP and BCAP work to ensure the Advertising Codes remain relevant and fit for purpose, for example by ensuring they are responsive to new evidence and are consistent with the law.
- 3.8.2 No alcohol producers or retailers sit on either CAP or BCAP.
- 3.8.3 The rules are developed in line with Government’s better regulation principles. These require that regulation is transparent, accountable, proportionate, consistent and targeted. The Codes are designed to protect those whose circumstances put them in need of special protection, while retaining an environment in which responsible advertising can operate—to the benefit of the wider economy.
- 3.8.4 Evidence that suggests a need to amend the Advertising Codes will be carefully assessed by CAP and BCAP.
- 3.8.5 CAP and BCAP periodically review the Codes to ensure they remain fit for purpose. The last full Code Review was undertaken in 2009. At this time, the alcohol advertising rules were reviewed and subject to a full public consultation in light of the latest evidence review commissioned by the Department of Health and conducted by Sheffield University (the SchARR Review). The latest edition of the Advertising Codes came into force in September 2010.

4. REGULATION OF ALCOHOL ADVERTISING

4.1 The ASA system shares the Government’s commitment to protect society from irresponsible alcohol advertisements.

4.2 The Codes contain robust alcohol rules that sit on top of other Code provisions that require ads not to mislead, harm or cause serious or widespread offence. The rules are designed to protect society by ensuring that only responsible drinking behaviours and outcomes are seen in ads. The rules protect young people by both reducing the likelihood that they will see alcohol ads and, if they do, by ensuring the ads will not appeal strongly or particularly to them.⁹¹

4.3 The alcohol rules are comprehensive, proportionate, and based upon detailed assessments of the best available evidence of the effect of alcohol advertising on drinking behaviour (see section 5).

4.4 In summary, the rules state that alcohol ads must not:

- link alcohol with daring, antisocial, aggressive or irresponsible behaviour;
- link alcohol with seduction, sex or social success;
- show alcohol being handled or served irresponsibly; and
- show people drinking or behaving in an adolescent or juvenile way or reflecting the culture of people under 18 years of age.

4.5 In non-broadcast media (including online and in the cinema) alcoholic drinks cannot be advertised if more than 25% of the audience is under 18 years of age. On television, alcohol ads cannot be shown around programmes of particular appeal to under 18s (see 4.6).

4.5.1 The content and placement rules should be viewed alongside one another. A complete set of the rules, including an explanation of the TV scheduling tool, are included in **Annex B**.

4.6 TV scheduling rules for alcohol

4.6.1 Alcohol ads are banned from appearing in and around programmes:

- commissioned for;
- principally directed at, or
- likely to appeal particularly to those under 18 years of age.

⁸⁹ Rt Hon Jeremy Hunt MP, Secretary of State for Culture, Media and Sport, in a letter to Rt Hon Chris Smith of Finsbury, ASA Chairman, 2 March 2012

⁹⁰ <http://www.portmangroup.org.uk/?pid=1&level=1>

⁹¹ e.g. through prohibiting juvenile humour and behaviour, the use cartoon-like techniques and endorsements by people who might particularly appeal to U-18s.

- 4.6.2 Whether or not a programme is “of particular appeal” to under 18s is assessed using a statistical approach called indexing, with the end result often referred to as a programme’s Conversion Index. The approach means that even late-night programmes popular with young people cannot carry alcohol ads.
- 4.6.3 The scheduling rules have recently been reviewed in light of the latest evidence, but the Committees acknowledge the recommendation in the strategy and will be considering the issue soon.

4.7 Low-alcohol

- 4.7.1 CAP and BCAP considered the rules around the promotion of lower strength alcohol drinks as part of their 2009 review.⁹²
- 4.7.2 Prior to the latest edition of the Codes, both the radio and non-broadcast rules allowed a drink to be advertised as preferable because of its lower alcohol content.
- 4.7.3 The Committees were concerned that the rules allowed the preferential promotion of what remained intoxicating beverages, and about the risk of confusion should these drinks be deemed responsible.
- 4.7.4 Consequently, the rules were tightened to permit only low-alcohol drinks (0.5%-1.2% ABV) to be presented as preferable to other types of alcoholic beverages because of their low strength.⁹³ Drinks over 1.2% are still able to state their strength and make factual comparisons.
- 4.7.5 The latest Alcohol Strategy calls for us to “*look at the rules and incentives that might inhibit the promotion of lower strength alcohol products and the encouragement of responsible drinking behaviours*”.
- 4.7.6 CAP and BCAP will explore this area further with Government. However, whilst we recognise the intention behind incentivising the promotion of lower-strength drinks, the benefits of any liberalisation of the advertising rules must outweigh the risks previously identified by the Committees.

4.8 Compliance with the Codes

- 4.8.1 We actively check ads for compliance with the rules. Our most recent survey of alcohol ads in 2009⁹⁴ revealed a compliance rate of 99.7%.⁹⁵

4.9 Pre-clearance

- 4.9.1 TV and radio advertisements are centrally pre-cleared by Clearcast⁹⁶ and the Radio Advertising Clearance Centre (RACC)⁹⁷ respectively. Clearcast and RACC approval does not, however, prevent the ASA from acting to remove ads that it considers to be problematic.
- 4.9.2 Cinema advertising also has a pre-clearance mechanism, which is provided by the Cinema Advertising Association (CAA).⁹⁸

4.10 Complaints

The ASA receives relatively few complaints about alcohol advertising. In 2011 the ASA received 336 complaints (out of a total of 31,458) about 179 alcohol ads (out of a total of 22,397). So alcohol ads comprised just 0.8% of all those complained about.

4.11 Examples of ASA action

- 4.11.1 Below are links to four recent ASA alcohol adjudications, full details of which are available on our website.⁹⁹
- AB InBev UK Ltd (Apr 2012)—The ASA concluded that a radio ad for Budweiser beer linked alcohol to sexual success and therefore breached the Code.
 - Cell Drinks (Aug 2011)—In a social media first, the ASA decided that these YouTube ads, featuring a free-runner jumping around and over buildings, would appeal particularly to young people and that the ad was in breach of the Code.
 - WM Magners Ltd (Feb 2009)—The ASA concluded that the ad breached the Code by suggesting alcohol would boost confidence and lead to the success of a social occasion.

4.12 Sanctions

⁹² <http://www.cap.org.uk/CAP-and-BCAP-Consultations/Closed-consultations/~media/Files/CAP/Consultations/BCAPConsultationdocumentandAnnex1.ashx>

⁹³ CAP Code rule 18.9. BCAP Code rule 19.10.

⁹⁴ Alcohol Advertising Survey 2009

⁹⁵ The result was an improvement on the compliance rate of 98.9% from the 2008 survey and 97.4% from the 2007 survey.

⁹⁶ <http://www.clearcast.co.uk/>

⁹⁷ <http://www.racc.co.uk/racc/showCategories.aspx?catID=1>

⁹⁸ <http://www.cinemaadvertisingassociation.co.uk/> Among other things, the CAA ensures that alcohol ads do not appear before films with an under 18 audience 25% or more of the total audience.

⁹⁹ <http://www.asa.org.uk/ASA-action/Adjudications.aspx>

- 4.12.1 Advertisers cannot opt out of the ASA system. It is not voluntary. Compliance with both the rules and ASA decisions is mandatory.
- 4.12.2 When advertisers do get it wrong, they face both financial loss from having an ad campaign pulled, and damage to their reputation through the publication of an upheld ASA adjudication.
- 4.12.3 In the rare event of an advertiser refusing to amend or withdraw their ad following an ASA adjudication, or in the event of a particularly serious breach, the system has a range of sanctions available to it to enforce its decisions, details of which can be found at www.asa.org.uk.

5. THE EVIDENCE BASE

5.1 The UK's relationship with alcohol is widely acknowledged to stem from a complex range of factors—including but not limited to socio-economic group, family influences and peer pressure.

5.2 In March 2004 the Government's Alcohol Harm Reduction Strategy concluded, "*There is no clear case of the effect of advertising on behaviour*". However, the strategy did highlight a possible link between young people's awareness and appreciation of alcohol advertising and their propensity to drink.

5.3 The Strategy recommended that Ofcom (who was at the time directly responsible for TV advertising regulation) should oversee a review of the TV alcohol advertising rules. In parallel with Ofcom's consultation, CAP reviewed its own non-broadcast alcohol rules.

5.4 Consequently, in 2005 the broadcast and non-broadcast alcohol advertising rules were significantly tightened, in recognition of the evidence of a possible link between young people's awareness of alcohol advertising and their attitudes to drinking. Any robust evidence that we have seen published since that date simply endorses that existing evidence base, but does not point to a stronger link to that which had been identified in 2004.

5.5 The alcohol rules were reviewed again in 2009, taking account of the latest Department of Health commissioned evidence (the SchHARR Review) and subject to a full public consultation. In so far as the SchHARR review related to advertisements, it did not offer persuasive evidence to support proposals to restrict alcohol advertising further. CAP and BCAP's assessments of the SchHARR Review evidence are available on CAP's website.¹⁰⁰

5.6 Other studies considered by CAP and BCAP as part of the 2009 Code Review, including that by the European Alcohol & Health Forum's Science Group (SGEAHF),¹⁰¹ had common methodological problems.¹⁰² CAP and BCAP's evidence-based approach requires it to look objectively at the balance of the evidence. None of these studies provided persuasive evidence that alcohol ads contribute to alcohol-related harms (beyond the possible link identified in 2004) or that further restrictions, on top of those already in place, would lead to a reduction in alcohol-related harm.

5.7 Further restrictions on alcohol ads must be proportionate and evidenced-based. If evidence is presented to CAP and BCAP that demonstrates a compelling case for a reconsideration of the rules, CAP and BCAP will act accordingly, as it has done in the past.

6. CURRENT/FUTURE ACTIVITIES

6.1 Perhaps the biggest challenge facing the ASA today is the pace at which media is changing; ads are reaching consumers on new platforms and in different ways. The Government's alcohol strategy recognises this development, and calls on the ASA to ensure the advertising rules are applied robustly online and to social media. The ASA is alive to this challenge, and is determined to ensure that online marketing material is regulated with the same sense of social responsibility as that in traditional media.

6.2 The ASA's new online remit is subject to a two-year review. The review will consider the applicability of the UK Code of Non-broadcast Advertising, Sales Promotion and Direct Marketing, including its alcohol rules, to online marketing communications, to ensure they are effective and provide adequate protection.

6.3 Separately, CAP is preparing to undertake a project researching young people's experience of advertising on social media. This research will help provide a clear understanding of the types of ads young people see on social networking sites, and will enable the ASA system to identify where and whether regulatory action is required.

¹⁰⁰ <http://www.cap.org.uk/CAP-and-BCAP-Consultations/Closed-consultations/BCAP-Code-Review-consultation/~/media/Files/CAP/New%20Codes%20Evaluation%20Tables/BCAP%20Evaluation%20Section%2019%20Alcohol.ashx>

¹⁰¹ http://www.tekry.fi/web/pdf/misc/Eptv_Scientific-opinion-on-marketing-communication.pdf

¹⁰² Most referred to evidence previously included in the SchHARR review, rather than offering anything new. Sometimes such evidence cherry-picked those studies that supported a particular hypothesis, but ignored the wider balance of evidence. Many were conducted in the US where the regulatory environment for alcohol advertising is very different from that in the UK. Not all of the studies reviewed looked at the relationship between advertising and consumption, but instead considered other types of influences on young people, such as film, music and videos.

7. SUMMARY

7.1 The alcohol advertising rules administered by the ASA are comprehensive and robust.

7.2 Complaints by the public about alcohol advertising are few (despite high public awareness of the advertising regulator) and advertiser compliance with the rules is high.

7.3 Having recently taken on the regulation of websites and social media, the ASA and CAP continue to work to identify emerging regulatory issues (particularly in new media).

7.4 The rules must remain evidence-based and proportionate. If policy makers have concerns about the strength of the rules in place, we are open to receiving and considering representations supported with appropriate evidence.

May 2012

Annex A

ABOUT THE ASA ONE-STOP SHOP

1. The ASA is the UK self-/co-regulatory body for ensuring that advertising in all media is legal, decent, honest and truthful, for the benefit of consumers, business and society. It does this by administering the UK Advertising Codes.

2. The Committee of Advertising Practice (CAP) and the Broadcast Committee of Advertising Practice (BCAP) are the industry bodies responsible for writing and maintaining the UK Advertising Codes. CAP writes and maintains the UK Code of Non-Broadcast Advertising, Sales Promotion and Direct Marketing and BCAP writes and maintains the UK Code of Broadcast Advertising.¹⁰³

3. The system is both self-regulatory (for non-broadcast advertising eg press, poster, cinema, online, video-on-demand (VOD) services and direct mail) and co-regulatory (for TV and radio advertising). For non-broadcast advertising this means that advertisers, agencies and media have come together to write the UK Code of Non-broadcast Advertising, Sales Promotion and Direct Marketing (the CAP Code) and have set up the ASA as an independent body to judge whether ads breach the Code. There is no formal Government involvement in the system. On the rare occasions we are unable to secure compliance with the rules on unfair, aggressive and misleading advertising in non-broadcast media we can refer advertisers to the OFT for further regulatory action under B2C and B2B laws.

4. For broadcast advertising we operate under a co-regulatory partnership with Ofcom. This means that we have a contract with Ofcom which gives us day-to-day responsibility for maintaining standards and for acting on complaints about TV and radio ads. Broadcasters are obliged to comply with the BCAP Code under their broadcast licences. Non-compliant broadcast advertisers can be referred to Ofcom. The Government's proposals do not impact upon this arrangement.¹⁰⁴

5. The Advertising Codes sit within a legal framework, which means that, where appropriate, they reflect the standards required in law, eg misleading and unfair advertising. However, they may also contain rules that go beyond legal requirements, such as those relating to harm, offence and social responsibility.

6. The ASA deals with more than 25,000 complaints per year and operates at no cost to the tax payer. In fact the system is entirely funded, voluntarily, by the advertising industry, by a levy on paid-for advertising.

7. The ASA is committed to upholding high standards in advertising. The system takes a 360° approach to regulation, which includes pro-active monitoring, comprehensively enforced rules and training and advice for advertisers on the requirements of the Codes.

8. The system is entirely funded by industry, through a levy of 0.1% on display advertising space and airtime and 0.2% on Royal Mail Mailsort contracts. The levies are collected by two arm-length funding bodies, the Advertising Standards Board of Finance (Asbof) and the Broadcast Advertising Standards Board of Finance (Basbof).¹⁰⁵ Last year the ASA was awarded £8 million to run the system.

9. The ASA "one-stop shop" advertising regulatory system brings great benefits for consumers and for business:

- **Easier for consumers**—The establishment of a single complaints body has made it easier for consumers to complain.
- **Free to the taxpayer**—Because it is funded by industry.
- **Simpler regulatory structure for advertisers**—and cheaper for business than seeking resolution through the courts.
- **Harmonious decision making**—Cross media adjudications are made by a single organisation.

¹⁰³ The Advertising Codes can be found at: <http://www.cap.org.uk/cap/codes/>

¹⁰⁴ Agreed through a formal Memorandum of Understanding (MOU), with the Deregulation and Contracting Out Act 1994 (DCOA) as the legal function that enables the partnership

¹⁰⁵ www.asbof.co.uk

- **Corporate Social Responsibility**—Effective self-regulation works because the advertising industry has a strong interest in maintaining a level playing field for business and consumer trust in advertising.

10. Further information about the ASA and the work we do can be found at www.asa.org.uk. The website also contains a searchable database of all our adjudications from the past five years.

Annex B

THE ALCOHOL RULES

To note: As well as adhering to the alcohol specific rules, alcohol advertisers must also adhere to the general Code provisions, that all ads must not mislead, harm or offend. The full Advertising Codes can be accessed on the CAP website at www.cap.org.uk.

THE UK CODE OF NON-BROADCAST ADVERTISING, SALES PROMOTION AND DIRECT MARKETING (CAP CODE)

Principle

Marketing communications for alcoholic drinks should not be targeted at people under 18 and should not imply, condone or encourage immoderate, irresponsible or anti-social drinking.

The spirit as well as the letter of the rules applies.

Definition

The rules in this section apply to marketing communications for alcoholic drinks and marketing communications that feature or refer to alcoholic drinks. Alcoholic drinks are defined as drinks containing at least 0.5% alcohol; for the purposes of this Code low-alcohol drinks are defined as drinks containing between 0.5% and 1.2% alcohol.

Where stated, exceptions are made for low-alcohol drinks. But, if a marketing communication for a low-alcohol drink could be considered to promote a stronger alcoholic drink or if the drink's low-alcohol content is not stated clearly in the marketing communications, all the rules in this section apply.

If a soft drink is promoted as a mixer, the rules in this section apply in full.

These rules are not intended to inhibit responsible marketing communications that are intended to counter problem drinking or tell consumers about alcohol-related health or safety themes. Those marketing communications should not be likely to promote an alcohol product or brand.

Rules

18.1 Marketing communications must be socially responsible and must contain nothing that is likely to lead people to adopt styles of drinking that are unwise. For example, they should not encourage excessive drinking. Care should be taken not to exploit the young, the immature or those who are mentally or socially vulnerable.

18.2 Marketing communications must not claim or imply that alcohol can enhance confidence or popularity.

18.3 Marketing communications must not imply that drinking alcohol is a key component of the success of a personal relationship or social event. The consumption of alcohol may be portrayed as sociable or thirst-quenching.

18.4 Drinking alcohol must not be portrayed as a challenge. Marketing communications must neither show, imply, encourage or refer to aggression or unruly, irresponsible or anti-social behaviour nor link alcohol with brave, tough or daring people or behaviour.

18.5 Marketing communications must neither link alcohol with seduction, sexual activity or sexual success nor imply that alcohol can enhance attractiveness.

18.6 Marketing communications must not imply that alcohol might be indispensable or take priority in life or that drinking alcohol can overcome boredom, loneliness or other problems.

18.7 Marketing communications must not imply that alcohol has therapeutic qualities. Alcohol must not be portrayed as capable of changing mood, physical condition or behaviour or as a source of nourishment. Marketing communications must not imply that alcohol can enhance mental or physical capabilities; for example, by contributing to professional or sporting achievements.

18.8 Marketing communications must not link alcohol to illicit drugs.

18.9 Marketing communications may give factual information about the alcoholic strength of a drink. They may also make a factual alcohol strength comparison with another product, but only when the comparison is with a higher strength product of a similar beverage.

Marketing communications must not imply that a drink may be preferred because of its alcohol content or intoxicating effect. There is an exception for low-alcohol drinks, which may be presented as preferable because of their low alcoholic strength. In the case of a drink with relatively high alcoholic strength in relation to its category, the factual information should not be given undue emphasis.

18.10 Marketing communications that include a sales promotion must not imply, condone or encourage excessive consumption of alcohol.

18.11 Marketing communications must not feature alcohol being handled or served irresponsibly.

18.12 Marketing communications must not link alcohol with activities or locations in which drinking would be unsafe or unwise.

Marketing communications must not link alcohol with the use of potentially dangerous machinery or driving. Marketing communications may feature sporting and other physical activities (subject to other rules in this section; for example, appeal to under-18s or link with daring or aggression) but must not imply that those activities have been undertaken after the consumption of alcohol.

18.13 Only in exceptional circumstances may marketing communications feature alcohol being drunk by anyone in their working environment.

18.14 Marketing communications must not be likely to appeal particularly to people under 18, especially by reflecting or being associated with youth culture. They should not feature or portray real or fictitious characters who are likely to appeal particularly to people under 18 in a way that might encourage the young to drink. People shown drinking or playing a significant role (see rule 18.16) should not be shown behaving in an adolescent or juvenile manner.

18.15 Marketing communications must not be directed at people under 18 through the selection of media or the context in which they appear. No medium should be used to advertise alcoholic drinks if more than 25% of its audience is under 18 years of age.

18.16 People shown drinking or playing a significant role must neither be nor seem to be under 25. People under 25 may be shown in marketing communications, for example, in the context of family celebrations, but must be obviously not drinking.

18.17 Marketing communications may give factual information about product contents, including comparisons, but must not make any health, fitness or weight-control claims.

The only permitted nutrition claims are “low-alcohol”, “reduced alcohol” and “reduced energy” and any claim likely to have the same meaning for the consumer.

THE UK CODE OF BROADCAST ADVERTISING (BCAP CODE)

Principle

Advertisements for alcoholic drinks should not be targeted at people under 18 years of age and should not imply, condone or encourage immoderate, irresponsible or anti-social drinking.

The spirit as well as the letter of the rules in this section applies.

Definitions

The rules in this section apply to advertisements for alcoholic drinks and advertisements that feature or refer to alcoholic drinks. Alcoholic drinks are defined as those containing at least 0.5% alcohol; for the purposes of this Code low-alcohol drinks are defined as drinks containing between 0.5% and

1.2% alcohol.

Where stated, exceptions are made for low-alcohol drinks. But, if an advertisement for a low-alcohol drink could be considered to promote a stronger alcoholic drink or if the low-alcohol content of a drink is not stated clearly in the advertisement, all the rules in this section apply.

If a soft drink is promoted as a mixer, the rules in this section apply in full.

The rules are not intended to inhibit responsible advertisements that are intended to counter problem drinking or tell consumers about alcohol-related health or safety themes. Those advertisements should not be likely to promote an alcohol product or brand.

Rules

19.1 Radio Central Copy Clearance—Radio broadcasters must ensure advertisements for alcoholic drinks are centrally cleared.

Rules that apply to all advertisements

19.2 Advertisements must not feature, imply, condone or encourage irresponsible or immoderate drinking. That applies to both the amount of drink and the way drinking is portrayed.

References to, or suggestions of, buying repeat rounds of alcoholic drinks are not acceptable. That does not prevent, for example, someone buying a drink for each member of a group. It does, however, prevent any suggestion that other members of the group will buy a round.

19.3 Advertisements must neither imply that alcohol can contribute to an individual's popularity or confidence nor imply that alcohol can enhance personal qualities.

19.4 Advertisements must not imply that drinking alcohol is a key component of social success or acceptance or that refusal is a sign of weakness. Advertisements must not imply that the success of a social occasion depends on the presence or consumption of alcohol.

19.5 Advertisements must not link alcohol with daring, toughness, aggression or unruly, irresponsible or antisocial behaviour.

19.6 Advertisements must not link alcohol with sexual activity, sexual success or seduction or imply that alcohol can enhance attractiveness. That does not preclude linking alcohol with romance or flirtation.

19.7 Advertisements must not portray alcohol as indispensable or as taking priority in life.

Advertisements must not imply that drinking can overcome problems or that regular solitary drinking is acceptable.

19.8 Advertisements must not imply that alcohol has therapeutic qualities. Alcohol must not be portrayed as capable of changing mood, physical condition or behaviour or as a source of nourishment. Although they may refer to refreshment, advertisements must not imply that alcohol can improve any type of performance.

19.9 Advertisements must not link alcohol to illicit drugs.

19.10 Advertisements may give factual information about the alcoholic strength of a drink. They may also make a factual alcohol strength comparison with another product, but only when the comparison is with a higher strength product of a similar beverage.

Advertisements must not imply that a drink may be preferred because of its alcohol content or intoxicating effect. There is an exception for low-alcohol drinks, which may be presented as preferable because of their low alcoholic strength.

In the case of a drink with relatively high alcoholic strength in relation to its category, the factual information should not be given undue emphasis.

19.11 Advertisements may include alcohol sales promotions but must not imply, condone or encourage immoderate drinking.

19.12 Advertisements must not feature alcohol being handled or served irresponsibly.

19.13 Advertisements must not link alcohol with the use of potentially dangerous machinery or driving.

Advertisements may feature sporting and other physical activities (subject to other rules in this section) but must not imply that those activities have been undertaken after the consumption of alcohol.

19.14 Advertisements must not normally show alcohol being drunk by anyone in their working environment.

Rules that apply to alcohol advertisements

19.15 Television only—Alcohol advertisements must not:

19.15.1 be likely to appeal strongly to people under 18, especially by reflecting or being associated with youth culture or showing adolescent or juvenile behaviour

19.15.2 include a person or character whose example is likely to be followed by those aged under 18 years or who has a strong appeal to those aged under 18.

19.16 Radio only—Alcohol advertisements must not:

19.16.1 be targeted at those under 18 years or use a treatment likely to be of particular appeal to them.

19.16.2 include a person or character whose example is likely to be followed by those aged under 18 years or who has a particular appeal to those aged under 18.

19.17 Alcohol advertisements must not feature in a significant role anyone who is, or seems to be, under 25 and must not feature children.

An exception is made for advertisements that feature families socialising responsibly. Here, children may be included but they should have an incidental role only and anyone who seems to be under the age of 25 must be obviously not drinking alcohol.

19.18 Advertisements for alcoholic drinks may give factual statements about product contents, including comparisons, but must not make any health claims, which include fitness or weight-control claims.

The only permitted nutrition claims are “low alcohol”, “reduced alcohol” and “reduced energy” and any claim likely to have the same meaning for the audience.

Scheduling of Television and Radio Advertisements

32.1 Broadcasters must exercise responsible judgement on the scheduling of advertisements and operate internal systems capable of identifying and avoiding unsuitable juxtapositions between advertising material and programmes, especially those that could distress or offend viewers or listeners.

Under-18s

32.2 These may not be advertised in or adjacent to programmes commissioned for, principally directed at or likely to appeal particularly to audiences below the age of 18:

32.2.1 alcoholic drinks containing 1.2% alcohol or more by volume (see rule 32.4.7)

AUDIENCE INDEXING

How does Ofcom define “of particular appeal to under-18s”?

The term “of particular appeal” is an approach that has been used for many years to ensure broadcasting regulation is appropriately targeted. This is the same approach used in restricting the scheduling of alcohol advertising.

Whether a programme is “of particular appeal” to the under 18s is assessed using a statistical approach called indexing and the end result is what is often referred to as a programme’s Conversion Index.

If the proportion of children aged 10–15 watching a programme is more than 20% higher than the proportion of the UK television population watching the programme (or in other words, a programme achieves a Conversion Index of 120 or higher), the programme is defined as one which attracts a significantly higher than average proportion of viewers in that age group.

Calculation

A Conversion Index is based on audience viewing figures measured by BARB (Broadcasters’ Audience Research Board Ltd).

Each programme achieves a TVR (Television Rating). The TVR measures the popularity of a programme by comparing its audience to the TV population as a whole.¹⁰⁶

One TVR is numerically equivalent to one% of a target audience. So for example, if Programme X achieves a rating of 10TVRs based on children aged 10–15, this would mean the average child audience of the programme is equal to 10% of all children aged 10–15 in television households.

A Conversion Index is calculated by comparing a programme’s TVR based on one audience (in this case children aged 10–15 years) with that of the base audience (all viewers).¹⁰⁷ This comparison demonstrates the extent to which children aged 10–15 are attracted to a particular programme.

Example 1

Programme A achieves a Child (aged 10–15) rating of 5TVRs and an All Viewer rating of 3TVR. The following calculation would provide us with the Conversion Index:

Conversion Index of Programme A= 14

Formula: Child TVR x 100 = Conversion
Index

All Viewer TVR

Example: 5 TVRs x 100 = 167
3 TVRs

The proportion of Children aged 10–15 watching Programme A is 67% higher than the proportion of the UK television population watching the programme (a Conversion Index of 167). This programme is therefore defined as one which is of particular appeal to under 18s.

¹⁰⁶ BARB figures are based on TV homes. If the programme in question is broadcast on the terrestrial channels, the TVR would be based on the Network, or the number of viewers living in TV households in the UK. If the programme is broadcast on a non-terrestrial channel, the TVR would be calculated based on the Multichannel Network, or the number of viewers living in multichannel television households in the UK.

¹⁰⁷ The BARB definition of all viewers is Individuals aged 4 or over. As per footnote 4, if the programme is broadcast on the terrestrial channel, the index would be based on the TVR figures for Children and All Viewers living in TV households in the UK. If the programme is broadcast on a non-terrestrial channel, the index would be based on the TVR figures for Children and All Viewers living in multichannel TV households in the UK

Example 2

Programme B achieves a 10–15 rating of 10TVRs and an All Viewer rating of 14TVRs. The following calculation would provide us with the Conversion Index:

Conversion Index of Programme B=

Formula: $\frac{\text{Child TVR} \times 100}{\text{All Viewer TVR}} = \text{Conversion Index}$

Example: $\frac{10 \text{ TVRs} \times 100}{14 \text{ TVRs}} = 71$

The proportion of Children aged 10–15 watching Programme A is 29% lower than the proportion of the UK television population watching the programme (a Conversion Index of 71). This programme does not attract a significantly higher than average proportion of Child viewers, and therefore is not said to be of particular appeal to this audience.

May 2012

Written evidence from the National Heart Forum (GAS 26)

ABOUT THE NATIONAL HEART FORUM

The National Heart Forum (NHF) is a leading charitable alliance of 70 national organisations working to reduce the risk of coronary heart disease and related conditions such as stroke, diabetes and cancer. NHF is both a UK forum and an international centre for chronic disease prevention. Our purpose is to co-ordinate public health policy development and advocacy among members drawn from professional representative bodies, consumer groups, voluntary and public sector organisations. Government departments have observer status. The views expressed here do not necessarily reflect the opinions of individual members of the forum. The National Heart Forum is a member of the Alcohol Health Alliance.

1. SUMMARY POINTS

- The NHF welcomes The Government’s Alcohol Strategy (the “Strategy”) and its acknowledgement of the harms associated with current levels of alcohol consumption in England.
- NHF is concerned that relatively too little emphasis is given to the health hazards of long term excessive drinking, including chronic disease and alcohol dependence, compared to the social problems of binge drinking.
- NHF welcomes the commitment to request the CMO review alcohol guidelines, but we would urge the Government to ensure complete independence from the alcohol industry in determining those guidelines.
- NHF supports the introduction of minimum unit pricing (MUP) and would like to see a Government levy on any surplus company profits from MUP used to support alcohol harm reduction programmes.
- Measures to reduce the impact of alcohol marketing are disappointingly weak or absent from the Strategy. NHF would like to see Government action to introduce a version of the French *Loi Evin* which strictly limits the nature and volume of alcohol marketing.
- We are not satisfied that voluntary actions by the industry will deliver adequate and consistent information on alcohol product labels and would recommend mandatory standardised labelling for all alcohol products.

2. UNDERSTANDING THE RISKS OF HARMFUL ALCOHOL CONSUMPTION

2.1 Excess alcohol consumption is an established risk factor for chronic diseases including cardiovascular disease, many cancers (including cancer of the breast, bowel and liver) and liver disease. Smoking and alcohol consumption combined account for three quarters of cancers of the mouth, pharynx and oesophagus. The Strategy is an important step forward in addressing these negative impacts of alcohol consumption in England.

2.2 The Strategy focuses on the effects of young people binge drinking, and the social disorder caused by excessive alcohol consumption. The NHF would like to see this **focus to be equitably balanced to better acknowledge the long term health harms** of excessive alcohol consumption, including chronic disease and alcohol dependence.¹⁰⁸

2.3 There is a large section of the population that is consuming well over the recommended limits, often in their own homes, and storing up problems (and demand for services) for the future.¹⁰⁹ NHF is concerned by the low public awareness of the harmful impact of alcohol and the **lack of actions and investment to address**

¹⁰⁸ National Institute for Health and Clinical Excellence. Alcohol-use Disorders: Preventing the Development of Hazardous and Harmful Drinking: PH24. London: NICE, 2010.

¹⁰⁹ National Institute for Health and Clinical Excellence. Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence. Clinical Guideline 115. London: NICE, 2011.

the significant proportion of the population who regularly drink at or above published guidelines over a sustained period of time, which can lead or contribute to a range of chronic illnesses.

2.4 The Government must ensure that the alcohol industry is not involved in the **review of alcohol health guidelines by the Chief Medical Officer**.

3. AVAILABILITY OF CHEAP ALCOHOL

3.1 Deep discounting and heavy promotion of alcohol in the on- and the off-trade has made drinking more affordable. NHF is encouraged by the recognition in the Strategy that affordability is a major factor in driving levels of excessive consumption and associated health harms.

3.2 The NHF supports the proposal for a minimum unit price (MUP) for alcohol. MUP is particularly important in helping to address alcohol consumption's contribution to avoidable chronic diseases and will primarily target harmful and hazardous drinkers, with comparatively little impact on the spending of moderate drinkers.¹¹⁰ Once implemented, it will be essential to establish an effective mechanism for reviewing and adjusting the MUP over time to account for inflation and rising disposable incomes. [2.8]¹¹¹

3.3 **The level at which MUP is set must take into account the evidence of effectiveness**, specifically, modelling research which shows that an MUP of 45p or 50p/unit will have a significantly greater impact than 40p/unit.¹¹² The decision should also take account of policy in Scotland and certainly be set no lower than the Scottish MUP when this is determined.

3.4 The NHF **strongly supports the call for a consultation on multi-buy promotions** in the off-trade and suggests that any ban should include multi-buy discounts in the on-trade as well as the off-trade. [2.9]

3.5 We disagree with the Strategy and contend that **the Government should introduce a levy on any surplus profits from MUP and use this money to support alcohol harm reduction programmes**, barring any industry involvement in its management. We note that when asked about tobacco, there is majority public support for hypothecated price increases (Beyond Smoking Kills 2008). One possible use for funds for such a levy would be to reinvest in specialist alcohol treatment services, an area of need previously identified by the Health Select Committee.¹¹³ [2.11]

4. ALCOHOL MARKETING AND ADVERTISING

4.1 The Strategy lacks strong Government action to address the gaps and weaknesses in the current controls of the marketing and advertising of alcohol products. A key weakness of current codes is that they fail to protect children and young people from alcohol marketing because they are narrowly framed around “targeting” of marketing messages, not “exposure” to those messages. Marketing channels which are very popular with children and young people are either exempted or fall outside the existing codes and include social networking sites, sports sponsorship and point of sale marketing.

4.2 Self-regulatory organisations like the Portman Group acknowledge the limits inherent in self-regulation, saying that if the rules are too stringent, then signatories may fail to comply with them. The explicit trade off between profitability and public protections severely limits the capacity of voluntary codes to function as proportionate response to the current crisis of alcohol health harm in the UK when more rigorous measures are evidently needed.¹¹⁴

4.3 It is our view that the strongest model of regulating alcohol marketing is one in which government establishes a regulatory framework and robust standards independent of industry, which focus on reducing exposure to all forms of marketing activity.

4.4 **The NHF recommend a UK adapted version of *Loi Evin***—a French regulatory framework that allows alcohol marketing and promotion only in media where adults are at least 90% of the audience. The *Loi Evin* model—which is the basis for the Private Members’ Alcohol Marketing Bill introduced by Sarah Wollaston MP in 2011—provides a simple framework that can offer clarity on what marketing practices are and are not allowed. Under this model, the promotion of alcohol would be explicitly restricted to: media that adults use; at point of sale in licensed premises; and at local producer events.

4.5 **As an interim measure, the NHF calls for an independent evaluation of controls on alcohol marketing and advertising**—not one linked to an industry lobby group such as the Portman Group. Excess alcohol consumption is of prime public health importance and the National Institute for Health Research could be an appropriate body to commission an evaluation of industry marketing and advertising practices. [2.12]

¹¹⁰ Purhouse, R et al, 2009. Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group.

¹¹¹ [] indicate associated section(s) of The Government’s Alcohol Strategy.

¹¹² Meier, P et al, 2012. Model-based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland using the Sheffield Alcohol Policy Model (v 2). University of Sheffield—Alcohol Minimum Price Modelling Research: Second Update

¹¹³ Health Committee, First Report of Session 2009–10, Alcohol, House of Commons 151-I, 2010.

¹¹⁴ Hastings, G, Brooks, O, Stead, M, Angus, K, Anker, T, & Farrell, T 2010. Failure of self regulation of UK alcohol advertising. *BMJ*, 340.

5. INDUSTRY'S RESPONSIBILITIES

5.1 The NHF welcomes the acknowledgement in the Strategy that “industry needs and commercial advantages have too frequently been prioritised over community concerns.”¹¹⁵ However, NHF remains concerned that the Strategy reinforces existing roles and structures for inappropriate industry involvement. To address this conflict of interest, the NHF recommends that industry contributes to public health initiatives via a truly independent charity or blind trust. The high extrinsic costs to society caused by alcohol harm are borne by the public purse. It is justifiable that the alcohol industry should be expected to contribute to meeting these costs on the basis that the “polluter must pay”.

5.2 NHF is not satisfied that the provision of adequate, consistent labelling of alcohol products will be achieved through voluntary commitments from the drinks industry. Under the Responsibility Deal, only 80% coverage is pledged by the end of 2013 and this does not yet include calorie labelling. **We would like to see Government action to introduce mandatory standardised labels on alcohol products** that incorporate unit content, CMO health guidelines and messages, calorie labelling and directions to independent health information.

5.3 The NHF recommends that the Government ensure a fully independent and transparent review of the industry-funded Drinkaware and its effectiveness. [4.10]

5.4 In line with WHO recommendations, **business operators should not be involved in setting public health policy priorities**.¹¹⁶ All programmes and policies should be subject to proactive monitoring and independent evaluation, including those with private investment.

May 2012

Written evidence from St Mungo's (GAS 28)

St Mungo's has been opening doors for homeless people since 1969. We currently run over 100 projects, providing accommodation for more than 1,700 people every night and helping thousands more who are rough sleeping or at risk of homelessness. St Mungo's delivers a range of residential services from emergency shelters to semi-independent flats, as well as non-residential health, education and employment services. We also prevent homelessness through our housing advice programmes.

St Mungo's services are based on a recovery approach and we aim to work in partnership with clients in a personalised, effective way. Our clients often have complex problems that cause, or are caused by, homelessness; we deliver holistic support to help people rebuild their lives.

1. OVERVIEW

1.1 We welcome the opportunity to contribute to the Health Select Committee Inquiry on the Government's Alcohol Strategy and would be delighted to provide further details if required. We have consulted with our clients to inform this response.

1.2 Our client group, single homeless people, are far more likely to be dependent drinkers than the general population. According to our latest client needs survey, 44% of our hostel residents regularly use alcohol problematically, and over two thirds of these have done so for over five years. For many of these clients alcohol dependency is part of a comorbidity, accompanied by illicit drug use, physical illness or mental health problems.

1.3 In the six months from September 2011 to February 2012 alcohol was a factor in over half of the ambulance call-outs to our projects. Research undertaken in partnership with the Marie Curie research team supports our own findings that alcohol-related liver disease is a primary cause of death for over half of the clients who die within our projects.¹¹⁷ Many clients in our services for older people who are dependent on alcohol suffer from alcohol-related brain damage, which causes irreversible damage and in some cases death.

1.4 We believe that the Alcohol Strategy should be a driving force in reducing the harm that alcohol causes to our clients, who are damaged and killed by alcohol.

2. KEY POINTS:

2.1 St Mungo's supports plans to introduce a minimum price per unit, but believes that this should be at 50 pence per unit as recommended by Alcohol Concern,¹¹⁸ rather than 40 pence.

2.2 The introduction of a minimum price per unit needs to be accompanied by a significantly improved provision of services for dependent drinkers to mitigate these risks. Our clients who are alcohol dependent require long term interventions that reduce the harm caused by alcohol.

¹¹⁵ Home Office, The Government's Alcohol Strategy. 2012:3

¹¹⁶ World Health Organization. The World Health Report 2002: reducing risks, promoting healthy life. Geneva: WHO, 2002.

¹¹⁷ St Mungo's and Marie Curie (2011) Supporting homeless people with advanced liver disease approaching the end of life

¹¹⁸ Alcohol Concern (2012) Briefing paper—The Government's Alcohol Strategy

2.3 It is vitally important that investment in alcohol treatment services is protected in NHS and public health reforms.

2.4 Government should expect and support the alcohol industry to do more to meet the costs that alcohol inflicts on society. St Mungo's strongly believes that any extra revenue that the industry earns from the introduction of a minimum price per unit should be directed towards services that support dependent drinkers.

3. Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role.

3.1 It appears to be clear from previous Government publications and announcements that the Department of Health will have responsibility for both the clinical and public health aspects of alcohol policy:

- According to the Government's Drug Strategy, the functions of the National Treatment Agency for Substance Misuse (NTA) currently include "helping to improve the provision of services for severe alcohol dependence."¹¹⁹ The functions of the NTA will be transferred in to Public Health England, which will sit within the Department of Health, from April 2013.
- In addition, s.2 of Health and Social Care Act 2012 makes it clear that the Secretary of State has a duty to secure continuous improvement in the quality of services for or in connection with the prevention, diagnosis or treatment of illness, or the protection or improvement of public health.

3.2 St Mungo's therefore understands that from April 2013 onwards the Department of Health, and ultimately the Secretary of State, will be responsible for improving the provision of services for severe alcohol dependence as well as alcohol-related public health policy.

3.3 The Health and Social Care Act 2012, s.4 states that the Secretary of State for Health is also responsible for reducing "inequalities between the people of England with respect to the benefits that they can obtain from the health service." It is widely acknowledged that people with substance use issues and psychiatric disorders experience worse outcomes than people with a single disorder,¹²⁰ the Secretary of State for Health must therefore accept responsibility for addressing this problem.

3.4 We believe that Public Health England must ensure that Local Authorities work with the NHS to commission better services for people who are dependent on alcohol. Public Health England can work towards this through its role in jointly appointing Directors of Public Health, as well as through the information it shares with local authorities and the evidence base that it builds.

3.5 Current investment in drug and alcohol treatment will represent up to half of the public health budget that will be allocated to local authorities and directors of public health. Given that drug and alcohol treatment is identified as one of seventeen public health responsibilities for Health and Wellbeing Boards, and the Public Health Outcomes Framework includes only three drug and alcohol specific indicators out of sixty six, we are extremely concerned that there will be disinvestment in drug and alcohol services.

3.6 We would like to introduction of transitional protection within the ring-fenced public health budget for a minimum of two years from April 2013 to allow drug and alcohol treatment time to "bed into" public health and secure sufficient investment to deliver the 2010 Drug Strategy.¹²¹

3.7 We would also welcome further clarification of the relationship between public health and criminal justice agencies. For example, how Police and Crime Commissioners and Community Safety Partnerships will be represented in the planning and commissioning of drug and alcohol services. We would also like to know how integrated offender management can be pursued when responsibility for prison treatment lies with under the NHS Commissioning Board, rather than public health bodies.

4. The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group.

4.1 In 2007 it was estimated that revenue from alcohol sales was £33.7 billion.¹²² A portion of this revenue comes from people who are suffering considerable harm from alcohol, including our clients, some of whom are being killed by cheap strong cider and lager.

4.2 The economic costs of health care, anti-social behaviour and criminal justice associated with hazardous and harmful alcohol use are huge. The Prime Minister has suggested that the total cost to society from alcohol is between £17 and £22 billion per annum.¹²³ We believe that alcohol producers share a large part of the responsibility for these costs, particularly as it is estimated that they spend £800 million a year promoting their

¹¹⁹ Home Office (2010) Drug Strategy, p19

¹²⁰ National Institute of Clinical Excellence (NICE) (2011) Psychosis with coexisting substance misuse: NICE clinical guideline p.120

¹²¹ This recommendation is taken from a letter from Drugscope to Theresa May and Andrew Lansley co-signed by St Mungo's Chief Executive, Charles Fraser.

¹²² British Medical Association (2009) Under the Influence

¹²³ <http://www.number10.gov.uk/news/alcohol-on-nhs/> (retrieved 27 April, 2012)

products.¹²⁴ The Government should ensure that the Portman Group are be more proactive in taking action against producers who market their products in a way that encourages harmful and hazardous drinking.

4.3 We would like the Government to work with alcohol producers and retailers to ensure that the industry contributes more to meeting the costs that alcohol inflicts on society. We believe alcohol producers and retailers should contribute to a fund that is used to support alcohol treatment and accommodation services.

4.4 There is evidence that introducing a minimum price per unit would substantially increase the revenue of alcohol producers and retailers.¹²⁵ St Mungo's believes that the Government should ensure this additional revenue is directed towards services that support those who are dependent on alcohol rather than, for example, on increased advertising and marketing.

5. The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing.

5.1 Cheap alcohol, in particular white cider, kills our clients. Research carried out by Alcohol Concern with St Mungo's illustrates the damaging effects that white cider has on our clients.¹²⁶ It is currently possible to buy "White Ace" cider at around 17 pence per unit. If it is assumed that a maximum weekly intake of alcohol is 28 units, it is possible to drink the weekly recommended limit of alcohol for £4.76, while a single three litre bottle contains over five and a half times the recommended daily limit.¹²⁷

5.2 In interviews with staff and clients the following effects of drinking white cider were mentioned: "*reduces appetite, dulls conscience, eventually unconsciousness; wake up shaking, no appetite; sleep deprivation, takes over the day; pain in back, really bad heartburn; makes me drunk and nauseous; tummy aches, not pleasant; makes me feel invincible, so more likely to get into fights.*"¹²⁸

5.3 St Mungo's supports the introduction of a minimum price per unit, however, we believe that the minimum fixed price should be 50 pence, rather than 40 pence. A bottle of cider containing 22.5 units would cost £11.25 if a minimum price per unit of 50 pence were introduced. This would make a three litre bottle of White Ace almost three times more expensive, which is likely to significantly reduce the amount that our clients drink.

5.4 We do not believe that a minimum price per unit would stop dependent users of alcohol from drinking, but do believe that it would encourage them to reduce the amount of strong alcohol that they drink or switch to weaker drinks, reducing the harm caused.

5.5 Research carried out by the University of Sheffield in 2008 found that a minimum price per unit could reduce the number of admissions to hospital due to alcohol by 97,000 each year. The study also found minimum price per unit of 50 pence would also have the most dramatic effect, compared to a range of other measures, on reducing admissions of people with a harmful pattern of alcohol consumption.¹²⁹

5.6 Although introducing a minimum price per unit of 50 pence would affect people who didn't necessarily use alcohol problematically, St Mungo's believes that these costs are outweighed by the benefits that would be achieved through reducing harmful drinking.

5.7 Our clients told us that introducing a minimum price per unit could also bring significant risks, for example homemade or "black market" alcohol could become more common and dependent drinkers may spend a higher proportion of their income on alcohol instead of food. They may also turn to street drugs. The introduction of a minimum price per unit needs to be accompanied by a significantly improved provision of services for dependent drinkers to mitigate these risks.

5.8 Our clients also told us that there are not enough residential detox, rehab or services that can support dependent drinkers' recovery, and that those that were available were often not appropriate for our client group. As stated above, the Government should expect the increased revenue from the introduction of a minimum price per unit for the alcohol industry to contribute towards the funding of these services.

6. Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm.

6.1 The Government appears to have recognised that services are not available for tens of thousands of people who are alcohol dependent and need support to recover.¹³⁰ Although investment is needed urgently, we are yet to see any solid proposals around how this problem will be addressed. We are concerned that central

¹²⁴ Gordon, R and Harris, F (2009) "Critical social marketing: Assessing the impact of alcohol marketing on youth drinking" International Journal of Non Profit Voluntary Sector Marketing 15(3), pp. 265-275

¹²⁵ Institute for Fiscal Studies (2010) Briefing note 109: The Impact of Introducing a Minimum Price on Alcohol in Britain

¹²⁶ Alcohol Concern (2011) White cider and street drinkers

¹²⁷ A three litre bottle of White Ace cider retails at £3.89 (price is printed on the bottle's labelling) and contains 22.5 units (as of April 26, 2012)

¹²⁸ Alcohol Concern (2011) White cider and street drinkers

¹²⁹ Meier, P et al. (2008) Independent Review of the effects of alcohol pricing and promotion: Part B

¹³⁰ Inter Ministerial Working Group on Drugs (2012) Putting Full Recovery First

Government's ability to deliver this investment will be curtailed as the assessment of need and decisions on commissioning are all taken locally.

6.2 It is right that there is a focus on integrated services. People who are dependent on alcohol often have a range of complex needs that require holistic support, not a disparate collection of needs that can be treated sequentially. This is especially true for our clients, our latest client needs survey shows that 42% of our clients with an alcohol problem also have a mental health problem and 50% have a significant medical condition.

6.3 NICE guidance makes clear that there should be services tailored to maximise engagement with the homeless population due to the extra complications that working with this group can bring.¹³¹ However, our clients often have to wait for weeks or months to access rehab services and our staff report that it is becoming more difficult for them to secure access to services.

Adam—St Mungo's Client

6.4 Adam came into a St Mungo's emergency shelter after sleeping rough. On entering the shelter, a substance use worker identified an urgent need for him to attend in-patient alcohol detox followed by residential rehab. Referrals to both of these services were made in January 2011. Adam was also had mental health issues and was an occasional user of heroin and crack.

6.5 Adam could not be admitted into the alcohol detox service until it was established that he could go to straight to residential rehab upon discharge. The way in which Adam used alcohol meant that it would have been unacceptably dangerous for him to be discharged straight back into the community after losing his tolerance to alcohol.

6.6 There is a great demand in London for the relatively few residential rehab services that are willing to admit people with Adam's range of problems. The earliest date that Adam was able to secure for an assessment that could have confirmed he could enter rehab following detox was on Monday, 28 March. Adam died from a suspected heroin overdose on Saturday 26 March.

6.7 We believe that the Alcohol Strategy is severely lacking in the key area of recovery—the Government needs to clarify how alcohol services in the reformed system can be improved for those who are most in need. Our severely dependent clients require a pathway of support that includes in-patient detox, residential rehab and post-rehab residential support. These services are routinely being cut back as a result of funding cuts, and specialist workers are laid off.

6.8 There is a need for innovative services that can help our clients to make a sustained recovery from alcohol dependence; we have a significant number of clients who have “successfully” completed detox and rehab over five times. There is a particular need for Tier Three A services that can act as “pre-treatment rehab”, which could work with other issues such as mental health or social integration simultaneously; and Tier Five services offering supported discharge from formal programmes, thereby aiding a smooth transition to alcohol dependency-free living in the community.

6.9 There is evidence that personal budgets can lead to improved outcomes through giving homeless people choice and control not offered by standard offers of support,¹³² we believe that personalised health and social care budgets for homeless dependent drinkers should be piloted.

6.10 We support calls made by the Chief Executive of the National Treatment Agency for local authorities and the NHS to pool their resources to expand specialist alcohol treatment to meet this gap in service provision.¹³³ Public Health England must also ensure that Directors of Public Health and local Clinical Commissioning Groups are aware of these gaps and have the expertise to commission appropriate services.

6.11 St Mungo's experience shows that service-user involvement can quickly and efficiently improve services. We strongly believe that people with experience of drug and alcohol dependency should be included in the commissioning process.

May 2012

¹³¹ National Collaborating Centre for Mental Health (2011) Alcohol use disorders: NICE clinical practice guideline 115, p.38

¹³² Joseph Rowntree Foundation (2011) Providing personalised support to rough sleepers. See also <http://homeless.org.uk/homeless-personalisation-pilots> (retrieved 27 April, 2012)

¹³³ <http://www.nta.nhs.uk/news2012-PH-LGA-alcohol.aspx> (retrieved 27 April, 2012)

Written evidence from Royal College of Nursing (GAS 29)

1.0 INTRODUCTION

1.1 With a membership of more than 410,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1.2 The RCN welcomes the Health Select Committee's decision to hold an inquiry into the Government's alcohol strategy and is pleased to have the opportunity to submit written evidence.

2.0 EXECUTIVE SUMMARY

2.1 The RCN general election manifesto of 2010, *Nursing counts*,¹³⁴ called for the introduction of a single mandatory code to better regulate the drinks industry and to minimise the dangers and health care costs associated with excessive drinking. This mandatory code would include a minimum unit price. Therefore, the RCN broadly welcomes the Government's intention to move in this direction.

2.2 The RCN believes that a minimum unit price is key to tackling the increasing problem of excessive alcohol consumption and the impact this has on the health of the nation.

2.3 Tackling alcohol misuse and its effects upon the general public should be seen as a priority across Government and not the sole responsibility of one department. As well as a drain upon the NHS, the effects of alcohol misuse are seen in schools, prison services and the welfare system.

2.4 Nurses are the health workers who have the most interaction with patients. They are ideally placed to carry out early interventions and to educate patients about the dangers of excessive alcohol consumption.

2.5 Nurses working in Accident and Emergency departments and elsewhere in the NHS, are often exposed to inebriated patients who unfortunately frequently turn violent.

2.6 We welcome the focus upon binge drinking and acknowledge the damage that this causes to individuals. However, the strategy, in order for it to truly tackle the issue of excessive alcohol consumption, should also focus on the chronic health impact of alcohol consumption on long-term moderate to high drinkers.

2.7 Any alcohol industry code must be mandatory as past voluntary codes have proved to be ineffective. The Government must maintain oversight and accountability for adherence to any regulatory alcohol code.

2.8 A disproportionate amount of those individuals who succumb to illnesses related to excessive alcohol consumption, such as liver disease, come from the most deprived areas of England.

3.0 *Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role.*

3.1 The RCN accepts that the scale of alcohol related harm in the UK means that alcohol misuse is an issue which naturally falls within the remit of a number of Government departments, for example those covering (but not limited to) health, crime and disorder and welfare. We therefore both support and encourage Departments outside the Department of Health to prioritise efforts to reduce alcohol related harms. For example, we engaged with and supported the changes made by the Home Office to the licensing regime in 2011 to shift the balance in favour of public health promotion.¹³⁵

3.2 However, we note that within the recently published alcohol strategy, the foreword by the Prime Minister focuses on tackling alcohol misuse as a problem of crime and violence, and clamping down on "binge drinking". The strategy was issued by the Home Office, which suggests that their remit of crime and licensing is the dominant area of concern for the Government. In contrast, the previous Government's strategy document *Safe, Sensible, Social* in 2007 was issued jointly by the Home Office and the Department of Health.¹³⁶

3.3 The RCN agrees that binge drinking is harmful to health in both the short and long term, and can result in acute injuries requiring medical care. Nurses working in Accident and Emergency departments, and elsewhere in the NHS, also fall victim to alcohol-fuelled violence.¹³⁷ We therefore support efforts to reduce binge drinking and anti-social and violent behaviour.

3.4 However, we believe that the UK's alcohol misuse problem must be primarily framed as a problem resulting in acute and chronic health harms, and we urge the Government to focus on the huge health toll that alcohol misuse takes on individuals, families and communities in the long-term. Whilst premature death from heart disease and stroke has reduced in recent years, deaths from liver disease have increased. By focusing on

¹³⁴ RCN General Election Manifesto campaign *Nursing Counts*—<http://generalelection.rcn.org.uk/>

¹³⁵ http://www.rcn.org.uk/__data/assets/pdf_file/0006/339270/RCN_response_to_Rebalancing_the_licensing_Act_Sept2010.pdf

¹³⁶ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_075218

¹³⁷ http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/SecurityManagement/2009-10_Physical_Assaults_Against_NHS_Staff_FINAL_241110.pdf

binge drinking and its impacts, the strategy therefore fails to recognise the chronic health impacts on long-term moderate to high drinkers. It is preferable to focus energy and resources on preventing alcohol misuse, rather than building a strategy around penalising poor or criminal behaviour related to that misuse.

3.5 We also note that Government strategy is not always as joined up as it could be. For example, during the legislation to alter the Licensing Act, the RCN and other experts in public health argued that there should be a fifth licensing objective on the “prevention of health harm”. This would have empowered relevant authorities to make licensing decisions which specifically take into account the protection of the current and future health of their communities. However, the recommendation was not included in the final legislation and represents a missed opportunity to align health, crime and anti social behaviour objectives.

3.6 We support the alcohol strategy’s stated commitment to tackling the root causes of alcohol abuse and support plans to introduce a minimum price per unit of alcohol. However, tackling these root causes of alcohol abuse also means understanding the cultural role that alcohol plays in society, and supporting people to make healthier choices in a number of ways. This might include regulation where necessary (for example on price, labelling and promotions); health promotion and education activities; and also investing in the professional workforce which can support behaviour change.

3.7 Nurses are the biggest group of health care professionals in the NHS, and as such have significant numbers of opportunities for teachable moments with patients each day. The nursing workforce can play a substantial role to identify and support people with alcohol misuse problems (eg alcohol liaison nurses in acute settings). They can also offer health promotion advice and signpost people to further support as well as to help ensure integrated care across the system, where people may have complex needs.

4.0 Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol.

4.1 As an organisation which represents nurses and nursing across the four countries of the UK, the RCN supports the principle that each country should have the power to initiate its own policies to improve public health, independently of others, where necessary.

4.2 We also believe there is value in learning lessons where other countries have implemented innovative public health policies. Scotland was the first country in the UK to introduce smoke free public places, and will be the first to implement the minimum price per unit for alcohol. The rest of the UK can use the evidence generated by the Scottish Government for example, the updated research commissioned from the University of Sheffield, as well as benefit from any learning points which result from evaluation of the policy’s implementation and effectiveness.

4.3 We further understand that in Northern Ireland there have been discussions with the Republic of Ireland about synchronising legislation on minimum pricing for alcohol, an example of public health “knowing no borders”.

5.0 The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group.

5.1 The RCN acknowledges that there is a role for everybody, including the alcohol industry, in tackling alcohol misuse in the UK. The industry for example, should commit to behaving more responsibly in the way alcohol is promoted. However, we believe ultimate accountability for the strategy to reduce harm caused by alcohol misuse should not rest with the alcohol industry, but with the Government.

5.2 There are examples that demonstrate the failure of the alcohol industry to date to take the appropriate voluntary action. For example, in 2010 the RCN responded to a consultation on whether mandatory alcoholic drinks labelling should be introduced.¹³⁸ Independent evidence published alongside this consultation showed that the industry had failed to establish a widely used, comprehensive and consistent alcohol information system, despite pledging to do so. The RCN and others therefore argued that the industry had failed to meet its commitments and that there should be a mandatory alcohol code, which would include a mandatory labelling system. This was not implemented.

5.3 In 2011, during discussions about the alcohol pledges being made by the industry as part of the Public Health Responsibility Deal, key stakeholders in improving public health were concerned at the level of commitment, ambition and monitoring attached to the pledges. As such many stakeholders refused to endorse them, including the RCN and other Royal Colleges. The RCN believes the Government must listen to the concerns of public health experts and for any future agreements achieve buy-in and support from all sectors and professionals.

5.4 The RCN believes that we need to support the population to make healthier choices and we know that empowering people with the right information helps them to change their lifestyle. However, people do not make decisions in a vacuum. The wider environment plays an important role, and the work of health

¹³⁸ http://www.rcn.org.uk/_data/assets/pdf_file/0003/323157/Options_for_improving_information_on_the_labels_of_alcoholic_drinks.pdf

professionals in helping people to improve their own health is undermined by the proliferation of cheap, readily available alcohol and inconsistent messages about the impact of alcohol on health.

5.5 We believe that whilst the alcohol industry should be encouraged to behave more responsibly, it should be acknowledged that there are limitations to the role industry can play in reducing alcohol harm. It is inevitable that the interests of the industry, who wish to profit from the sale of alcohol, and public health will not always align. Therefore the Government must maintain oversight of and accountability for the alcohol strategy, by taking regulatory action where necessary (for example on price) and strictly monitoring voluntary pledges taken by the industry. Where the industry is found to have failed in these pledges, the Government should step in to regulate without delay.

6.0 *The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing.*

6.1 The RCN supports the conclusions of the modelling developed by the University of Sheffield¹³⁹, first in 2008 and updated in 2012.

6.2 Nurses witness the impact of dangerous and excessive consumption of alcohol every day. For RCN members the problem is too urgent not to take every available step to tackle the issue, including addressing price. In a survey of RCN members carried out in 2009,¹⁴⁰ 81% of respondents believed that if alcohol was more expensive there would be a decrease in consumption. We have therefore been calling for the Government to introduce a minimum price per unit across the UK for some time and were keen to support the efforts of the Scottish Government to introduce a minimum price per unit.

6.3 The recently updated University of Sheffield research found that a minimum price of 45p a unit would reduce consumption by 4.3%. There would be a fall in hospital admissions of 6,630 within ten years and a reduction of 1,000 acute and 260 chronic illnesses in the first year.¹⁴¹

6.4 RCN notes that some parties have expressed concern that a minimum price would penalise people who drink responsibly. However, findings from Sheffield University suggest that whilst a harmful drinker would pay an extra £132 a year, a moderate drinker would only be £9 a year worse off if a minimum price was introduced.¹⁴² We therefore support the presumption that people who are only drinking moderate amounts, within recommended guidelines, will not be disproportionately impacted by a minimum price.

6.5 We are not suitably placed to comment on the legalities of minimum unit pricing.

7.0 *The impact that current levels of alcohol consumption will have on the public's health in the longer term.*

7.1 Excessive alcohol consumption is a major source of morbidity and premature death in the UK. The World Health Organisation lists alcohol as the third leading risk factor for premature death in developed countries, with only tobacco and blood pressure causing more premature death and disability.¹⁴³

7.2 Alcohol misuse can cause and contribute to a range of illnesses and diseases including, but not limited to, liver damage, brain damage, stroke, heart disease and cancer. It can also lead to dependency and other mental health problems. Alcohol inebriation is also associated with individuals taking greater risks during sexual encounters, including failure to take safer sex precautions.

7.3 Premature death from liver disease is rising, in contrast to many other chronic diseases. Whilst available statistics suggest that, as a nation, we drink less than we once did, there is still a significant minority who are drinking at dangerous levels which will have inevitable consequences.

7.4 Figures released in 2012 show that the number of people who died from liver disease in England rose by 25% in the last decade.¹⁴⁴ The report by the NHS National End of Life Care Programme also showed that liver disease disproportionately affects younger age groups with 90% of people who die from the disease being aged under 70. Statistics show that three times as many deaths from alcoholic liver disease occur in the most deprived areas of England, compared with the least deprived.

8.0 *Whether the proposed reforms for the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm?*

8.1 The RCN notes that in England the Government provides no specific money to the NHS for alcohol treatment in comparison with other cessation and prevention services such as those provided for drug abuse. We are concerned about a lack of clarity around the provision of alcohol programmes. We know that a number of service commissioners will be involved and responsibilities shared across the various NHS commissioning bodies as well as local Government and crime and youth offending bodies. This may create barriers to

¹³⁹ University of Sheffield, Alcohol Research Group <http://www.sheffield.ac.uk/scharr/sections/ph/research/alpol/publications>

¹⁴⁰ Royal College of Physicians and Royal College of Nursing Survey on Alcohol Treatment Services, 2009

¹⁴¹ University of Sheffield, Alcohol Research Group <http://www.sheffield.ac.uk/scharr/sections/ph/research/alpol/publications>

¹⁴² University of Sheffield, Alcohol Research Group <http://www.sheffield.ac.uk/scharr/sections/ph/research/alpol/publications>

¹⁴³ World Health Organisation (2002), *World Health Report: Reducing Risks, Promoting Healthy Life.*

¹⁴⁴ <http://www.nhs.uk/news/2012/03march/Pages/liver-disease-death-alcohol-increase.aspx>

integrated and collaborative working. For example, whilst Local Authorities will pick up some responsibility for commissioning to reduce alcohol harm, the new Police and Crime Commissioners will also have some responsibilities in this area, as will Probation Trusts. In addition, the NHS Commissioning Board will have some responsibilities for prison health services which will include alcohol programmes; and Clinical Commissioning Groups will likewise have some responsibilities for NHS services. Services designed for young people will also be divided between commissioners from the NHS as well as youth offending teams.

8.2 We believe the situation for the planning and integration of services for alcohol programmes will become more, rather than less, complicated. Furthermore, the above examples focus on treatment rather than prevention services. The role of Public Health England in health promotion and prevention of alcohol misuse is still unclear.

8.3 In the current environment of financial constraint, with the NHS required to save £20 billion and local authorities also making huge savings, the RCN is concerned that alcohol services could potentially fall through the gaps between different commissioners. Whilst welcoming the Government's focus upon alcohol misuse within the strategy, it is vital that the desired outcomes are robustly monitored and sufficient Government focus remains during the delivery of the strategies aims.

May 2012

Written evidence from Newcastle City Council and Newcastle Primary Care Trust (GAS 30)

1. *Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role.*

2. We have found that one when a single government department leads on alcohol policy then the focus naturally becomes skewed towards the priorities of that department. The current strategy published by the Home Office, has a strong criminal justice focus and is about enforcement interventions and less about the health, wellbeing and social interventions that are required for individuals in active addiction to recover. Whereas the Department of Health's policy position of "nudging" behaviour change would not necessarily meet the objectives of the Home Office. As action is required across a number of government departments with often competing priorities and objectives, then this requires the agreement of a shared policy direction for alcohol and leadership at the highest level ie the Cabinet Office to make this happen.

3. *Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol.*

4. We welcome the accelerated progress of devolved administrations on alcohol policy, in particular on the affordability of alcohol, which we believe has been instrumental in prompting action in England on minimum unit price (MUP). Population level interventions such as addressing advertising, availability and affordability need to be coordinated across the whole of the UK. Without this, there is the issue of cross boundary access to cheaper products/advice as well as the potential to widen health inequalities.

5. *The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group.*

6. The Alcohol Industry should not be involved in the setting of alcohol policy or its implementation as this presents a direct conflict of interest. There are many examples showing why this is inappropriate:

- 6.1.1 The industry appears to have had a key role in setting alcohol policy such as proposing the banning of the sale of alcohol below cost plus VAT where there is research that this will be ineffective in reducing alcohol consumption.¹⁴⁵
- 6.1.2 The industry has been frustratingly slow in complying with the alcohol labeling pledges under the Responsibility Deal.
- 6.1.3 The industry has been aggressively and highly critical of minimum unit pricing for alcohol and the impact of alcohol advertising on young people when there is a long standing, international, robust and credible evidence base.
- 6.1.4 Drinkaware's website has recommended a "daily alcohol allowance" rather than "low risk limits" which could give the public the impression that it is recommended to drink alcohol on a daily basis which is contrary to Department of Health advice.

7. The Mainstreaming Health Promotion Project¹⁴⁶ which carried out a rapid review of the current evidence for health promotion actions for hazardous and harmful alcohol use, with specific reference to low- and middle-income countries; identified evidence which showed self-regulation by means of industry voluntary codes was found not to prevent the exposure of younger people to alcohol marketing.

¹⁴⁵ Price Discounts on Alcohol in a City in Northern England—Adams and Beenstock December 2011

¹⁴⁶ Mainstreaming health promotion project—rapid review of current evidence for health promotion actions for hazardous and harmful alcohol use, with specific reference to low- and middle-income countries, Bador et al June 2011

8. Balance the North East Regional Alcohol Office has developed work which provides a helpful thought process for policy makers to go through when deciding if it is appropriate to work locally with industry. This could provide a model of working with the industry at a national level.

9. *The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing.*

10. Newcastle City Council¹⁴⁷ along with all the Councils in the North East Region¹⁴⁸ fully support the introduction of a national MUP for alcohol and will continue to campaign for its introduction. Balance recently completed a survey of supermarkets in the North East which showed that alcohol was available for as little as 16p per unit. It is not responsible drinkers that are drinking cheap alcohol but our children and young people and individuals drinking at harmful levels.

11. The introduction of a national MUP would also level the playing field for local community pubs which have been closing on a regular basis and have been adversely affected by the sale of low cost alcohol particularly from supermarkets.

12. The School of Health and Related Research at Sheffield University identified that the introduction of a MUP of 50p per unit would:

- reduce the number of deaths from alcohol related causes by more than a quarter;
- reduce the number of crimes by 46,000;
- reduce hospital admissions by almost 100,000; and
- save the county an estimated £1 billion a year.

13. Sheffield University has recently re-modeled the impact of a MUP which continues to show that the higher the minimum price is then the greater the harm reduction and this goes up steeply. The modeling found there to be relatively little effect for a 25p minimum price, but 40p, 50p and 60p have increasing effects. It is important to recognise the impact of changes to the price of alcohol as a result of inflation and deflation. Therefore the MUP level will require continuous monitoring to ensure it continues to achieve the desired reduction in consumption.

14. This study also showed that the introduction of a MUP would be most effective in reducing consumption amongst young people and the most harmful drinkers who are most likely to be drinking at harmful levels. Those drinking moderately or at low risk limits would only be marginally affected.

15. *The effects of marketing on alcohol consumption, in particular in relation to children and young people.*

16. We are particularly concerned about the impact of alcohol advertising on children and young people. That is why the Council has supported the North East campaign See What Sam Sees. This campaign aims to raise awareness of how much young people are exposed to alcohol advertising on a daily basis. Alcohol Concern¹⁴⁹ monitored television advertising and found that during the period of the research there was a rising number of alcohol adverts shown from 3pm to 5pm which coincides with the time when most children arrive home from school.

17. Studies¹⁵⁰ consistently suggest that exposure to media and commercial communications on alcohol is associated with the likelihood that adolescents will start to drink alcohol at a younger age and they go on to drink more.

18. A report by Alcohol Concern¹⁵¹ highlights the issue of social networking sites such as Facebook, You Tube and Twitter which are hugely popular with under 18's. According to Ofcom¹⁵² almost half of children aged 8–17 years of age who use the internet have set up their own profile on a social networking site. Despite age verification gateways, these sites are popular with young people and alcohol brand websites often include interactive games, competitions and videos which appeal to young people. It has been reported that in 2009 online alcohol advertising expenditure overtook television expenditure for the first time. The National Alcohol Strategy is currently silent on this issue.

19. *The impact that current levels of alcohol consumption will have on the public's health in the longer term.*

20. Rather than quote national statistics of which the Health Select Committee will already be familiar, we have highlighted the perspective from local health practitioners:

¹⁴⁷ Notice of Motion at Newcastle City Council 7 September 2011 Minute Number 59

¹⁴⁸ Association of North East Councils Regional Leaders and Elected Mayors March 2012

¹⁴⁹ Alcohol Concern—Not in front of the children Child Protection and Advertising

¹⁵⁰ Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies Anderson, de Bruijn, Gordon and Hastings and studies by Snyder et al., 2006; Anderson et al., 2009,

¹⁵¹ New media, new problem? Alcohol, young people and the internet Alcohol Concern 2011

¹⁵² Ofcom: Engaging with social networking sites

- Dr Chris Record a liver specialist from Newcastle University and Newcastle Hospitals has reported that only a few years ago alcoholic liver disease was very unusual in people in their early 30s, now many patients are presenting with terminal liver disease in Newcastle in their late-20s and early-30s.
- Our alcohol specialist nurses who were told when training that they would be unlikely to see a case of Korsakoff's syndrome¹⁵³ during their career, report seeing one or two cases a year.

21. Alcohol related health issues can be prevented and therefore a significant proportion can be avoided. There needs to be integrated alcohol care pathway from prevention and early identification through to specialised treatment and recovery, with sufficient resource to staff and manage the populations' needs.

22. Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services.

23. As a result of increased alcohol assumption incidence of liver related mortality in the UK has approximately trebled since 1970 and continues to escalate, this is in contrast with apparent declines in most other European countries. Liver transplantation is one treatment option to manage the symptoms of liver cirrhosis with approximately 500–600 adult liver transplants undertaken each year. Liver transplants cost in the region of £60,000—£80,000 for the transplant procedure itself, the initial hospital stay after transplantation and the costs incurred in lifelong medical follow-up, investigations and immunosuppressive medications. This is a significant financial cost to the NHS.¹⁵⁴

24. As described earlier, we are seeing increasing numbers of younger people in their late 20's and 30's with complex health problems as a result of their drinking. This can result in costs to adult social care for residential, personal home care or supported housing which can continue throughout their lifetime. There are also the increasing costs of looked after children where the main reasons for child referrals being related to domestic violence (where 50% of cases involved alcohol) and parental substance misuse.

25. Without a reduction in alcohol consumption, these costs will continue to escalate.

26. Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm.

27. The transfer of commissioning responsibilities for alcohol treatment services to local authorities provides an opportunity to pool resources currently spent on alcohol harm eg social care and supported housing. If the ring fencing of funding for the drug treatment systems is removed it will also present the opportunity for the commissioning of a more integrated treatment system for people who misuse both drugs and alcohol and to rebalance resources locally in recognition of the needs of the population. Whilst there are clearly some similarities in the drugs and alcohol agenda in terms of treatment, recovery, the links with crime and social problems, it is important that the distinctions are also recognised: such as the legality and social acceptability of these substances, and the different demographic profile of people who misuse alcohol in isolation compared with those who also misuse drugs. If this distinction is lost then treatment pathways may not meet the needs of people needing treatment services.

28. It is also essential to have close working relationships with Clinical Commissioning Groups to develop a shared responsibility for the care of this population across multiple service providers. This relationship is critical to be an effective integrated approach.

29. International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking, such as:

30. Public health interventions such as education and information;

31. Education and information should not be seen as a stand alone intervention because by itself it is relatively ineffective. Instead it should be an element of a coordinated alcohol strategy incorporating: social marketing promotional campaigns such as Change4Life, enforcement, screening and brief advice as well as signposting into effective and integrated care pathways. At a local level we should also be supporting national direction regarding minimum pricing and banning advertising to children

32. Children and young people

33. There is a need to have more robust evidence on the most effective interventions to work with young people, especially within the school setting. Newcastle University are part of a large trial researching the impact of alcohol brief intervention and advice within a school setting (Junior SIPS). The results from this research are eagerly awaited.

34. There is stronger evidence to demonstrate the importance of thinking about alcohol in the context of risk taking behavior. Therefore the links with sexual health services is essential and should be prioritized locally.

¹⁵³ A neurological disorder caused by a lack of thiamine in the brain linked to chronic alcohol abuse

¹⁵⁴ Alcohol Use & Liver Transplantation—Alcohol Learning Centre

35. The work on social norms for young people has been proven to be effective in a number of settings. Working with higher education institutions such as universities regarding the social norms of alcohol is vital alongside working with local landlords regarding targeting promotional offers to students, especially during Freshers weeks for new university entrants.

36. *Universal and targeted messages*

37. There are certain elements of the population who will be more receptive to a health message at a certain point in their life. These “teachable moments” are an opportunity to discuss changing health behaviors and have been well researched. Pregnancy or planning for a baby is one of those teachable moment opportunities and should be optimized at a local level through consistent messages about how alcohol can cause harm to the developing baby.

38. The SIPS alcohol screen and brief intervention research¹⁵⁵ looked at a range of different methods of screening and brief intervention across settings A&E, Primary Health Care and Probation. This identified the value of brief intervention and advice and the benefits of having a structured conversation about alcohol with a trained professional. Universal application of alcohol screening and brief advice within a primary care setting has demonstrated effectiveness and should be part of standard care within primary care. The research also found that in some settings a patient information leaflet was also found to be the most effective intervention.

39. *Reducing the strength of alcoholic beverages;*

40. We are not aware of any studies relating to reducing alcohol strength, but would suggest that the introduction of a national MUP should logically lead to a halt in the upward drift in product strength that has occurred over many years and maybe even lead to reductions in product strength in due course—but this has not really been investigated empirically.

41. *Raising the legal drinking age;*

42. The Mainstream Health Promotion Project referred to earlier¹⁵⁶ found that measures that restricted the affordability, availability and advertising of alcohol had evidence of effectiveness. With regard to young people it found that laws which raised the minimum purchase age reduced alcohol sales provided they were at least minimally enforced. There was also strong evidence that this approach would have substantial impacts on reducing road traffic accidents and other casualties if the purchase age were changed.

May 2012

Written evidence from Pharmacy Voice (GAS 31)

SUMMARY

1. **Pharmacy IBAs** Identification and Brief Advice (IBA) services delivered through community pharmacies are an effective way of raising awareness of alcohol risks with large numbers of people, including those who are not regular users of other health services

2. **Communication** Members of the public see community pharmacies as a non-threatening environment in which to seek or receive advice relating to alcohol consumption and other public health issues

3. **Public health** Alcohol IBAs can be incorporated into wider pharmacy-based public health initiatives, including “Healthy Living Pharmacies”. This builds on the training and experience that pharmacy staff already have

4. **Commissioning** Some PCTs have commissioned IBAs from pharmacies, and evidence shows that the services are effective, however, there are difficulties in delivering the service consistently because of variations in specifications, accreditation and payment

5. **Specification** The establishment of Public Health England gives the opportunity to design a single national specification for pharmacy-based IBAs. Using this as the basis for commissioning by local authorities would be more cost-effective and efficient and allow for a wide-scale roll out of IBAs

PHARMACY INTERVENTIONS AND ALCOHOL HARM REDUCTION

In this response, we are confining our comments to one specific area of the Government’s Alcohol Strategy. Under the heading “Evidence based action on health harms” [Alcohol Strategy, p15], it says:

3.24 Local authorities and clinical commissioning groups will need to work together to meet local needs as identified in the Joint Strategic Needs Assessment. Funding through the public health grant will allow local authorities to commission identification and brief advice, which is proven to be effective in reducing the drinking of people at risk of ill health...

¹⁵⁵ SIPS Research Factsheets

¹⁵⁶ Para 7

3.25 Local areas should work in partnership to support as much integration across clinical pathways as possible, maximising the scope for early interventions...

Pharmacy Voice would like to wholeheartedly endorse this section of the Strategy and we would like to set out evidence that clearly demonstrates how pharmacy can play an active and important part in delivering identification and brief advice (IBA) as part of its role in public health. We also want to set out how this could be made more effective and efficient, through the setting of a national service specification.

Community pharmacies are a place where members of the public feel comfortable asking advice about alcohol consumption. “Can I still drink alcohol while taking these tablets?” is a question that pharmacists hear every day. Pharmacy customers also expect to be asked questions about their own health by pharmacists or pharmacy staff, including on alcohol consumption, and these can lead to suitable “brief advice” conversations.

Pharmacies are perceived as a non-threatening healthcare environment. Customers can seek advice from a pharmacist or trained member of the pharmacy team at a time of their own convenience and without appointment. Many pharmacies are open for extended hours and at weekends.

Pharmacies have extremely high footfalls. Those located within shopping destinations and supermarkets see many customers, such as young women and working age men, who do not regularly visit GP surgeries or other healthcare providers. This provides an opportunity to spread public health messages to a much wider audience.

The ability of pharmacist and their staff to deliver alcohol related IBAs has been proven in a number of studies. Many primary care trusts are already commissioning such services from pharmacies. Details of some of these are given below.

WINDSOR AND MAIDENHEAD

A Pharmacy Brief Advice (PBA) service commissioned by Windsor and Maidenhead Community Safety Partnership was evaluated as part of the South East Alcohol Innovation Programme. The PBA service was one of the top five projects (from an initial range of 23) chosen for a second year of funding and further development.

The PBA project engaged with community pharmacies to provide pro-active alcohol brief advice offering health awareness, understanding units, early identification of possible excess, data capture on awareness and units consumed and signposting/referral for additional support where required. This project sought to raise awareness of safe alcohol consumption among those who are not aware of how much alcohol they are consuming. The project specifically sought to target low- and increasing-risk drinkers.

The evaluation found IBAs provided in pharmacies “are effective interventions directed at patients drinking at increasing or higher risk levels who are not typically complaining about or seeking help for an alcohol problem”. Some issues with delivering the service were identified—such as starting the service in December, pharmacies’ busiest time of year, and attempting to deliver it alongside another pharmacy service—but the evaluation stated that the project “has the potential to succeed” and it is being taken forward locally.

PORTSMOUTH

An alcohol IBA forms part of the “Healthy Living Pharmacy” (HLP) project in Portsmouth, which is part of a wider Healthy Living initiative run by the PCT and local authority. The IBA includes the use of “Rethink your drink” scratchcards through which customers can assess their drinking in a non-judgemental way.

An initial assessment by the PCT found that pharmacies which were part of the HLP scheme delivered almost four times more IBAs than those not in it. A key part of the HLP project is enhanced “health champion” training for pharmacy staff. The PCT has long-term plans to develop the IBA to include behaviour change counselling and, eventually, structured care plans for higher-risk alcohol users and cancer risk assessments.

The HLP project is currently being extended through a pathfinder programme in 30 PCT areas. Over 200 pharmacies have so far been accredited to HLP status.

NORTH WEST ENGLAND

A range of pharmacy-based IBA services are being run by seven PCTs in the North West. A formal evaluation of these services is being undertaken by Liverpool John Moores University and University of Central Lancashire, sponsored by Lundbeck UK Ltd and is expected to be published in September 2012. We would be pleased to update the Committee when this information is available.

Feedback from Pharmacy Voice members who have pharmacies delivering the service provides pointers to why the service is generally successful:

- Alcohol IBAs can easily be integrated with other public health services, such as smoking cessation or weight management.
- The training that pharmacy staff receive on behaviour change, such as for smoking cessation, can readily be applied to alcohol management.

- The public are becoming familiar with the public health role of pharmacies and see this approach as part of that.
- Community pharmacy staff, who normally live in the local area, are regarded as “peers” by local people. This supports and adds weight to the intervention. Pharmacy staff are motivated by supporting the health of their own communities.

However, the experience of Pharmacy Voice members with the commissioning of IBAs in the North West gives a clear flavour of the difficulties pharmacies experience across the country:

- Wirral PCT, one of the originators of the pharmacy IBA has decommissioned the service.
- Sefton and Blackpool PCTs have gone from pilot to full commissioning.
- Warrington PCT has gone live with an IBA service.
- Despite the existence of a standardised North West service specification, there are at least three variations of it in use.

Dealing with these variations increases the costs for pharmacy businesses. Some services require specific training or accreditation, which may be difficult to acquire or renew, especially for locums. This restricts the pool of qualified staff, making service continuity more difficult than necessary. Services can require different levels of reporting or result in differing payments.

It is also important to ensure that pharmacies that are providing IBAs are linked into wider care networks and pathways, so that patients identified as being at high risk can be referred for appropriate support.

Pharmacy Voice believes that the establishment of Public Health England gives an ideal opportunity to implement a single national service specification for pharmacy-based IBAs. Designing such a service once, at a national level, using all existing experience and evidence, would enable local authorities to roll out this highly effective service quickly. Local authorities should focus their attention on the scale and location of alcohol-related issues—identified in their Joint Strategic Needs Assessment—and commission in response to this. Service redesign at a local level is inefficient and should be avoided wherever possible. Having a single service model should also help simplify referral pathways.

Evidence from the Scottish pharmacy contract, where key services are commissioned nationally, shows what an impact this can have. Supplies of emergency hormonal contraception quickly rose four-fold after the introduction of a national service in 2008. More than half of all NHS-funded attempts to stop smoking in Scotland now happen in pharmacies (leaving aside the thousands of self-funded attempts that use products purchased from pharmacies).

Therefore, Pharmacy Voice recommends to the Committee **that Public Health England should set out a single national service specification for pharmacy-based IBAs** and that **local authorities should only use the national specification when commissioning IBAs from pharmacies**. Where appropriate, alcohol IBAs should form part of wider Healthy Living Pharmacy initiatives.

ABOUT PHARMACY VOICE

Pharmacy Voice (PV) represents community pharmacy owners. Its founder members are the Association of Independent Multiple pharmacies (AIMp), the Company Chemists’ Association (CCA) and the National Pharmacy Association (NPA). The principal aim of Pharmacy Voice is to enable community pharmacy to fulfil its potential and play an expanded role as a healthcare provider of choice in the new NHS, offering unrivalled accessibility, value and quality for patients and driving forward the medicines optimisation, public health and long term conditions agendas.

Pharmacy Voice creates a stronger, unified voice for community pharmacy. We are pleased to have the opportunity to provide written evidence to the inquiry on the Government’s Alcohol Strategy.

May 2012

Written evidence from Northumberland Alcohol Strategy Implementation Group (GAS 32)

The Alcohol Strategy (AS) tends towards a “law and order” approach and would benefit from other targets and outcomes. In particular the AS aims to “turn the tide” against binge drinking, it is weak on a clear strategy around the marketing and promotion of alcohol. Exposing children and young people to alcohol promotion and advertising is irresponsible. Other countries such as France have taken a responsible approach which could be adopted in England. Self regulation of the industry won’t address this, and hasn’t done so to date. The industry is driven by a requirement to raise profit for shareholders and should remain at arm’s length in policy development processes. There is a need to reduce consumption and label bottles, which has so failed on the scale requested. Legislation is needed to effect this.

Of course not all problems relate to young binge drinkers and greater emphasis on a population approach to increasing and higher levels of risk is needed. Support for IBA and liaison nurses is welcomed, however this

represents a need for significant resources. Resources are also needed to develop work in schools linked with a social norms approach.

The level of a minimum unit price needs to be evidence based to ensure its effectiveness, and should increase with inflation. Any increased profits from a MUP should be used to address the harms caused by alcohol.

Multibuy and discounted alcohol promotions offered by Supermarkets should be regulated, as the trend towards preloading is a growing problem. Government enforcement to prevent illegal sale of alcohol is increasingly important when pricing policy makes it more expensive. Local police are concerned that theft of alcohol, and illegal sales will increase in Northumberland and are mindful of the extra resources needed to address this. An increase in the price per unit may have an effect in the lower socioeconomic parts of the County. It will undoubtedly affect those who purchase alcohol legitimately, but we may see the theft of alcohol increasing. Additionally, the risks we see around young people and access to alcohol are always present; we work with partners to engage with young people and enforce the message of safety—we have some success with 12–14 year olds (who we find drinking).

Perceptions for us in our communities equally are important and we are working to address the drunk/rowdy perceptions in neighbourhoods. We as ever work with the media and Local Authority, but we are keen to promote positive perceptions of towns around the County and that not all Night Time Economy has an undertone of drunkenness.

The 2010 drug strategy focus on recovery should not dilute the need for guidance on alcohol use disorders. Liver disease is mainly due to alcohol and is a significant cause of death. Funding for alcohol services should meet need and investment in this is lacking.

Public health intervention through sexual health clinics and Change4Life is endorsed and will be supported as part of the wider approach to shifting cultural norms. We feel that raising the legal drinking age should not be approached lightly and should take account of a review of the body of literature which highlights the affects of alcohol on the brain of young adults. Further research into this should be funded and account taken of the findings.

May 2012

Written evidence from the British Medical Association (GAS 33)

ABOUT THE BMA

The BMA is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine throughout the UK. With a membership of over 149,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

Our members witness firsthand the devastating effects of alcohol on their patients, from disturbances in accident and emergency (A&E) departments to the acute and chronic harm caused to individual drinkers and those around them. The BMA has called for the implementation of wide-ranging measures that will reduce alcohol consumption across the population, rather than policies targeted at irresponsible drinkers alone.

EXECUTIVE SUMMARY

- The scale of alcohol consumption in England represents a significant cause of medical, psychological and social harm, and is placing an unsustainable burden on the NHS. This is not caused by binge drinkers alone but is as a result of the high level of consumption across the population.
- The BMA welcomes some aspects of the Government's strategy, acknowledging positive aspects such as the recognition of the need to take action on price and availability. The BMA strongly believes that insufficient attention has been given to the management of harmful alcohol use or population-level measures to reduce chronic health harms and per capita consumption. A comprehensive strategy to tackle alcohol harm is required, and the BMA believes that this should give a voice to Government intervention and should not rely wholly on voluntary agreements with industry.
- In order to reduce the affordability of alcohol, further increases in alcohol duty are needed, along with the rationalisation of the tax system to favour lower strength products. A minimum price for the sale of alcohol should be set at no less than 50p per unit.
- While the new local licensing powers are welcome, stronger action is required through a national directive to reduce licensing hours for on- and off-licensed premises.
- In light of the impact alcohol marketing has on young people's drinking and the ineffectiveness of the existing regulatory framework, there should be a comprehensive ban on all alcohol marketing communications.

- Alcohol education programmes should only be used to supplement policies that are effective at altering drinking behaviour, and to promote public support for comprehensive alcohol control measures. The continued reliance on the Drinkaware Trust to provide public health communications on alcohol is counterproductive, and should be replaced by information from a genuinely independent body.
- With the lack of progress on voluntary agreements for product labelling, there should be a mandatory requirement to show unit information, alcohol guidelines, advice on alcohol-free days, and a health warning message on all product labels, printed and electronic marketing material, and at the point of sale.
- The commitment to improve the identification of individuals at risk of harm is welcome, but there should be greater emphasis in the strategy on providing comprehensive treatment services for individuals who develop alcohol problems. Further assessments of the need for alcohol treatment services are required to ensure demand is matched by provision and funding.
- As a consequence of reforms to the NHS, safeguards are needed to ensure public health expertise is retained at a local level to advise local authorities and licensing bodies on all aspects of alcohol policy.

INTRODUCTION

1. Alcohol is the nation's favourite drug and its consumption in moderation can lead to feelings of relaxation and euphoria but it is also an addictive, powerful drug, capable of causing serious harm. Consumption in large doses manifests itself in aberrant behaviour as well as acute and chronic toxicity and doctors want an increased understanding of this. The BMA has repeatedly called for tough action to reduce alcohol-related harm and prevent generations of young people from growing up in a pro-alcohol society.

2. Alcohol consumption has increased steadily in the UK over the past 60 years.¹ Since 1990, the average amount drunk each year by adults (aged over 15) in the UK increased from 9.8 litres of pure alcohol per head to a peak of 11.5 litres in 2004, and subsequently declined to 10.2 litres in 2009.¹ It is difficult to assess the amount the average drinker consumes given that the proportion of the population abstaining from alcohol (predominantly for religious or cultural reasons) is increasing.² This suggests that average amount drunk per drinker may not have decreased.

3. Survey data have found that a significant proportion of the population consume alcohol above recommended amounts. In England in 2009, 37% of men and 29% of women drank more than the recommended daily amount in the last week, with 20% of men and 13% of women consuming double this level.³ Twenty-six per cent of men and 18% of women consumed more than recommended weekly amounts in an average week.³ For men this was highest in the 45–64 age group, followed by the 25–44 age group and the 16–24 age group.³ For women it was highest in the 16–24 age group, followed by the 45–64 age group and the 25–44 age group.³

4. These data illustrate that excessive alcohol consumption is not a problem restricted to young people binging to excess, but that the population as a whole is drinking in a way that is causing significant health and social harm (see *Figure 1*). The high levels of consumption are particularly significant given the dose-response relationship that exists with alcohol consumption, where increased consumption is directly related to an increased risk of premature death, cancer, and cerebrovascular disease.^{4, 5, 6}

Figure 1

OVERVIEW OF THE BURDEN OF ALCOHOL-RELATED HARM

- Alcohol is causally related to over 60 different medical conditions.^{5, 6} The acute direct and indirect harms include intoxication, alcohol poisoning, unsafe sex, and accidents and injuries, while chronic consumption can cause dependence, liver cirrhosis, alcoholic psychoses, alcoholic cardiomyopathy, polyneuropathy and gastritis.^{5, 6, 7}
- In 2009–10 there were over one million alcohol-related admissions to hospital, which is a 12% increase from 2008–09 and over double the number in 2002–03.³
- Deaths directly attributable to alcohol have doubled in the UK in the last two decades, from 6.7 per 100,000 population in 1992 to 12.9 per 100,000 in 2010.⁸
- In 2010, there were nearly 6,630 road traffic casualties as a result of drink driving, in which 250 people were estimated to be killed and 1,230 seriously injured.⁹
- Alcohol consumption is a contributory factor in domestic violence incidents, child abuse and in criminal and disorderly behaviour.⁷
- The total annual cost of alcohol-related harm in England has been estimated to range from £20 billion to £55 billion,^{10, 11} with the annual cost to the NHS (using 2006/7 prices) estimated at £2.7 billion.¹²

BMA VIEW OF THE GOVERNMENT'S ALCOHOL STRATEGY AND THE ROLE OF THE ALCOHOL INDUSTRY

5. The BMA believes there are a number of positive aspects in the Government's alcohol strategy, including recognition of the need to take action on the price and availability of alcohol. We are, however, concerned that the primary aim is to tackle irresponsible drinking, in particular bingeing to excess. This has resulted in a disproportionate focus on reducing acute social problems such as alcohol-related crime and disorder. Insufficient attention has been given to the need to reduce per capita alcohol consumption and the unmanageable burden alcohol is placing on the health and wellbeing of the population. Focusing on the binge pattern of drinking fails to recognise the strong relationship between total population alcohol consumption and the prevalence of harmful consumption.¹³ As a nation, we have a collective responsibility to reduce alcohol consumption, rather than targeting irresponsible drinkers alone. As set out elsewhere in this submission, there is a need for tougher population-level measures to reduce the affordability and accessibility of alcohol, as well as limiting alcohol marketing and promotion. More focus is needed on providing comprehensive treatment services for individuals who develop problems with alcohol.

6. The BMA is extremely concerned that a core component of the strategy is partnership working with the alcohol industry, as this has at its heart a fundamental conflict of interest that does not adequately address public health. The greater the emphasis on partnership with the industry, the more likely it is that policy makers will veer toward the use of ineffective policies. This is illustrated by the responsibility deal on alcohol where the public health organisations had not been given an equal voice compared to the industry in the formation of the network's pledges. This led to a set of weak proposals that the BMA was not willing to endorse and therefore declined the invitation to sign up to the initiative. While the alcohol industry has a role to play, this should only be when a strategy is in place and regulations are being implemented.

The BMA recommends:

- That greater attention needs to be given to the management of harmful alcohol use or population-level measures to reduce chronic health harms and per capita consumption.
- That a comprehensive strategy to tackle alcohol harm is adopted, and believes that this should give a voice to Government intervention and should not rely wholly on voluntary agreements with industry.

RESPONSIBILITY WITHIN GOVERNMENT FOR ALCOHOL POLICY

7. Effectively reducing the high levels of alcohol-related harm requires a cross-government alcohol strategy that places the protection and promotion of public health at the heart of all policy decisions. The new strategy contains a number of robust measures to tackle crime, disorder and violence under the responsibility of the Home Office. Key areas where stronger measures are required are taxation and licensing—two of the most effective alcohol control measures. Despite strong and consistent evidence that increases in the price of alcohol are associated with reduced consumption and harm, the HM Treasury has made only limited changes to duty levels since the mid-1990s (see paragraph 10). In line with the evidence that increased opening hours are associated with higher levels of consumption and harm, the BMA believes a stronger stance is required from the Home Office at a national level to reduce licensing hours (see paragraph 14).

8. The strategy appears to lack significant input from the Department of Health as limited attention is given to the management of harmful alcohol use or population-level measures to reduce chronic health harms. We also note with concern that the strategy omits any action on drink driving.

9. With the development of different approaches to reducing alcohol-related harm in the devolved nations, cross-border partnership working is essential to ensure there is a coordinated approach throughout the UK. This will also facilitate learning from, and taking advantage of, policy developments between nations.

The BMA recommends:

- That a cross governmental approach is taken to tackling alcohol related harm, and believes that more attention needs to be given to:
 - tackling the burden alcohol places on the health and wellbeing at a population level;
 - using taxation more effectively to reduce overall consumption; and
 - reducing licensing hours.

SPECIFIC POLICY INTERVENTIONS

Reducing the affordability of alcohol

10. There is strong and consistent evidence that increases in the price of alcohol are associated with reduced consumption and alcohol-related harm at a population level.^{6, 13–28} Heavy drinkers and young drinkers are known to be especially responsive to price.^{15, 17, 29–32}

11. The affordability of alcohol in the UK has increased significantly due to the widening gap between household disposable income and alcohol prices.^{3, 33, 34} At the same time, duty levels have remained relatively static: between 1997 and 2007, duty on beer and wine was only adjusted for inflation, and duty on spirits did not increase at all.³⁵ Although the BMA notes the commitment to increase alcohol duty at two% above inflation

annually to 2014–15, further increases are needed to significantly reduce the affordability of alcohol and lower population-level consumption. This could be achieved by a significant increase in duty levels on all alcohol products (eg in the region of 10%), with continued annual increases above inflation.

12. There is also a need for further rationalisation of the duty system to reduce the comparative affordability of higher strength products. The commitment to support a change in EU regulations to tax wine proportional to its alcoholic content is welcome; similar changes are needed for cider. The narrowing of existing duty bands for beer, cider and wines, and the introduction of narrow duty bands for spirits, should also be used to favour lower strength products.

13. The BMA welcomes the commitment to introduce a minimum price per unit as a way of tackling the deep discounting of alcohol in the off-trade, which is known to encourage consumption and undermine the effectiveness of tax-based approaches. It will also encourage alcohol to be consumed in the on-trade (where there are stronger controls on its use) rather than the off-trade, by reducing the price differentials for the sale of alcohol between these two settings. A minimum price per unit strategy is preferable to other pricing policies because it targets cheap drinks, has a disproportionate effect on heavier drinkers, and is unlikely to be significantly regressive when the effects are considered for the whole population.^{14, 15, 36–40} Modelling has found that increasing the level of a minimum price per unit leads to steep reductions in alcohol consumption and harm (see *Figures 2 and 3*).^{38, 41–44} In reviewing available research, the BMA Board of Science concluded that a minimum price for the sale of alcohol should be set at no less than 50p per unit.

14. The BMA welcomes the commitment to introduce a ban on multi-buy promotions as a way of reducing irresponsible retailing in the off-trade. This could be expanded to include multi-buy discounts in the on-trade.

Figure 2

INCREASES IN MINIMUM PRICE PER UNIT AND PERCENTAGE CHANGE IN CONSUMPTION⁴¹

<i>Minimum price per unit</i>	<i>Percentage change in consumption</i>
20p	0.0
25p	-0.1
30p	-0.4
35p	-1.1
40p	-2.4
45p	-4.3
50p	-6.7
60p	-11.9
70p	-17.7

Figure 3

COMPARISON OF THE IMPACT OF A MINIMUM PRICE PER UNIT AT 40P AND 50P ON VARIOUS OUTCOMES AFTER 10 YEARS⁴¹

<i>Outcome</i>	<i>Minimum price per unit level</i>	
	<i>40p</i>	<i>50p</i>
Alcohol-related hospital admissions	39,400 fewer admissions per annum	97,700 fewer admissions per annum
Alcohol-related crimes	10,100 fewer offences per annum	42,500 fewer offences per annum
Alcohol-related absenteeism from work	133,600 fewer days absent per annum	442,300 fewer days absent per annum
Unemployment due to alcohol problems	11,500 avoided cases of unemployment per annum	25,900 avoided cases of unemployment per annum

The BMA recommends:

- Duty levels on alcohol need to increase significantly in order to reduce the affordability of alcohol and lower population-level consumption.
- That the tax system is rationalised so the excise duty levied on alcohol is proportionate to the amount of alcohol in the product.
- A minimum price per unit of no less than 50p should be set.
- That a ban on multi-buy promotions be introduced to reduce irresponsible retailing in the on- and off-trade.

Restricting access to alcohol

15. There is strong evidence that increased opening hours and a high density of outlets are associated with increased alcohol consumption and alcohol-related problems.^{6, 13, 19, 45–55} The BMA welcomes the new powers

to allow local authorities to control the density of licensed premises, make health a licensing objective, review licenses, and restrict alcohol sales. We believe that the liberalisation of licensing legislation in recent years (including the introduction of the Licensing Act 2003 which permits 24-hour sales) requires stronger action through a national directive to reduce licensing hours for on- and off-licensed premises.

16. There is also a need to assess the impact of the emergence of “pubcos” on alcohol consumption and harm. These companies buy up and let pubs to prospective landlords, charging them high rents and tying them in to expensive supply contracts. The resulting high costs and narrow margins result in increased pressure on landlords to maximise sales. There is concern that this may be encouraging excessive consumption, and lowering the commitment to important measures such as not serving those who are intoxicated.

The BMA recommends:

- That an assessment of the impact the commercial practices of companies that own pubs has on alcohol consumption and harm is made.

Marketing, promotion and product development

17. A substantial body of research has found that alcohol advertising and promotion influences the onset, continuance and amount of alcohol consumption among young people.^{14, 26, 56–58} This includes all major forms of mass media advertising—press, television and billboards—as well as broader marketing communications such as sponsorship, merchandising and product placement. These all have a cumulative effect of generating a pro-alcohol social norm and limiting the effectiveness of public health messages—the more common and acceptable young people think drinking is, the more likely they are to drink and to consume alcohol in greater quantities.^{59–65}

18. The BMA is disappointed that the new strategy has not strengthened existing controls on alcohol advertising. The use of co-regulation and self-regulation is an entirely inadequate response to the impact alcohol marketing communications has on young people’s drinking. This system of regulation has a number of major weaknesses:

- With the exception of the pre-vetting of television advertisements, regulatory controls are only applied after an advertisement has been run and a complaint has been made.
- The penalties for transgressions are minimal and do not act as an effective deterrent.
- The reliance on public complaint is of limited effectiveness in an increasingly fragmented media market place where the target audience is unlikely to be a critical audience.
- The focus on content cannot adequately address promotion in the form of associations (eg sports sponsorship clearly draws connections between alcohol and sporting success).
- Objections can be made on the style, language or design of a particular advertisement, but not on the volume of advertising.

19. Given the link between alcohol marketing, social norms and young people’s drinking, as well as the ineffectiveness of co-regulation and self-regulation, the BMA believes there should be a comprehensive ban on all alcohol marketing communications.

20. There has been an unprecedented increase in the number of new alcohol products and associated marketing and promotional activities in recent years. This has made it difficult to maintain a clear indication of the range of available products. Numerous studies have examined how new alcoholic drinks have directly met the needs of various segments of the youth market, are very popular with them, and can contribute to heavier drinking and to lowering the age of onset of drinking.^{66–72} The BMA believes that a full audit of the market should be conducted, and consideration given to how any drinks that either appeal to young people more than adults, or are particularly associated with problematic drinking, are removed.

The BMA recommends:

- That a comprehensive ban on all alcohol marketing communications is introduced.

Education and information

21. Alcohol education programmes can have an effect on raising awareness, increasing knowledge and modifying attitudes. They are not effective in changing drinking behaviour.^{6, 13, 17, 18, 21, 73–84} The BMA believes it is essential that the disproportionate focus on educational programmes in the strategy is redressed. Educational strategies should only be used to supplement other policies that are effective at altering drinking behaviour, and to promote public support for comprehensive alcohol control measures.

22. The involvement of the Drinkaware Trust in providing public health communications is a significant area of concern. This form of industry social marketing is counterproductive because industry responsibility campaigns are less effective than ones from other sources, keep messages in a commercial comfort zone, and distract attention away from more effective measures to regulate alcohol use.^{85, 86} Industry-related messages about alcohol have been found to subtly enhance sales and company reputations.^{87, 88} This is despite the fact that the public is cynical about the motives of corporate sponsors, and that non-governmental organisations make a more effective and credible source.^{89, 90} There is also evidence that alcohol companies avoid the use

of messages focusing on the harmful consequences of irresponsible drinking,⁹¹ and set their messages within a “drinking as normal” context.⁹² The Drinkaware Trust, for example, states that “*We promote responsible drinking and find innovative ways to challenge the national drinking culture to help reduce alcohol misuse and minimise alcohol-related harm*”.⁹³ This overlooks the possibility that abstinence may be the best option for some people all the time, and for all people some of the time. It also reinforces the idea of safe limits rather than relative risks, and maintains that problems only arise when people use the product in certain ways. The BMA believes that health promotion, such as guidance and advice on responsible drinking, should only be provided by a genuinely independent public health body, and not through industry-sponsored social marketing, or by individual drinks companies. This should be funded by a compulsory levy on the alcohol industry, set as a proportion of current expenditure on alcohol marketing.

The BMA recommends:

- Health promotion guidance, including information on responsible drinking, should only be provided by a genuinely independent public health body.

Labelling and drinking guidelines

23. The BMA welcomes the decision to review the alcohol guidelines as this will provide a useful opportunity to ensure there is clear and consistent messaging regarding the health harms of alcohol consumption and the importance of alcohol-free days.

24. While most people are aware of the existence of alcohol guidelines, few can accurately recall them, understand them, or appreciate the relationship between units, glass sizes and drink strengths.^{21, 94–96} Labelling of alcoholic products provides a useful method for raising awareness about and understanding of alcohol guidelines.^{13, 97, 98} As insufficient progress has been made on product labelling through voluntary agreements,⁹⁹ the BMA believes that it should be a mandatory requirement to label all products to show unit information, alcohol guidelines, advice on alcohol-free days, and a health warning message. This information should also be readily available at the point of sale (through the use of standardised posters), and in all printed and electronic material.

The BMA recommends:

- That it should be a mandatory requirement to label all alcoholic products to show unit information, alcohol guidelines, advice on alcohol-free days, and a health warning message. This information should also be readily available at the point of sale and in all printed and electronic material.

Reducing the strength of alcoholic beverages

25. In principle the BMA supports the commitment to reduce the strength of alcoholic beverages through reformation and smaller product sizes. As noted in paragraph 14, this should be supported by tax incentives that favour lower strength products. Controls will be required to ensure this leads to the substitution of high strength products by lower strength versions (rather than the development of an additional market), and that it is not used as a marketing opportunity to promote lower strength products (eg as “a healthier option”).

Raising the legal drinking age

26. Research from North America has found that regulating access to alcohol through restrictions on the legal age of consumption and purchase is an effective strategy for preventing alcohol-related health and social problems among young people.^{13, 19, 100–106} While it is illegal for anyone under 18 to buy alcohol, attempt to buy alcohol, or to be sold alcohol in the UK,¹⁵⁷ the legal age for consumption is five, provided it is on private premises and parental consent is given. In light of the evidence from America and the disparity in the legal drinking age for the purchase and consumption of alcohol, consideration could be given to reviewing the legal age of consumption.

Drink driving

27. The BMA has repeatedly highlighted the need for further measures to reduce the number of people killed or seriously injured as a result of drink driving. This includes a reduction in the legal alcohol limit from 80mg/100ml to 50mg/100ml, with consideration for further reductions for newly qualified drivers.

Early intervention and treatment

28. The BMA welcomes the commitment to improve the identification of individuals at risk of harm from alcohol through the use of evidence-based screening tests and brief advice¹⁰⁷ where this is clinically appropriate. This will require adequate funding and resources, and comprehensive training and guidance for all healthcare professionals. The BMA has previously objected to alcohol being an indicator in the Quality and Outcomes (QOF) framework, and supported the implementation of a directed enhanced service (DES) or

¹⁵⁷ In the UK, young people aged 16 and 17, with the licensee’s permission, can drink beer, wine or cider with a meal if it is bought by an adult and they are accompanied by an adult. It is illegal for this age group to drink spirits in pubs even with a meal.

locally enhanced service (LES), which can achieve the same goal, and has the advantage of ensuring equal service provision.

29. The BMA believes there is insufficient focus in the strategy on the referral, management and treatment of individuals with alcohol problems or who are alcohol dependent. Further emphasis is needed on the recommendations from the National Institute of Health and Clinical Excellence (NICE) on the assessment of, and interventions for, harmful drinking and alcohol dependence, as well as alcohol-related physical complications.^{108–111} We also urge the Government to publish its National Liver Disease Strategy that has been subject to continued delays since it was first announced in October 2010.

30. The BMA is concerned about the inadequate provision of specialised alcohol treatment services highlighted by the 2004 Alcohol Needs Assessment Research Project (ANARP).¹¹² It is essential that further assessments of the need for alcohol treatment services are undertaken, to ensure there is adequate provision of, and funding for, services to support individuals who have severe alcohol problems or who are alcohol dependent.

The BMA recommends:

- That greater provision for the referral, management and treatment of individuals with alcohol problems or who are alcohol dependent is offered as part of a comprehensive strategy.

IMPACT OF THE NHS REFORMS

31. The reforms to the public health service are the largest in a generation and are occurring as the entire NHS is being reformed. The relationship between the reforms to public health and the wider NHS has been complicated by the overlapping timescales of the reforms. Many important aspects of the changes to the delivery of public health form an integral part of the Health and Social Care Act. The Government's plan to place Public Health England within the Department of Health causes several interrelated and unnecessary problems. With other elements of public health being transferred to local authorities, and possibly other bodies such as the NHS Commissioning Board or clinical commissioning groups, such a move risks fragmentation of public health.

32. As yet it is not possible to make a full assessment on whether the reforms will support an integrated approach to future planning of services for people who experience alcohol-related harm. However, the BMA believes that it is essential that public health expertise is retained at a local level to advise local authorities and licensing bodies on the impact of decisions on public health, as well as to inform the development of local alcohol prevention programmes, needs assessments and the commissioning of treatment services.

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May 2012

Written evidence from Diageo (GAS 34)

EXECUTIVE SUMMARY

- Alcohol beverages bring pleasure to millions of adults, all over the world, as they have done for thousands of years. We are proud of the unique part that alcohol plays in the social lives and celebrations of many cultures. However, Diageo is aware of the sometimes negative role alcohol can play in the lives of individuals and in society. We agree with the Government that it is vital that we tackle irresponsible drinking and that alcohol-related harm must be reduced.
- Diageo actively promotes responsible drinking and works with Government, police, communities and other stakeholders on a range of targeted interventions aimed at reducing alcohol misuse. We are a founder member of The Portman Group and a longstanding funder of The Drinkaware Trust, and play an active role in, and fully support, the Government's Public Health Responsibility Deal.
- However, whilst we agree with the Government that a rebalanced relationship with alcohol is needed for some groups and individuals in Great Britain, we do not agree that minimum unit pricing is the way to achieve this. Diageo believes such a policy would: disproportionately penalise the majority of the population who drink responsibly, particularly affecting those on modest incomes; be ineffective in tackling alcohol misuse among the minority; jeopardise the competitiveness of the alcohol industry based in Great Britain; have the unintended consequence of increasing the prevalence of counterfeit, and potentially be in breach of UK and EU Competition Law.
- There is no strong evidence as to the effectiveness of minimum pricing as a policy to reduce alcohol-related harm.¹⁵⁸ It is often portrayed as a targeted measure having greatest impact on problem drinkers with limited impact on moderate drinkers. A recent report from the Institute for Fiscal Studies rejected these assertions, finding that minimum unit pricing will hit responsible drinkers and, in particular, those on lower incomes at a time when household budgets are already under extreme pressure.¹⁵⁹ The Government carried out little to no consultation with industry before announcing its intention to introduce a minimum unit price and we would strongly dispute the evidence on which it bases its support for such a market-distorting intervention.
- Rather than introduce a minimum price, we believe the Government should focus on enforcing existing laws designed to prevent alcohol misuse and continue to work with industry and other partners to help consumers make informed choices about how they drink. Government should continue to deliver targeted and impactful interventions for those individuals and groups who drink irresponsibly—there is no one solution for the differing types of irresponsible drinker. Such measures are a proven and effective response to the problem and are already delivering results shown by the decreasing levels of total alcohol consumption in Great Britain as well as the falling rates of binge drinking, underage drinking and most importantly, alcohol related deaths.¹⁶⁰

TACKLING ALCOHOL MISUSE: THE ROLES OF INDUSTRY AND GOVERNMENT

1. Diageo recognises that there are issues of excessive and irresponsible drinking in Britain. We believe the solution lies in: (i) sustained education and awareness; (ii) strong enforcement of existing laws applying to drinkers and drink retailers; and (iii) targeted interventions aimed at those who misuse alcohol or are at risk of misusing alcohol. In addition, every alcohol drinker has to take responsibility for their own actions.

2. Industry has an important role to play. The Responsibility Deal taps into the potential for businesses and other organisations to work together to improve public health. Diageo has signed up to all eight collective pledges on alcohol (ranging from health information on labels to removing one billion units from the market to the prevention of under-age sales). We have also made an individual pledge to fund the training of 10,000 midwives, over three years.

EDUCATION AND AWARENESS

3. Diageo fully supports the Government's proposals to educate young people and families about responsible drinking. We have been supporting initiatives for a number of years designed to do just this, for instance "Smashed", an educational play/workshop performed in schools by Collingwood Learning, seen by almost

¹⁵⁸ Babor *et al*, *Alcohol: No Ordinary Commodity*, 2nd Edition, Oxford University Press 2010.

¹⁵⁹ *Alcohol Pricing and Taxation Policies*, IFS Briefing Note NB 124, 2011

¹⁶⁰ *Statistics on Alcohol England*, 2011

200,000 pupils. We also communicated responsible drinking messages to 100,000s of Londoners over the 2011 festive period through our sponsorship of Transport for London's "Free travel on New Year's Eve" initiative.

IMPACT AND ENFORCEMENT OF EXISTING MEASURES

4. As the Government states in its Strategy, it has "already taken action to tackle the availability of heavily discounted alcohol" making significant changes to the alcohol excise duty system such as introducing a new higher rate of duty for high strength beer over 7.5% ABV and a new lower rate of duty for beer at 2.8% ABV.¹⁶¹ Other initiatives are being delivered through the Responsibility Deal. Their impact should be fully assessed before new policies are introduced.

5. The Government should ensure that existing laws designed to tackle alcohol misuse are fully enforced before introducing new ones. The Alcohol Strategy notes that it is an offence to knowingly serve alcohol to someone who is intoxicated and that the proper enforcement of this law would have a significant impact on irresponsible drinking. Only 15 individuals were found guilty of serving intoxicated people between 2005 and 2009.¹⁶²

TARGETED INTERVENTIONS

6. Measures to tackle the irresponsible consumption of alcohol should address specific at-risk populations. We fully support such measures in the Government's Alcohol Strategy, for instance its commitment to help the 120,000 most troubled families in the country.

7. The strategy emphasises the importance of helping town centres to deal with problems caused by alcohol misuse, which we also fully support. Diageo works with schemes such as Best Bar None, Pubwatch and Purple Flag and we would request that any new programmes complement these existing initiatives.

ALCOHOL CONSUMPTION LEVELS IN GREAT BRITAIN

8. The Government's own data demonstrates that this approach is working. Alcohol consumption in Great Britain has reduced by 20% since 2005 and there has also been a consistent decline in misuse. Alcohol consumption in the UK is now at its lowest level since 1999.¹⁶³ There have also been falls in the proportions of both men and women who drink heavily and binge drinking is down across all age groups except those over 65.¹⁶⁴ Additionally, in recent years, there has been a steady decline in the proportion of pupils (aged 11–15) who drink alcohol. In 2010, the year on year decline from 2009 was more pronounced than previously; the proportion of children who have never drunk alcohol rose from 39% in 2003 to 55% in 2010.¹⁶⁵

9. Government data also demonstrates that awareness raising programmes are working, with increases in the number of people who have heard of the Government's recommended drinking guidelines.¹⁶⁶

THE EVIDENCE BASE FOR AND IMPACT OF ESTABLISHING A MINIMUM ALCOHOL SALES PRICE BASED ON A UNIT OF ALCOHOL

10. If the Government does introduce minimum unit pricing, we would strongly request that it does so with a "sunset clause" so that the impacts of the policy can be properly assessed:

Minimum Pricing Would not Tackle Alcohol Misuse among the Minority

11. And would disproportionately penalise responsible drinkers who make up the overwhelming majority (78.5% of the adult population).¹⁶⁷

12. The relationship between price and consumption is complex, as are the causes of alcohol misuse. For instance, the price of alcohol is largely the same in Scotland as it is in England, however alcohol health harms in Scotland are far higher than in England.¹⁶⁸

13. There is little evidence to support a direct correlation between the level of alcohol price in a country and the level of drinking. Studies have shown that consumers respond differently to price changes in different countries¹⁶⁹ and recent empirical evidence from Denmark, Finland, and Sweden indicates that despite predictions to the contrary, the lowering of the price of alcohol did not lead to increased consumption.¹⁷⁰

¹⁶¹ In the Government's "Review of Alcohol Taxation", November 2010

¹⁶² In addition, only 16 people were found guilty between 2005 and 2009 of buying alcohol for a minor (proxy purchase).

¹⁶³ Summary from Office for National Statistics (ONS) General Lifestyle Survey 2010, March 2012

¹⁶⁴ Summary from Office for National Statistics (ONS) General Lifestyle Survey 2010, March 2012

¹⁶⁵ Statistics on Alcohol England, 2011

¹⁶⁶ Summary from 2011 NHS Statistics on Alcohol, 26 May 2011

¹⁶⁷ As referenced in the Government's Alcohol Strategy, page 6

¹⁶⁸ In 2009 alcohol-related mortality rates for men in Scotland were nearly double those for men in England and Wales (30 per 100,000 population compared to 16 per 100,000 population). Monitoring and Evaluating Scotland's Alcohol Strategy. Setting the Scene: Theory of change and baseline picture. Edinburgh: NHS Health Scotland; 2011, referred to as the "MESAS baseline report".

¹⁶⁹ Do alcohol prices affect consumption and related problems? Österberg, E. in H. Holder & G. Edwards (Eds.), Alcohol and public policy: Evidence and issues, Oxford University Press, 1995, 145–163

¹⁷⁰ Changes in volume of drinking after changes in alcohol taxes and travelers' allowances: results from a panel study, Mäkelä, P, Bloomfield, K, Gustafsson, N-K, Huhtanen, P, & Room, R, Addiction, 2007, 181–191

14. Furthermore, there is no strong evidence on the effectiveness of minimum pricing as a policy to reduce alcohol-related harm and indeed some evidence to suggest that decreases in population consumption do not lead to a reduction in alcohol related harm (see 15 below).

15. The evidence on which the Government bases its support for minimum pricing, the University of Sheffield's report, is flawed. The report claims that a 1% fall in alcohol consumption will result in 3,403 fewer alcohol related hospital admissions per annum. According to its calculations, the fall in consumption of over 6% between 2004 and 2008 should have resulted in around 20,000 fewer alcohol-related hospital admissions in 2008 alone. Official figures for alcohol related admissions actually detail a *rise* of over 300,000 from 2004 to 2008, apparently disproving the theory underlying the Sheffield report.

16. Furthermore, it is rightly pointed out in the evidence in the Sheffield report that harmful consumers among young people are more price inelastic than moderate consumers. However, when that is entered into the report's model, that inelasticity is reversed, so a greater outcome is predicted, amongst young people, for harmful consumers than is predicted for moderate ones.

Disproportionately Penalise the Majority of the Population Who Drink Responsibly

17. A minimum price set at around 40p per unit would affect the majority of responsible drinkers with 45% of all alcohol sold in the off-trade in England and Wales having its price increased, and disproportionately impact those on a modest or low income. According to the Government's own data, those living in the lowest income households are already far less likely to drink beyond the recommended daily guidelines than those in the richest households, 22% (households on less than £200 pw) compared to 45% (households on £1,000+ pw).¹⁷¹

18. A recent report from the CEBR also supports this,¹⁷² outlining how a price of 40p or 45p has a negligible impact on hazardous and harmful drinking levels among the richest 20% of households in England & Wales.

Potentially Breach EU Competition Law

19. Diageo agrees with the Wine and Spirit Trade Association that it is inconsistent with the operation of a free market for the state to intervene on price.

20. The Public Health Minister, Anne Milton MP, also recently suggested that the UK Government has legal advice which indicates that the policy is probably illegal.¹⁷³ In addition, Andrew Lansley MP, Secretary of State for Health, has cast doubts over the efficacy of such a measure, stating "Are we really saying that because a bottle of vodka isn't £8 but £12.50 they are not going to preload with a bottle of vodka for a night out when they are in clubs where they pay £5 for a drink? That is absurd. They are still going to do this binge drinking because that is a behaviour issue".¹⁷⁴

21. We are disappointed that the Government will not publish the legal advice it has so far received on minimum pricing.

Impact on Competitiveness and Other Unintended Consequences

22. John Fingleton, recently CEO of the UK's Office of Fair Trading, has stated that a minimum price "has a number of undesirable effects... It would reduce the incentives of firms to compete, innovate and cut costs. So the dynamic benefits of competition are lost... such a short term fix can have serious and long-lasting negative effects."

23. There is also a risk that if some people are priced out of the legitimate market, they will simply turn to illicit sources from which to obtain their drinks. There is very strong evidence to suggest that price increases illicit production or cross-border trade in alcohol.¹⁷⁵

RESPONSIBLE MARKETING AND THE EFFECTS OF MARKETING ON ALCOHOL CONSUMPTION

24. Diageo's own Global Marketing Code is designed to ensure that wherever in the world our brands are marketed, they are done so responsibly and that they also promote responsible drinking.

25. Diageo markets its brands for three principal reasons: (i) to maintain their integrity, credibility and image; (ii) to maintain the loyalty of existing customers; (iii) to gain market share by encouraging consumers to switch from other brands to one of ours. Our marketing is not designed to increase overall consumption of alcohol and, as the UK consumption rates recently published by the ONS demonstrate, it has not.¹⁷⁶

26. All of our marketing is targeted at people over the legal drinking age (18 in UK).

¹⁷¹ Summary from 2011 NHS Statistics on Alcohol, published 26 May 2011

¹⁷² CEBR: Minimum Alcohol Pricing and the Squeeze on Low-Income Households, published April 2012

¹⁷³ Stating "Our advice is that in itself is probably illegal as it contravenes European free trade legislation."

¹⁷⁴ Interview in Independent, December 2011

¹⁷⁵ Alavaikko, M. & Osterberg, E (2000). The influence of economic interests on alcohol control policy: A case study from Finland. *Addiction*, 95(Suppl.4), S565-S579.

¹⁷⁶ Summary from Office for National Statistics (ONS) General Lifestyle Survey 2010, published March 2012.

27. International examples of the effects of marketing on alcohol consumption suggest that advertising does not have an effect on total consumption. For instance, Sweden introduced an advertising ban in 1979 and yet continues to have significant issues with immoderate consumption. Italy, by contrast, has far fewer marketing restrictions for alcohol yet does not suffer the same problems with irresponsible consumption as countries like Sweden. Dr. Alain Rigaud, President of the French National Association for the Prevention of Addiction and Alcoholism (ANPAA), concluded in his analysis of the highly restrictive alcohol advertising ban—*The Loi Evin*, that no effect on alcohol consumption could be established.¹⁷⁷ In Norway, where there is also a long-standing and rigorously enforced ban on alcohol advertising, the National Statistics Office figures show that alcohol sales increased by 27.7% between 2000 and 2010.¹⁷⁸

INTERNATIONAL EXAMPLES OF TACKLING HARMFUL DRINKING

28. In Great Britain and throughout our global markets we run and support initiatives designed to promote responsible drinking and we would be happy to share details of these with the Committee if they are of interest.

ABOUT DIAGEO

Diageo is the world's leading premium drinks business and a top-20 FTSE 100 company. We employ more than 22,000 people worldwide, in more than 80 countries, including over 5,000 people in the UK, in more than 50 sites. Our brands include: Bell's, Johnnie Walker and J&B whiskies as well as a range of malt whiskies from our 29 Scottish distilleries alongside Smirnoff vodka, Captain Morgan rum, Baileys liqueur, José Cuervo tequila, Tanqueray and Gordon's gin, Guinness beer and Blossom Hill wines.

May 2012

Written evidence from Waitrose (GAS 35)

1.0 INTRODUCTION

1.1 Waitrose—a trading division of the John Lewis Partnership—is co-owned by over 47,500 Partners (employees). Through our 277 branches in the UK and Channel Islands, we are a growing and successful British business that combines the convenience of a supermarket with the expertise of a specialist shop. We also operate a growing online business.

1.2 Our co-ownership model makes us unique to other supermarkets and enables us to act in the interests of society as opposed to being influenced by shareholders. This guides our approach to the responsible sale of food and drink which is based on our commitment to the wellbeing of the communities we trade in.

1.3 We welcome the opportunity to contribute to the Health Select Committee's inquiry on alcohol. We have a long-term commitment to selling alcohol responsibly, we are therefore well placed to input to the development of future alcohol legislation.

1.4 Our written response focuses on the issues the Committee is considering which are most relevant to our business and our experience.

2.0 EXECUTIVE SUMMARY

2.1 There is widespread debate and concern about Britain's drinking culture and the issues it poses to the health of the nation. We believe that a long-term and considered approach is required to fundamentally change the binge drinking culture. Retailers have an integral role to play in rising to this challenge at a national and local level.

2.2 As stated in the Alcohol Strategy, the majority of consumers drink sensibly and the alcohol industry makes a significant contribution to the UK economy. The Alcohol Strategy therefore needs to strike a balance between allowing people to buy and drink alcohol responsibly while also tackling irresponsible behaviour.

2.3 As well as focussing on the role that price and promotions can play in influencing behaviour, we are also extremely encouraged that the Government's strategy incorporates education and community support.

3.0 OUR RESPONSIBLE APPROACH

3.1 Doing the right thing is part of the way we do business. It is at the heart of our industry-leading approach to positioning, pricing, labelling, selling and promoting alcohol to our customers. This includes:

- Never positioning alcohol in our foyers.
- Not including alcohol products in our entry level brand—essential Waitrose.
- Never running 50% discount offers on spirits, still wine, beer, cider, ready-to-serve and fortified wine.

¹⁷⁷ The *Loi Evin*: a French exception, Dr. Alain Rigaud, Président Association Nationale de Prévention en Alcoologie et Addictologie (ANPAA), 1999.

¹⁷⁸ Statistisk Sentralbyrå—Norwegian Statistics Office, 2011

- Always offering a non-alcoholic alternative in our Meal Deals.
- Supporting Community Alcohol Partnerships through the Retail of Alcohol Standards Group (RASG).

3.2 We adopt a voluntary approach to informing our customers when they are purchasing alcohol. This includes comprehensive information on our website, unit information on our own label products and shelf edge ticketing. We were the first retailer to communicate alcohol units and safe limits in 2004. All our own label products now comply with the Department of Health's voluntary labelling requirements.

3.3 We operate a Challenge 25 policy. We consistently monitor our performance in this area using Serve Legal to ensure that we have the most robust system in place for preventing any underage sales in our branches. We consistently review our procedures, retrain Partners twice a year and ensure that all Partners are aware of the importance of not selling alcohol to people who are underage. We also verify a person's age when they place an order online and specify that someone over 18 must sign for the delivery of their online order.

3.4 We have Beers, Wines and Spirits specialists in our branches who can advise customers on the products we offer. Our beers, wines and spirits section has its own dedicated area of the shop in our core/large branches, as opposed to forming part of the main shopping aisles.

3.5 We are developing our range of low/no alcohol products, which includes the recent introduction of our Merlot grape juice, a light beer and a pale ale (both at 2.8% ABV). We are also aiming to reduce the average alcohol content of our range as part of our Responsibility Deal unit reduction pledge.

4.0 THE GOVERNMENT'S APPROACH TO ALCOHOL POLICY

4.1 We do not believe that it matters where alcohol policy is set by the Government but rather how it is set. A coordinated and collaborative approach is key. For example, the Responsibility Deal needs to be inextricably linked to the Government's overall Alcohol Strategy.

4.2 When it comes to the devolved administrations, we would urge a consistent and efficient approach to legislation. Major retailers manage their businesses centrally so the need to have regionally varied pricing systems causes businesses unnecessary cost and complexity. To lessen the financial burden on businesses of implementing the new legislation, consistent policy and legislation is essential. For example, the MPU cost calculation that will determine the lowest price for a product should be the same formula in England as in Scotland.

5.0 THE ALCOHOL INDUSTRY'S ROLE

5.1 We fully accept that the industry has an important role to play in helping to tackle the binge drinking culture. This goes much further than adhering to basic licensing legislation and has been demonstrated by working with the Government to inform alcohol policy, financial contributions to Drinkaware, agreeing to, and exceeding, voluntary commitments and informing and educating our customers.

5.2 We are signatories of the Government's Public Health Responsibility Deal and believe that we will only overcome the social and health harms of excessive consumption by working in partnership with the drinks industry, the Government and NGOs.

5.3 We include the Drinkaware Trust's branding and messages in our communications with customers as we believe it is important to give consumers simple and consistent advice. We also support the Portman Code.

6.0 MINIMUM PRICE PER UNIT

6.1 We are supportive of the Government's proposal to introduce MPU legislation. However it is only part of the solution not the ultimate answer to tackling irresponsible drinking. To be effective it needs to be combined with restrictions on promotional activity, for example a ban on heavy discounts such as 50% off, and education to achieve the radical change the Government is setting out to achieve.

6.2 We do not have sufficient evidence to make an informed view about the most effective minimum price point. However, it is important that it is high enough to eradicate the irresponsible pricing practice that the Alcohol Strategy highlights while maintaining a price that doesn't penalise responsible drinkers. More evidence is essential in determining the most effective price point.

6.3 We believe that restrictions on pricing and promotions will create a fairer and more sustainable market for the drinks industry. It will also help consumers to understand the true value of alcohol.

6.4 We would ask the Government to consider the practical complexities of implementing the proposed legislation, for example, we will need to develop fully automated systems. We estimate the time for delivery as 12–18 months so our preference would be for guidance to be issued as far as possible in advance of enforcement of the legislation. It would also be preferable to implement the changes outside of our busiest trading periods which are the new year, Easter and Christmas. It is worth noting that a heavy discount ban would be much less complex, and therefore much quicker, for retailers to implement.

6.5 We believe it is important to have a degree of flexibility in the MPU to ensure that the price point can be reviewed when there is substantial evidence to assess its impact.

6.6 We welcome the Government's support for changes to the EU rules to allow duty to rise in line with alcoholic strength. The current tax points are set on a wide scale of 8.5 to 15% ABV so there is no incentive for producers to develop wines at 8.5–11.5%. We have seen that the tax incentive for beer has encouraged more suppliers to produce lower strength products.

7.0 PUBLIC HEALTH INTERVENTIONS

7.1 Educating and informing people about safe and responsible alcohol consumption is essential in achieving sustained behavioural change. Education should start at an early age through the school curriculum to ensure young people make responsible choices when they reach the legal drinking age.

7.2 We will continue to make information available to our customers to help them make responsible decisions but this must be strengthened by the bold and targeted government led marketing and education campaigns that the Alcohol Strategy refers to. We particularly welcome the Government's commitment to invest £2.6 million in a youth marketing programme.

8.0 MARKETING OF ALCOHOL

8.1 The majority of our advertising does not focus on alcohol. However, if alcohol is included in our advertisements, it is alongside food to encourage people to consume alcohol responsibly. We always include the Drinkaware branding on any advertisements with alcohol.

8.2 We also include information and advice about alcohol in our customer publications, such as Waitrose Weekend. The focus is on the taste and quality of our range as opposed to encouraging excess consumption.

8.3 We do not believe that marketing restrictions are required if the Government effectively tackles irresponsible pricing and promotions.

May 2012

Written evidence from British Society of Gastroenterology (GAS 36)

1. INTRODUCTION

1.1 The British Society of Gastroenterology (BSG) is a professional society dedicated to the advancement of standards of care, research, education and training in gastroenterology and hepatology.

1.2 The improvement of clinical services for patients suffering with alcohol-related ill health is a stated priority for the BSG's Council and broader membership.¹⁷⁹

1.3 In response to increasing numbers of patients on gastroenterology and hepatology wards with alcohol related ill health the BSG has produced a range of service design proposals, in conjunction with partner organisations—in particular, the establishment of multi-disciplinary *Alcohol Care Teams*. The aim of these has been to improve services across hospital trusts and community settings for patients presenting with alcohol-related health problems. These proposals were initially set out in the Joint Position Paper by the BSG, BASL and the AHA which was published in 2010.¹⁸⁰ This has since resulted in the publication by NHS Evidence of a co-authored BSG/Royal Bolton Hospital NHS Foundation Trust QIPP Evidence publication. This was most recently updated in February 2012.¹⁸¹ We would like to see the promotion and widespread establishment of Alcohol Care Teams given a higher priority and prominence in the Government's Alcohol Strategy

1.4 The BSG has for many years supported the introduction of a Minimum Unit Price (MUP) for alcohol and greater regulation of the marketing and availability of alcohol based on the international evidence available. It fully supports the submission of the AHA, in particular its call for the initial level of MUP for alcohol to be set at *at least 50p per unit*.

2. A MULTIDISCIPLINARY & INTEGRATED APPROACH TO ALCOHOL SERVICE DESIGN & DELIVERY

2.1 As outlined above there is an increasing demand for NHS services for patients presenting with alcohol related ill health. Greater leadership and planning is required to effectively deliver better services for these patients and reduce wider costs associated with acute alcohol-related hospital admissions and readmissions. This demand is felt by A&E departments but is also having a significant impact on gastroenterology and hepatology departments.

2.2 Admissions and readmissions could be reduced if planning was put in place to ensure effective joint working. Each local health area should have a plan to deliver evidence-based care in an appropriate setting,

¹⁷⁹ The BSG is also a member of The Alcohol Health Alliance (AHA) and has close working relationships with a range of patient and advocacy groups that share an interest in improving patient care for people with alcohol-related disease or ill-health

¹⁸⁰ Moriarty et al: http://www.bsg.org.uk/images/stories/docs/clinical/publications/bsg_alc_disease_10.pdf

¹⁸¹ NHS Evidence: <http://arms.evidence.nhs.uk/resources/qipp/29420/attachment>

integrated between primary and secondary care. The BSG describes such joint working as “Alcohol Care Teams”. However, the BSG notes that there are unfortunately very few dedicated teams in the NHS.

2.3 The principal recommendation is for a multidisciplinary “Alcohol Care Team” in each District Hospital, led by a Consultant, with designated sessions in their work plans, who will collaborate across hospitals and primary care to develop a coordinated alcohol treatment and prevention programme. This team would organise systematic interventions and alcohol specialist nurses.

2.4 Coordinated policies are essential and the BSG firmly believes that that the NHS and public health (local authority) services need integrated Alcohol Treatment Pathways developed between primary and secondary care, particularly in the light financial penalties for readmissions and for the wider policy agenda of integrating health and social care services. Alcohol Pathways must be led by a clearly defined Alcohol Care Team.

2.5 The BSG believes this approach would have a huge impact on the care of patients with alcohol-related disease, where there are a large number of “frequent attenders”. This serves to highlight the urgent need for commissioners, providers and clinicians to better manage pathways of alcohol care between hospitals and the community. If this is not an active consideration it is patients with alcohol-related ill health that will fall through the gap.

2.6 In addition to this being an opportunity to improve quality of care, both at a population and individual level, there are also substantial savings to be made. The savings arise from (i) reduced admissions for detoxification (“drying out”) and (ii) reduced readmissions consequent on better management of alcohol addiction and mental health problems, such as, secondary prevention.

2.7 BSG proposals put forward that each multidisciplinary “Alcohol Care Team” should be led by a consultant, with both a clinical and strategic role and five dedicated sessions weekly, who will also collaborate with Public Health structures in Local Authorities, Primary Care Trusts (Clusters and/or CCGs), patient groups and key stakeholders to develop and implement a district alcohol strategy.

2.8 The Team would be a formalised group of individuals, with an overall Lead Clinician. It would include a lead from hepatology, gastroenterology, psychiatry, accident and emergency and acute medicine, other key specialist leads, the Lead alcohol specialist nurse and an executive member of the Trust Board, with a locally appropriate balance of representatives from public health, primary care and patient groups.

2.9 Integration between the Alcohol Care Team and other relevant bodies is vital to a strategy for reducing alcohol-related problems in the district. The BSG strongly advocates that patient groups should be encouraged and supported to develop their own pathways of care, in collaboration with service providers.

2.10 The Lead Clinician would have shared responsibility, with Public Health and primary care, for delivering timely and responsive high quality support services and for achieving targeted quality metrics, including:

- reductions in alcohol-related admissions, readmissions and mortality;
- improvements in public understanding and awareness of alcohol; and
- increased rates of early detection of alcohol misuse.

These metrics align to the NHS and Public Health Outcomes Frameworks.

2.11 The Lead Clinician would usually be a hepatologist, gastroenterologist or liaison psychiatrist. However, the lead could also be an acute medicine physician, accident and emergency consultant or nurse consultant. The lead clinician would identify individuals responsible for alcohol policy in key clinical areas. The lead clinician requires the skills and knowledge to be able to develop, implement, monitor and evaluate effective treatment pathways across disciplines and services, and the ability to provide clinical supervision and support to a range of care providers of different professional groups and specialties. The lead would also provide clinical expertise to policy makers at local, regional and national level (for example at local authority level, within Public Health England or the NHS Commissioning Board).

2.12 The BSG estimates that these proposals could generate £1.6 million savings for a District General Hospital serving a 250, 000 population. This equates to £640,000 per 100,000 population (based on national indicators and length of stay costs).

3. A LEADING ROLE FOR ALCOHOL SPECIALIST NURSES

3.1 The dramatic impact of Alcohol Specialist Nurses (ASNs) during a five-day working week highlights the need for them to work routinely on a seven-day basis in hospitals, especially since such a large proportion of alcohol-related problems present out-of-hours, particularly at weekends. Alcohol specialist nurses pay for themselves many times over, in terms of improved detection of alcohol misuse, accessibility, waiting times, DNA rates, reduced inpatient detoxifications and length of stay, thus achieving four-hour trolley waits, relieving bed pressures and reducing A&E attendances, admissions and readmissions.

3.2 A hospital requires a minimum of four Alcohol Specialist Nurses to provide a seven-day rota. Their primary role is to assess and treat all patients admitted to the Acute Medical Units, A&E admissions and to

supervise the care of all inpatients with an alcohol-related problem. This improves clinical outcomes, including patient engagement with treatment, inpatient length of stay and mortality.

3.3 The nurses would require a skill mix of mental health, liver and accident and emergency experience, and the competencies to recognise liver disease and psychiatric disorders, especially depression, at an early stage. Where appropriate, two hospitals might provide a combined rota, or a combined hospital and community nurse service could be developed, as in Liverpool.

3.4 Implementation of an ASN service in Nottingham improved the health outcomes and quality of care of patients admitted to hospital for detoxification, and also of those admitted for the complications of alcohol-related cirrhosis (S.D.Ryder *et al*, 2010). Hospital admissions were reduced by two thirds, resulting in a saving of 36.4 bed days per month in patients admitted for detoxification. Clinical incidents were reduced by 75%. Liver enzyme abnormalities were halved and there was also a reduction in bed days used in the cirrhotic group from 6.3 to 3.2 days per month. Nurse- led follow-up attendance was high in both groups (see Figures 1 & 2).

Figure 1: Impact of Nurse-led Alcohol Care Team compared with “conventional” care on (a) self-reported alcohol intake and (b) the liver enzyme gamma GT, showing halving of alcohol intake and liver damage. Ryder et al, 2010

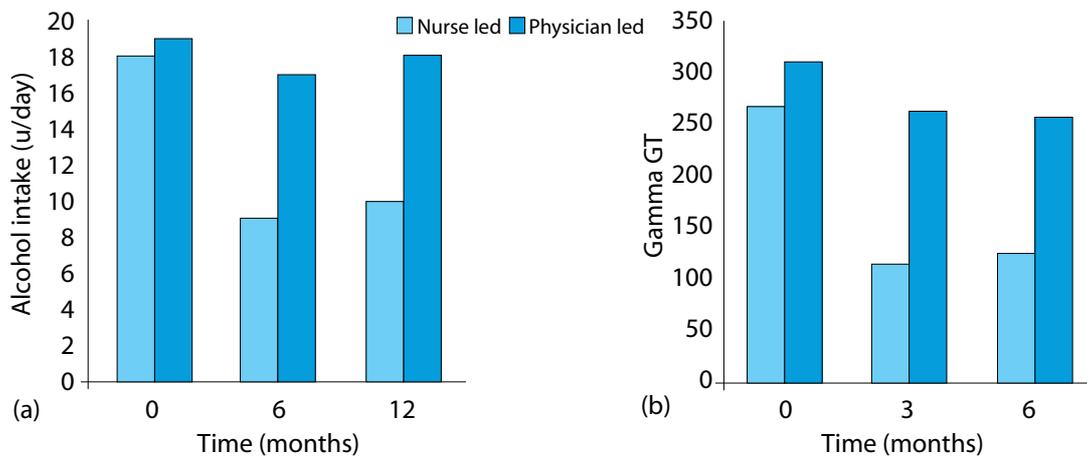
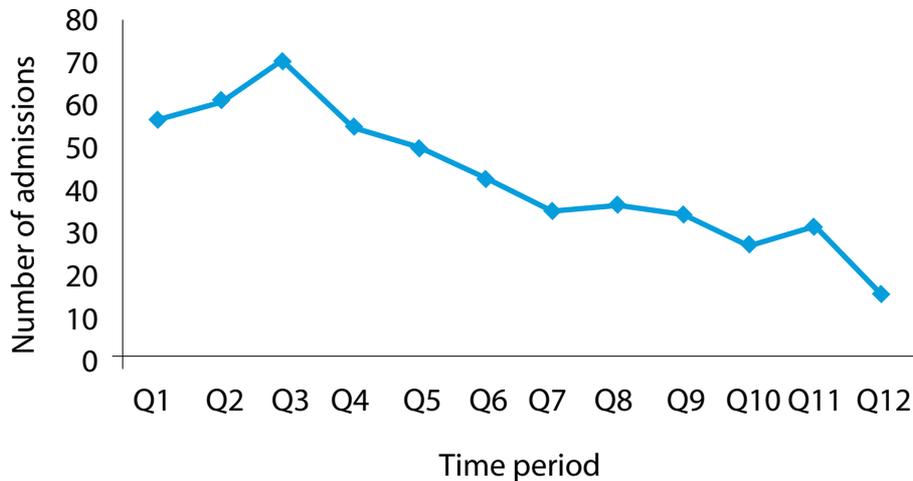


Figure 2: Impact of Nurse-led Alcohol Care Team on admissions to hospital for alcohol withdrawal. The service was introduced in Q2. (Q1 etc refer to three-month periods from 2002). Ryder et al, 2010



4. ALCOHOL OUTREACH SERVICES TO REDUCE ADMISSIONS AND READMISSIONS

4.1 The BSG recommends that each DGH should establish a hospital-led, multi-agency Assertive Outreach Alcohol Service (AOAS), including an emergency physician, acute physician, psychiatric crisis team member, alcohol specialist nurse, Drug and Alcohol Action Team member, hospital/community manager and Primary Care Trust Alcohol Commissioner, with links to local authority, social services, third sector agencies and charities. This will provide integrated medical, psychiatric and social care, especially housing, for the most frequent attenders, some of whom attend Emergency departments, often in different hospitals, on more than 100 occasions per year.

4.2 Salford Royal NHS Foundation Trust has established a hospital-led AOAS. The team works with a cohort of the top 30 patients (frequent attenders), with the highest levels of alcohol-related admissions over a six month period. Each six months, this cohort is refreshed. The team also works proactively with any patient, who has had two alcohol-related admissions within a short period of time, the so-called “fast risers”. Work with the first top 30 cohort resulted in a 66% reduction in Emergency Department attendances in the three month period post-intervention, when compared to the three month period prior to intervention (average monthly attendances were reduced from 83 to 28). There was also a 63% reduction in hospital admissions (35 to 13). This reduction in admissions is being maintained, even though the team is now working with the next top 30 cohort.

4.3. If each DGH establishes a seven-day Alcohol Specialist Nurse Service to care for patients admitted for 0–1 day, together with an AOAS to care for frequent hospital attenders and long-stay patients, for example those with alcohol-related liver disease, healthcare modelling methodology suggests that this could result in a 5% reduction in alcohol-related hospital admissions, with potential cost-savings to its locality of £1.6 million annually. Since the UK population in 2008 was £61.4 million, this would equate to an annual saving for the overall UK economy of £393 million.

5. THE ALCOHOL STRATEGY

5.1 The BSG welcomes the Government’s recently published Alcohol Strategy and has been actively engaged with both the Department of Health and other parts of Government in the lead up to its publication.

5.2 The focus on price within the Alcohol Strategy is to be welcomed, given that this is the principal drivers of alcohol-related health problems in the UK. While it is understandable that binge drinking, and the associated impacts on the criminal justice system, draw the attention of the headlines, it is important to address the long term effects of population level alcohol consumption on the health of the general population.

The BSG is disappointed that the strategy does not contain specific proposals to reduce the exposure of children and young people to alcohol marketing. Increases in alcohol marketing, together with the development of alcopops in the 1990s were a key factor in the development of our current problems with young people and alcohol. The first ever independent analysis (commissioned by the EU Alcohol Forum) recently showed that children in the UK have a higher exposure to alcohol marketing than adults; the forum science committee previously concluded that “alcohol marketing increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol.” A simple solution to this problem was proposed by a member of the Health Committee, Dr Sarah Wollaston, in a 10 Minute Rule Bill introduced last year—a proposal supported by the BSG.

5.3 While the Alcohol Strategy is clearly a cross-Government document drawing in a range of social policy drivers, it is vital that the health challenges and potential health benefits remain at the forefront of the Government’s efforts. The BSG recognises that these issues are interlinked, but hopes that the Department of Health and the emerging structures that follow the Health and Social Care Act 2012 will be given a leading role in implementation. It is equally important that these bodies work effectively across an issue, which spans the various strata of health and social care delivery. The remits of Clinical Commissioning Groups, Local Authorities, the NHS Commissioning Board and Public Health England need to work effectively together, to truly address the problems of alcohol-related harm.

5.4 As outlined in previous sections, it is vital that services are properly designed, planned and integrated to ensure the outcomes for alcohol-related ill health are achieved. While there is some recognition of the need to invest in services (for example alcohol specialist nurses), the Strategy is disappointingly vague on the need for service reform.

5.5 The BSG notes the very distinct possibility that the commissioning of alcohol services, such as those described above, will be pushed between commissioning bodies as “someone else’s responsibility”.

5.6 The levels of consumption of alcohol are still a serious issue for the UK, given that high rates of consumption correlate with alcohol-related harms. Any evidence of a recent fall in alcohol consumption does not constitute a return to the historically much lower levels of consumption. Attempts by the previous Government to liberalise licensing laws has most probably not reduced the amount of alcohol being consumed in the UK and could well have increased the levels.

5.7 The BSG notes that messages about alcohol consumption are often confused and unhelpful. The most important point for policymakers should be the amount of alcohol being consumed, rather than where the alcohol is consumed, who it is consumed with, or the type of alcohol being consumed. As referenced previously, the focus on binge drinking can obscure or deflect from the serious health problems that long term consumption of alcohol can cause.

5.8 The BSG also notes that it is vital that hospital trusts drastically improve the granularity of coding in hospital admissions, in order for the true extent of alcohol-related health service delivery to be reflected and measured. For admissions where alcohol is a secondary factor in hospitalisation, this must also be reflected in statistics, rather than just when it is part of the primary diagnosis.

5.9 A range of studies and modelling have shown the relationship between increasing alcohol unit prices and a reduction in alcohol consumption. The BSG also notes that minimum unit prices affect those who drink at the most harmful level, as they tend to buy the cheapest alcohol in larger quantities. In Canada, where minimum pricing has been implemented, it has been shown to have an effect on levels of consumption.

5.10 The BSG believes that minimum unit pricing is the fairest and most targeted way of addressing harm because it will impact on the heaviest drinkers and on underage drinkers. The BSG also notes that the impact on the most serious drinkers will be seen within a relatively short time frame (three to four years).

5.11 The BSG supports the introduction of a minimum unit price at 50p as this will have the most significant impact on consumption and mortality.

5.12 Alcohol-related mortality is very strongly linked to income and deprivation. According to the ONS, there is a five-fold excess mortality in the most deprived 20th of the male population, compared with the least deprived. The solution to this problem is to take extremely cheap alcohol completely out of the system. The welfare of most deprived sectors of the population should be improved by reducing inequalities in society, not by the provision of cheap alcohol, with its manifold effects on the health of consumers, their families and children. The spurious arguments of the drinks industry, which reaps 75% of its profitability from hazardous and harmful drinkers, should be rejected. The industry is no more interested in the welfare of the poorer sections of society than it is of the children, for whom alcopops was developed.

May 2012

Written evidence from the British Brands Group (GAS 37)

PLAIN PACKAGING

SUMMARY

- There is no hard evidence on the impact of plain packaging on consumption of alcohol. The likely harm arising from such a policy has also not been assessed;
- Brand imagery on packaging performs primarily a differentiation function. There is no evidence that on-pack designs prompt purchase or consumption;
- An assessment of any link between brand imagery and purchase or consumption must be accompanied by an assessment of all the other functions of on-pack branding (eg information, competition, economic, export and illicit trade) for the policy to be evidence-based and proportionate;
- The impact on intellectual property rights would also require assessment, in terms of the legality of disallowing use of previously-granted rights, potential compensation to industry and the effect on the UK's reputation at home and abroad as a place to do business.

1. The British Brands Group welcomes the opportunity to contribute to the Health Committee's scrutiny of the Government's alcohol strategy.

2. The British Brands Group is a trade organisation that provides the voice for brand manufacturers in the UK. Our members range in size and supply a variety of branded goods in a wide range of product categories, of which alcohol is but one. Many supply packaged products, where the packaging plays a crucial role in allowing them to communicate with consumers and compete in the marketplace.

3. The Group is cross-sectoral, focusing on branding and the implications of current and proposed policy and regulation. We therefore confine our comments to the Committee's request for evidence on the role of plain packaging as a means to reduce alcohol consumption and harmful drinking. We leave it to others to comment on other brand-related aspects of the inquiry requiring specific knowledge of the alcohol sector.

4. We understand "plain packaging" to mean generic packaging, where all products in a category are packaged the same, in similar containers with similar labels featuring one design, with the only distinctive element being the brand name of the product, reproduced in a standard typeface of standard size and colour.

EVIDENCE

5. We know of no product category in any country where regulation has required plain packaging. There is therefore no hard evidence of pre- and post-effects to inform policy. Where such policies are being considered or yet to be implemented, "evidence" takes the form of consumer surveys exploring the relative appeal of one type of packaging over another (in terms of attractiveness, perceived quality and brand identification). Such methodologies give no insight into the likely behavioural impact of plain packaging, where consumers would have no choice.

6. Distinctive brand design elements that trigger consumer recognition and understanding of products fulfil extremely important consumer, social and economic functions over and above the appeal of the packaging. Evidence would be needed on the harm to these functions under a plain packaging proposal. No such evidence currently exists.

7. In the absence of any evidence on the extent to which plain packaging might achieve the policy objectives outlined (if at all), we focus below on some of the implications to be considered in an assessment of a plain packaging policy.

PACKAGING APPEAL

8. Packaging's alleged appeal underlies the policy hypothesis that brand designs affect consumption. It would be necessary to compare any such effect with other drivers of consumption (eg parental or peer influences) to determine proportionality. It would also be necessary to draw a direct link between differentiated packaging designs and increased consumption, a link we consider implausible.

9. Consumers (people) tend to see things in relative, comparative, not absolute, terms. In the context of packaging therefore, consumers make choices relative to the options that are available. Distinctive brand designs are more a mechanism for recognising, understanding and distinguishing, rather than for persuasion or compulsion. We are not aware of any evidence that suggests that the packaging of any product in any category is so appealing as to compel purchase and, then, to compel consumption.

INFORMATION

10. Distinctive pack designs convey complex information to consumers in a matter of milliseconds, such as the main characteristics of the product, its quality, heritage, values and, most importantly, whether or not that product is their preferred choice.

11. A plain packaging policy, with all products looking the same bar the brand name, would remove such information to a significant extent. This is likely to result in a more complex purchasing process, less informed consumers and a high incidence of mistaken purchase. Such an effect would run counter to existing Government policy, which considers that well-functioning markets are those in which consumers are able to make well-informed, confident purchasing decisions.

COMPETITION

12. Markets in which products are differentiated through branding are those in which competition is based on a combination of quality, reputation, innovation and price. A consumer is quickly able to differentiate between premium, middle-of-the-range and lower quality products, and different offerings in these segments.

13. The ability of consumers to differentiate between products goes hand-in-hand with producers' incentives to invest in quality, innovation and reputation (including responsible and sustainable ways of doing business). Being able to communicate the consumer and societal benefits of such investment, through marketing and presentation at point-of-sale, allows that investment to be recouped through higher demand and/or higher pricing.

14. Competition in commodity markets (where all products are—or are perceived to be—the same) is fundamentally different, with the focus being predominantly on price. Where products are (or through regulation have to be) undifferentiated, investments in additional quality, innovation and reputation are far more difficult—it not impossible—to recoup as the consumer benefits cannot be communicated and therefore not identified. Barriers to entry for such products are in effect raised.

15. A plain packaging regime would fundamentally shift the nature of competition, with significant implications. Reduced investment in innovation means consumers lose out from fewer new and improved products, while less investment in reputation is likely to be detrimental to sustainable production and societal well-being.

16. Moreover, innovation effort would likely shift to ways to reduce price (which could still be communicated), leading to sclerosis of the market for higher quality products and stronger competition in lower price brackets through the launch of new price-fighting products. This may result in higher consumption of alcohol, not lower.

ECONOMIC IMPLICATIONS

17. Innovation is closely linked with economic growth and the creation of new markets. Reduced incentives to innovate on the basis of quality and/or reputation are likely to inhibit economic growth.

18. Reduced UK innovation and saliency of brands as a result of plain packaging may also damage the competitiveness of UK products overseas and may well result in innovation and marketing investment and skills leaving the UK for markets more conducive to brand creation and brand building. Bearing in mind the size and success of UK alcoholic drinks products abroad, this effect is likely to be significant.

ILLICIT TRADE

19. There are three potential illicit trade effects to be considered, increased "parallel" trade from European markets, increased "grey" trade from markets outside the EU and increased trade in counterfeit goods.

20. Were it to be found that branding on packaging does have a greater appeal for consumers than we believe, and were the UK to be the only EU market to introduce plain packaging, there would be enhanced demand for branded packaged products from other EU markets. A similar effect can be expected in relation to grey trade, with products being increasingly imported from markets outside the EU.

21. Should parallel trade increase and be of a scale that exceeds use for personal consumption and should grey trade also increase, this would increase the risk of such products entering the illicit supply chain, with an accompanying increased risk of individual traders circumventing the strict age controls in place in the legitimate supply chain. This would run counter to the policy objectives and may impact duty revenues.

22. In the area of counterfeiting, there are two potential risks:

- (1) greater simplicity and homogeneity of pack designs make it easier for counterfeiters to produce fakes. Counterfeits are more likely to be distributed through illicit supply chain, circumventing age controls;
- (2) with all products in a category looking very similar, it will be much harder for consumers to detect—and steer clear of—fakes.

23. Any increase in illicit trade will increase pressure on already stretched enforcement organisations, notably customs, police and trading standards services.

INTELLECTUAL PROPERTY RIGHTS (IPRs)

24. Brand imagery on pack is protected by IPRs which are granted by the state and protect many of the features that differentiate one product from another. Through significant investment over time, trade marks in particular have become crucial heuristics (mental shortcuts) used by consumers to identify and understand different products, becoming amongst the most valuable of corporate assets.

25. Not only are IPRs granted by the state, they are also protected by international agreements, notably TRIPs. Interference with or the removal of such rights by the state may breach those agreements and obligations and be open to challenge. This was highlighted by Economiesuisse, the Swiss business federation, which stated,

“[R]equiring generic packaging of products . . . amount[s] to an indirect expropriation of intellectual property and constitute[s] a clear breach of international law.”

26. Furthermore, there may be a strong case for the state to pay compensation to those companies who have made huge investments over decades in the reputation of their products and the heuristics associated with them, reflected in their IPRs.

27. Separate from the legality of withdrawing previously-granted IPRs and any case for compensation, a strong message would be sent to the world that the UK is willing to confiscate IPRs (quite possibly without evidence that they inhibit policy goals). This would be a hostile message to business generally and to inward business investment, damaging the UK’s reputation and “brand” abroad.

CONCLUSION

28. Any potential that plain packaging may have to reduce alcohol consumption and/or harmful drinking must be balanced with a full understanding of the harm such an approach may inflict, on consumers, competition, innovation, the economy, exports, the illicit trade and IPRs. Without it, the policy amounts to a leap in the dark.

29. We believe that, in exploring plain packaging, the role of brand imagery in stimulating purchase and consumption is being enormously exaggerated while the accompanying risks are being ignored. We also believe it would represent a policy move diametrically opposed to mainstream Government policies, leading to less informed, empowered consumers, less competition, less innovation, reduced or no growth and markets that work less well, with the burden on enforcement authorities becoming heavier not lighter.

May 2012

Written evidence from the Wine and Spirit Trade Association (GAS 38)

The Wine and Spirit Trade Association (WSTA) welcomes the opportunity to submit written evidence to the Committee’s inquiry into the Government’s Alcohol Strategy. We represent 340 companies in the UK alcoholic drinks sector, which range from global businesses to SMEs. We work with our members to promote the responsible production, marketing and sale of alcohol.

SUMMARY

- Alcohol consumption in the UK has declined and the majority of people drink responsibly. Alcohol policy should be targeted at the minority who misuse alcohol.
- Alcohol-related policy measures must be shown to be necessary, evidence-based and proportionate, with policy-making fully coordinated between different government departments.

- The alcohol industry has an important role to play in tackling alcohol misuse. Our commitment is demonstrated through pledges made through the Public Health Responsibility Deal.
- There is no evidence that minimum unit pricing will reduce alcohol misuse. It will affect all consumers, regardless of whether they contribute to alcohol harm and a 40p minimum unit price will hit the poorest 30% of households hardest.
- Minimum pricing is likely to be illegal. It is inconsistent with the operation of the free market for the state to intervene on price. This is a view previously shared by government ministers.
- We want to see businesses able to offer a greater range of lower alcohol products and we welcome the Government's intention to look at existing barriers to the promotion of lower strength alcohol products.

1. GENERAL COMMENTS

1.1 The debate about alcohol misuse and how to tackle it must be based on all the available evidence. While a minority of people continue to misuse alcohol, it is important to recognise that alcohol consumption in the UK has declined and most people drink within recommended guidelines.

1.2 Measures to tackle alcohol misuse should be targeted at those who misuse alcohol, rather than the majority of people—and businesses—who produce, sell and consumer alcohol responsibly.

1.3 The drinks sector plays a valuable role in the UK economy, as a source of employment, growth and investment. The cumulative weight of regulation on the alcohol industry, in addition to year-on-year duty increases, is a major concern for businesses, particularly given the challenge to remain competitive in the current economic climate.

Key facts about UK Alcohol Consumption

- *UK consumption has fallen.* An analysis of HMRC clearance data shows that total alcohol consumption per head of the UK population fell by 13% between 2004 and 2011, from 9.5 litres of pure alcohol per person to 8.3 litres.¹⁸²
- ONS survey data reveals that between 2005 and 2010, average weekly alcohol consumption in Great Britain decreased from 14.3 units to 11.5 units per adult.¹⁸³
- *More people are drinking within recommended limits.* Fewer people in Great Britain are drinking over the recommended weekly guidelines. The proportion of men drinking more than 21 units a week has fallen from 31% in 2005 to 26% in 2010. The number of women drinking more than 14 units a week down from 21% to 17% over the same period.¹⁸⁴
- *Binge drinking continues to decline.* The proportion of men drinking more than eight units on their heaviest drinking day in a week fell from 23% in 2005 to 19% in 2010. Women drinking more than six units were 15% in 2005 and 13% in 2010.¹⁸⁵

2. RESPONSIBILITY WITHIN GOVERNMENT FOR ALCOHOL POLICY

2.1 The question of which government department should have responsibility for alcohol policy is not a matter for industry. However we would like to emphasise that there must be effective, joined-up policy-making across Whitehall, with all measures affecting industry shown to be necessary, evidence-based and proportionate.

3. THE COORDINATION OF ALCOHOL POLICY ACROSS THE UK

3.1 It is important that the UK Government and Devolved Administrations recognise the implications for industry of imposing different regulatory requirements within one marketplace. Compliance with different regimes in the constituent parts of the UK imposes additional operating costs on businesses, which over time could have an impact on the ability of the industry to contribute to growth, investment and job creation. There have already been several successive reforms to licensing laws across England, Wales, Scotland and Northern Ireland in recent years.

4. THE INDUSTRY'S ROLE IN ADDRESSING ALCOHOL-RELATED HEALTH PROBLEMS

4.1 The industry has an important role to play in tackling alcohol misuse and encouraging people to drink sensibly. We want alcohol products to be made, sold and enjoyed responsibly.

4.2 We believe that the most effective way to promote responsible drinking is not through government action in isolation, such as regulation, but through a partnership approach involving government, industry and the health community. Industry has much to contribute to such a partnership, as it can reach consumers in ways which government cannot.

¹⁸² British Beer & Pub Association, New figures show UK Alcohol consumption down again in 2011, 11 March 2012

¹⁸³ Office for National Statistics, *General Lifestyle Survey Overview Report 2010*, 8 March 2012, Table 2.1

¹⁸⁴ *Ibid.*, Table 2.2

¹⁸⁵ *Ibid.*, Table 2.4

The Public Health Responsibility Deal

4.3 The Responsibility Deal, launched in March 2011, is a good example of how the industry takes its responsibility to address alcohol misuse seriously. We welcome the Government's recognition in the Alcohol Strategy of our voluntary support for the Deal.

4.4 As a Trade Association, the WSTA has been at the forefront of the work on the alcohol strand of the Deal. Our former Chief Executive, Jeremy Beadles, was co-chairman of the Alcohol Network until January 2012, the group charged with overseeing development of alcohol pledges. There are now eight collective alcohol pledges supported by the industry. More detail about some of these is set out below.¹⁸⁶

Pledge A1: Labelling

4.5 Building on the 2007 voluntary labelling agreement with the Department of Health, the industry has pledged to include clear unit labelling, NHS guidelines and a warning about drinking when pregnant on over 80% of alcohol products on shelves by 2013. Businesses will also be encouraged to include two additional elements, which are the Drinkaware web address and a responsibility statement such as "drink sensibly" or "know your limits".

4.6 Left is an example of the kind of label format we wish to see on alcohol products.¹⁸⁷ The Portman Group has agreed to monitor implementation of the pledge, with criteria agreed with the Department of Health to ensure labels display information in a clear and consistent manner.

Pledge A3: Unit Awareness

4.7 The industry has committed to raising people's awareness and understanding of units to help people drink within recommended guidelines. In February retailers launched the "How many units in your drink?" consumer campaign. This is based on a simple "2-2-2-1" message, to show the number of units in a typical can of 4% abv lager, 330ml bottle of 5% lager, 175 ml glass of 12% ABV wine and a single measure of a 40% abv spirit. Campaign materials are being displayed by major retailers across the UK on posters, shelf talkers and till screens. Some WSTA members have supplemented in-store messaging with communication through other channels, such as membership magazines.

4.8 The off-trade campaign has drawn on unit awareness material produced for use in pubs and clubs, in order to provide consistent messaging wherever alcohol is being consumed.

Pledge A7: Community action to tackle alcohol harm

4.9 The industry has committed to supporting local schemes to tackle alcohol-related harms. The WSTA has made an individual pledge in support of this, to extend Community Alcohol Partnerships (CAPs) around the UK. CAPs, developed by retailers and coordinated by the WSTA, aim to tackle the problems caused by underage access to alcohol through local partnership working by licence holders, trading standards, police and local authorities.

4.10 In 2011, CAPs were established as a standalone Community Interest Company with an Advisory Board, Chaired by Baroness Helen Newlove, to oversee expansion of the scheme.

4.11 There are now 36 operational CAP schemes across the UK and there have been several successful launches of new schemes over the last year. These have included a partnership in Derry, the first scheme of its kind in Northern Ireland, and our first inner city project in Islington, London. Independent evaluations of CAP projects have demonstrated positive impacts on underage drinking and alcohol-related anti-social behaviour.

5. MINIMUM UNIT PRICING

5.1 The WSTA is opposed to a policy of minimum unit pricing both in principle and in practice. There is no evidence to prove that it will tackle alcohol misuse yet it will raise prices for consumers who do not have a problem with alcohol. A 40p minimum unit price will hit the poorest 30% of households in England and Wales the hardest.

No evidence it will tackle misuse

5.2 Minimum unit pricing has not been successfully implemented anywhere in the world, so there is no real-world evidence to support it. It is clear that there is no simple link between price, consumption and alcohol misuse. Countries that have the highest alcohol taxes and highest prices are also ones where alcohol misuse is a problem. In the UK, alcohol consumption has dropped since 2004, but there has been reportedly no decrease in harm indicators, such as alcohol-related hospital admissions.

¹⁸⁶ The list of alcohol pledges can be found at: <http://responsibilitydeal.dh.gov.uk/pledges/>

¹⁸⁷ Not printed. For examples visit <http://www.wsta.co.uk/images/label/labellingguide.pdf>

It will punish responsible consumers- particularly the poorest

5.3 Minimum unit pricing will affect all consumers regardless of whether they contribute to alcohol harm. Evidence suggests that the heaviest and most harmful drinkers are the least responsive to price changes, meaning that higher prices will penalise moderate drinkers whilst having little impact on those whose behaviour we want to change.

5.4 Minimum pricing would be a highly regressive measure which would hit the poorest hardest. An ONS study noted that people in poorer households spend a greater proportion of their disposable income on alcohol duty than higher wage earners.¹⁸⁸ A minimum alcohol price of 40p would hit the 30% of households in England and Wales on the lowest incomes.¹⁸⁹

It is likely to be illegal

5.5 It is inconsistent with the operation of the free market for the state to intervene on price. Minimum pricing could therefore represent a barrier to trade and be illegal under EU law. Government Ministers have previously shared this opinion. For example, Chloe Smith, Economic Secretary to the Treasury said: “The Scottish Government have recently introduced a Bill that seeks to bring in a 45p per unit minimum price... we believe that it could be incompatible with article 34 of the treaty of the functioning of the European Union...That is the position.”¹⁹⁰

5.6 Article 34 of the EU Treaty prevents Member States from adopting and maintaining unjustified restrictions on intra-EU trade. It states that “Quantitative restrictions on imports and all measures having equivalent effect shall be prohibited”. Article 36 allows restrictions for the protection of health, but the measures must be proportionate and not “constitute a means of arbitrary discrimination or a disguised restriction on trade between Member States”. By fixing a minimum price for alcohol, the UK Government would risk impeding the free trade of alcohol within the EU. For example, even though a minimum price would be applied equally to domestically produced and imported products, it is likely to put imported products at a disadvantage if their lower cost price could not be reflected in the retail selling price.

5.7 Legal precedents for this include the *Openbaar Ministerie v Van Tiggele*¹⁹¹ case in 1978, when the European Court of Justice ruled that Dutch legislation setting out minimum selling prices for certain spirits was illegal. The ECJ found that imports may be impeded where prices or profit margins are fixed at a level that places imported products at a disadvantage. In 2010, the ECJ judged that French, Austrian and Irish legislation on minimum prices for tobacco products were illegal.¹⁹² The court rejected public health justifications for a minimum price.

6. THE EFFECTS OF MARKETING ON ALCOHOL CONSUMPTION

6.1 The UK already has some of the strictest restrictions on alcohol advertising and marketing in the world. The industry’s self-regulation through the Portman Group Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks works to ensure that products do not encourage irresponsible consumption or appeal to children. Alongside this, the Advertising Standards Authority enforces strict standards in all “paid for” space, such as television and radio. The Portman Groups’ submission to the Committee contains more detailed comments on this issue.

6.2 The Government has announced an intention to introduce a ban on multi-buy discounts, which the WSTA opposes. There is no compelling evidence that retailer promotions are causing alcohol misuse and that banning such promotions will reduce alcohol harm.

7. EDUCATION AND INFORMATION

7.1 We believe that better education to help people make sensible choices about their consumption is very important. In recent years there have been concerted alcohol education and information campaigns by government, industry and NGOs and evidence suggests this is having an impact. For example, knowledge of units and sensible drinking guidelines amongst the public has increased.¹⁹³

7.2 Industry commitments under the Responsibility Deal will go even further towards educating people about sensible drinking. (See Section 4). The industry is also developing a new pledge to support well-evidenced alcohol prevention and education programmes for under 18s.

¹⁸⁸ ONS, *The effects of alcohol and tobacco duties on household disposable income*, 19 December 2011

¹⁸⁹ Analysis for WSTA by the Centre for Economics and Business Research (CEBR), March 2012

¹⁹⁰ *Hansard*, 14 Dec 2011, Col. 341WH

¹⁹¹ Case 82/77

¹⁹² *Commission of the European Communities versus the French Republic, Republic of Austria and Ireland*, Case 197/08, Case 198/08 and Case 221/08

¹⁹³ Office of National Statistics, *Omnibus Survey Report: Drinking: Adults’ Behaviour and Knowledge in 2009, 2010*

8. REDUCING THE STRENGTH OF ALCOHOLIC BEVERAGES

8.1 Market intelligence suggests that people are increasingly looking for lower alcohol products and industry is working to improve consumer choice in this area. In March a new collective industry pledge was launched under the Responsibility Deal to remove more than one billion units of alcohol from the UK market by 2015. This will be achieved in a range of ways, such as through lowering the strength of existing brands and introducing new lower strength products.

8.2 For some time the WSTA has been working to highlight the obstacles which hinder businesses being able to develop and market lower alcohol products. For example, under the Committee of Advertising Practice's Code, the only alcoholic drinks which may be presented as preferable because of their low strength are those under 1.2% abv.¹⁹⁴

8.3 We welcome the statement in the Alcohol Strategy that the Government will work with the Advertising Standards Authority and others to look at the rules and incentives that might inhibit the promotion of lower strength alcohol products. We look forward to working with the Government on this matter.

9. PLAIN PACKAGING

9.1 The Government is currently consulting on the issue of plain packaging for tobacco. To consider this in relation to alcohol products effectively equates drinking with smoking, which we utterly reject. Smoking is harmful in any quantity, whereas drinking in moderation is not. This is a view shared by the Secretary for State for Health, Andrew Lansley:

“My objective is to achieve smoke-free communities; theirs [the tobacco industry] is to make a profit from selling intrinsically harmful products. We don't have common ground. This is not like alcohol, where there is a level of responsible drinking and potential shared campaigns between Government and retailers. That's why there is no place in the Responsibility Deal for tobacco companies. There is no responsible level of tobacco consumption.”¹⁹⁵

May 2012

Written evidence from Business In Sport and Leisure (GAS 39)

- Business In Sport and Leisure represents over seventy private sector companies and organisations in the important sport, leisure and hospitality industry. Its membership is comprised of a mixture of leisure operators, a majority of whom provide a licensed bar or other licensable activity even where it is not their primary business.
- BISL is disappointed that the Alcohol Strategy is still seeking to use blunt instruments to deal with those few premises that do not abide by current legislation instead of ensuring that the legislation is properly applied.
- The Strategy is riddled with inaccurate and, or out of date evidence—and continues to place almost total responsibility on the retailer. Whilst the strategy claims, and does, give greater power to the community; it does very little indeed to reinforce the concept of any “individual responsibility.”
- Despite recognition that supervised drinking is safer than in particular young people left to their own devices and the success of voluntary industry led initiatives such as Best Bar None, Purple Flag and Business Improvement Districts the strategy recommends powers for local government to place a late night levy on premises operating beyond 24.00 hours that threatens to undermine existing voluntary initiatives.

INTRODUCTION

1. Business In Sport and Leisure represents over seventy private sector companies and organisations in the important sport, leisure and hospitality industry. Its membership is comprised of a mixture of leisure operators, a majority of whom provide a licensed bar or other licensable activity even where it is not their primary business. Membership also includes a large number of professionals from law and finance that support the sector. BISL was an active member of the DCMS Advisory Group on licensing during the passage of the Licensing Act 2003 and subsequently has continued that dialogue more recently at the Home Office where specific discussions around EMROs and the Late Night Levy were appreciated.

OVERVIEW

2. BISL Members were somewhat disappointed at the tone, content and lack of balance in both the Alcohol Strategy itself and the statement by the Home Secretary to the House of Commons at its launch.

3. Whilst the ambitions of the strategy as outlined in paragraph 1.6 are ones that everyone can applaud the document is riddled with inaccurate and, or out of date evidence—and continues to place almost total

¹⁹⁴ The UK Code of Non-broadcast Advertising, Sales Promotion and Direct Marketing (CAP Code)

¹⁹⁵ Speech by Andrew Lansley, *Smoking and Health*, 6 March 2012
<http://mediacentre.dh.gov.uk/2012/03/07/speech-6-march-2012-andrew-lansley-smoking-and-health/>

responsibility on the retailer. Whilst the strategy claims, and does, give greater power to the community; it does very little indeed to reinforce the concept of any “individual responsibility”. Surely circumstances in which under 18s when caught breaking the law should be dealt with in a manner that is a genuine deterrent rather than get off scot-free.

4. Whilst the Alcohol Strategy does contain an acknowledgement that “alcohol consumption can have a positive impact on adults well being... Well run community pubs and other businesses form a key part of the fabrics of neighbourhood, providing employment and social venues and a profitable alcohol industry enhances the UK economy” the tone and policy content of the document is set in the first two words of the Prime Minister’s foreword “Binge drinking”. BISL accepts the need to deal with excessive drinking pattern but the use of the term “BINGE DRINKING” is undefined and emotive.

5. In essence the strategy is still seeking to use blunt instruments to deal with those few premises that do not abide by current legislation instead of ensuring that the legislation is properly applied. It is turning away from all the key principles that underpin the Licensing Act 2003, legislation that was enacted after extensive research and consultation in particular around zoning and artificially early closing times.

6. BISL like many others is nervous of any Government intervention on pricing in the marketplace and members agreed that there is the potential of unintended consequences ie of such a low minimum unit price actually fuelling supermarket sales as limited disposable income drives customers away from the pub to private parties.

DETAILED COMMENTS: ALCOHOL CONSUMPTION

7. In the introduction (para 1.1) the report highlights an increase in alcohol consumption over the past 50 years and yet it fails to acknowledge the ONS report in March 2012 that between 2005 and 2010 average weekly alcohol consumption in the UK decreased from 14.3 units to 11.5 units per adult. Among men average alcohol consumption decreased from 19.9 units to 15.9 units a week and for women from 9.4 units to 7.6 units a week.

8. Since 2005 the GHS/GLF has shown a decline in the proportion of men drinking more than 21 units of alcohol a week and in the proportion of women drinking more than 14 units of alcohol a week. The proportion of men drinking more than 21 units a week fell from 31% in 2005 to 26% in 2010 and the proportion of women drinking more than 14 units a week fell from 21% to 17% over the same period. These changes were driven by falls in the younger age groups. Among men, the percentage drinking more than 21 units of alcohol a week decreased in the 16 to 24 age group (from 32% to 21%) and in the 25 to 44 age group (from 34% to 27%). Falls were also present among women; the percentage drinking more than 14 units of alcohol a week fell in the 25 to 44 age group from 25% to 19%. When using the average weekly consumption measure, heavy drinking is defined as consuming more than 50 units a week for men and consuming more than 35 units a week for women. There have been falls in the proportions of both men and women who drink heavily since 2005. The estimates for men fell from 9% to 6% and for women fell from 5% to 3% from 2005 to 2010.

SALE OF ALCOHOL TO YOUNG PEOPLE

9. Amongst young people the proportion who have never drunk alcohol rose from 39% in 2003 to 55% in 2010. Less than half (45%) of pupils aged between 11 and 15 said that they had drunk alcohol at least once in their lifetimes. This increased with age from 10% of 11 year olds to 77% of 15 year olds.

10. BISL recognises the importance of protecting young people and even a rate of increase to 55% between 11 and 15 is insufficient to allow complacency. BISL accepts that severe penalties are still required to prevent underage sales.

11. However in April 2007, a premises licence holder could face up to three months licence suspension and/or a fine of up to £10,000 if any premises is subject to three failed under aged alcohol test purchases within a three month period. As an alternative, at the option of the enforcing authority, they could accept voluntary closure of up to 48 hours (again at a timing chosen by the authority). Most took this option rather than chancing their hand before the Magistrates. There is no defence available to the operator.

12. The previous Government reduced the threshold to just two failed test purchases in January 2010. Under the Police Reform and Social Responsibility Act which came in to force on 25 April 2012, the maximum penalty was increased from £10,000 to £20,000 and the period for voluntary closure will extend from up to two days to a minimum of two days up to a maximum of 14 days. In these circumstances it would seem unlikely that a premises licence holder will accept voluntary closure and will more likely remain open and await an appearance before a magistrate.

13. Many operators have now adopted as standard practice non statutory proof of age schemes such as Challenge 21/Challenge 25 and some now undertake their own test purchasing to ensure compliance.

LATE NIGHT LEVY

14. The Strategy makes reference (para 3.10) to the powers for local licensing authorities to impose a late night levy on premises operating beyond 24.00 hours. It is within precisely such premises that supervised drinking takes place rather than outdoors or at an increasing number of private parties.

15. Many of these premises are already engaged in voluntary accreditation programmes such as Best Bar none or part of area initiatives such as Business Improvement Districts and Purple Flag Programme all of which encourage a safer supervised environment.

16. Despite a widespread recognition of the success of the voluntary initiative, funded on a consensual basis by the operators the strategy seeks to impose through the levy a further charge on premises licence holders. There is already evidence that the present reduction in sales and escalating costs of duty, energy etc are making some operators review such voluntary contributions. The introduction of a Late Night Levy is likely to exacerbate the problem in areas such as Lancashire where five schemes have been lost and West Yorkshire where 6 schemes have disappeared.

17. At best regulations for the introduction of both the Late night Levy and the Early Morning Restriction Order should advise exemption for those premises already engaged in appropriate, voluntary accreditation schemes.

May 2012

Written evidence from Mentor (GAS 40)

SUMMARY

- Mentor welcomes the alcohol strategy, including the introduction of minimum unit pricing, but would like to have seen a more comprehensive approach to preventing the harms of alcohol misuse among young people.
- We are concerned not only that evidence-based programmes are failing to reach scale, but also that school health education is given a low priority and the quality of delivery is highly variable.
- Universal alcohol misuse prevention programmes in schools have been shown to have an impact on alcohol use as well as other drugs such as tobacco and cannabis.
- The approaches which appear to be most effective are those based on social influences and life skills, for example Life Skills Training and Unplugged.
- Interventions which are not alcohol-specific but focus on children and young people's attachment to school (eg Good Behaviour Game) or personality type (eg Preventure) can also be effective in reducing alcohol misuse.
- Economic modelling suggests that programmes do not need to have dramatic impacts on behaviour to be cost-effective when delivered universally.

1. INTRODUCTION

1.1 Mentor is a UK charity which believes that prevention is better than cure. We focus on protecting children from the harms caused by drugs and alcohol through evidence based programmes and interventions, inspiring them with choices to achieve their best as individuals and citizens, and working in partnership with schools, parents and carers and communities.

1.2 We support the move towards minimum unit pricing (MUP), which we expect to be an effective environmental intervention. The table below sets out the expected impacts if set at 40p and the considerably greater impacts of a 50p minimum unit price.¹⁹⁶

<i>Negative outcomes averted per year</i>	<i>40p</i>	<i>50p</i>
Hospital admissions (first year)	7,500	17,600
Hospital admissions (after 10 years)	38,900	94,200
Deaths (first year)	156	402
Deaths (after 10 years)	1,149	2,941
Violent crimes	2,100	7,700
Crimes (total)	8,900	30,100

1.3 We also welcome the focus on parents, since they have been shown to have a strong influence over young people's decisions about drugs and alcohol. We are glad that earlier guidance from the Chief Medical Officer on young people's drinking is reinforced. The strategy also promises social marketing for young people which will support parents to have a real impact on their children's behaviour. We hope that this will be implemented in a way most likely to achieve behavioural change and recommend that the government looks

¹⁹⁶ Purshouse, R, *et al* (2009). Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. NICE

at evidence suggesting that using a “social norms” approach (stressing the positive behaviour of the majority) can be effective.¹⁹⁷

1.4 However, the government’s alcohol strategy falls short of the comprehensive, evidence-based prevention strategy for young people that the scale of the problem requires. “Comprehensive” means prevention that works: across different settings (schools, families and community); for children and young people of different ages and at different levels of risk; and at different levels (changing the environment, increasing knowledge and understanding, and developing skills and values). “Evidence-based” means based on the knowledge we currently have about what works, but also implies continued investment in building that knowledge base.

1.5 The main gap that we identify in the alcohol strategy is universal school-based alcohol prevention, based on developing young people’s skills as well as their knowledge and understanding.

2. HARMS AND COSTS OF ALCOHOL CONSUMPTION BY UNDER-18S

2.1 Alcohol consumption in excess is a problem across society. However, regular drinking in adolescence carries particular risks and costs, both for the individual and for the wider community. Although the proportion of young people who drink has fallen in the past decade, there is still cause for concern. A quarter of 12 year olds have had an alcoholic drink. By the time they are 15, almost a third say they have drunk alcohol in the past week, consuming an average of 14 units in that time. One in ten say they have been drunk at least three times in the past month.¹⁹⁸

2.2 Drinking too much can put a young person in hospital. In England, in 2007–08 over 7,600 under 18s were admitted to hospital for conditions directly related to alcohol, almost all alcohol poisoning and/or acute intoxication.¹⁹⁹

2.3 Lowered inhibitions also lead to risky behaviour. The 2007 ESPAD survey of 15- and 16-year-olds found a quarter (26%) of teenagers from the UK had had an accident or injury as a result of alcohol use. Also, 12% had performed poorly at school as a consequence of alcohol use; 17% had got into a fight; 15% had got into trouble with the police; and 11% had engaged in unprotected sexual intercourse.²⁰⁰

2.4 Young people’s drinking aged 15 to 16 results in 195,000 accidents and injuries a year and costs the NHS over £4 million a year through attendance at A&E alone.²⁰¹ Around 80,000 violent offences and 27,000 property-related offences were carried out by under-18s and directly attributed to drunkenness.²⁰²

2.5 Other impacts of early alcohol consumption are less immediate, but still worrying. Heavy drinking in adolescence can interfere with normal development of the brain, liver and bones and affect hormone levels.²⁰³ Studies estimate that the probability of alcohol dependence can be reduced by 10% for each year drinking onset is delayed in adolescence.²⁰⁴

3. THE STATE OF SCHOOL-BASED PREVENTION

3.1 The alcohol strategy identifies schools as having a vital role as promoters of health and wellbeing in the local community. However, this role is currently not being used to full advantage.

3.2 Ofsted’s 2010 report on PSHE found: “*Lack of discrete curriculum time in a quarter of the schools visited, particularly the secondary schools, meant that programmes of study were not covered in full. The areas that suffered included aspects of sex and relationships education; education about drugs, including alcohol; and mental health issues that were not covered at all or were dealt with superficially.*”²⁰⁵

3.3 In many schools, PSHE education is taught by non-specialists. Unsurprisingly, the Ofsted report cited above found better quality teaching from teachers trained in PSHE.

3.4 As outlined below, there is a growing evidence base for classroom-based drug and alcohol prevention. However, these are currently very little used in the UK, while a significant proportion of drug and alcohol education uses approaches which are not believed to be effective. A recent EMCDDA review found that across Europe, personal and social skills training programmes have not increased, while interventions with little

¹⁹⁷ Perkins, H W (ed) (2003). *The Social Norms Approach to Preventing School and College Age Substance Abuse*. John Wiley & Sons

¹⁹⁸ Fuller, E (ed) (2011). *Smoking, drinking and drug use among young people in England in 2010*. Health and Social Care Information Centre,

¹⁹⁹ Donaldson, L (2009). *Guidance on the Consumption of Alcohol by Children and Young People*. Department of Health

²⁰⁰ Hibell B, Guttormsson U, Ahlström S, *et al* (2009). *The 2007 ESPAD Report: Substance Use Among Students in 35 European Countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs

²⁰¹ Jones, L, Stokes, E and Bellis, M (2007). A review of the effectiveness and cost-effectiveness of interventions delivered in primary and secondary schools to prevent and/or reduce alcohol use by young people under 18 years old. Addendum: Additional economic evidence prepared for the Public Health Interventions Advisory Committee (PHIAC). NICE

²⁰² Jones, L, Stokes, E and Bellis, M (2007). A review of the effectiveness and cost-effectiveness of interventions delivered in primary and secondary schools to prevent and/or reduce alcohol use by young people under 18 years old. Addendum: Additional economic evidence prepared for the Public Health Interventions Advisory Committee (PHIAC). NICE

²⁰³ Donaldson, L (2009). *Guidance on the Consumption of Alcohol by Children and Young People*. Department of Health

²⁰⁴ Grant, B F, Stinson, F S, & Harford, T C (2001). Age of onset of alcohol use and DSM-IV alcohol abuse and dependence: A 12 year follow-up. *Journal of Substance Abuse*, 13, 493–504.

²⁰⁵ Ofsted (2010). *Personal, social, health and economic education in schools*. Ofsted.

evidence of effectiveness continue to be widely provided: information days about drugs; visits of police officers or other external visitors to schools; and information about the risk of alcohol without skills training.²⁰⁶

3.5 Mentor is concerned that with a lack of guidance for schools in how to commission effective alcohol prevention, approaches can be taken which are counterproductive, for example seeking to scare pupils into taking healthy decisions or staying within the law. A cost-benefit analysis of the Scared Straight programme (which seeks to shock young people out of anti-social behaviour) estimates that for every £1 spent on delivering the programme society has to pay an additional £32.69.²⁰⁷ We are aware of at least one UK charity using what appears to be this approach that claims to have reached 100,000 pupils in the last year.

3.6 Outside lesson time, school based primary prevention spending for children and young people was £143 million in 2006–07. This included £17 million for the National Healthy School programme, which has since been cut.²⁰⁸ Direct services to pupils included routine medical checks, sexual health advice and family planning, smoking cessation and substance misuse advice and support.

4. EFFECTIVE SCHOOL-BASED INTERVENTIONS

4.1 Rigorous evaluation of the research base, for example through Cochrane reviews (a gold standard in public health research), shows that developmental programmes in schools can have a measurable impact, reducing harmful drinking, smoking, and cannabis use. A 2011 Cochrane review of universal alcohol prevention programmes in schools concluded “*Current evidence suggests that certain generic psychosocial and developmental prevention programs can be effective and could be considered as policy and practice options. These include the Life Skills Training Program, the Unplugged program, and the Good Behaviour Game.*”²⁰⁹

4.2 Life Skills Training and Unplugged have a similar approach, often described as life skills. They provide information about drugs and alcohol, in particular correcting misperceptions about how common and acceptable substance misuse is among the young people’s peer group (normative education). They also teach interpersonal skills to help handle realistic situations where alcohol or drugs are available, and to improve resilience in pupils.

4.3 Interventions which are not alcohol-specific but focus on children and young people’s attachment to school can also be effective in reducing substance misuse. The Good Behaviour Game (GBG) is one example, explained in more detail below.

4.4 The programmes so far mentioned are all school-based universal primary prevention programmes. There are also promising approaches targeted at higher-risk groups. For example, Preventure is a programme which focuses on addressing specific personality elements (impulsivity, sensation seeking, anxiety sensitivity, and depression proneness) which in different ways increase the likelihood of early-onset substance misuse and other risky behaviours. Lessons are delivered to sub-groups of pupils identified as high-risk personality types.

4.5 The vast majority of the research evidence for alcohol misuse prevention comes from the United States, where implementation of universal school-based programmes is much further advanced, and more randomised controlled trials have been carried out. There is an urgent need to expand the evidence base in the UK. We welcome the work that the Centre for Analysis of Youth Transitions is doing, both in making information about evidence-based youth programmes more easily available, and in helping programme developers collect better evidence.

5. COST-BENEFIT ANALYSIS

5.1 The cost-effectiveness of the programmes described is increased because they have a wider focus than alcohol. Reductions in tobacco and cannabis use have been demonstrated, and some evaluations have also found impacts on educational achievement and anti-social behaviour.

5.2 On the evidence so far, it appears that universal drug and alcohol prevention programmes do not need to have dramatic impacts to be cost-effective. For example, modelling for NICE concluded that if an alcohol misuse prevention programme in schools cost £75 million and achieved at least a 1.4% reduction in alcohol consumption amongst young people it would be a cost-effective public health intervention.²¹⁰

5.3 A study on cost-effectiveness by the US Department of Health and Human Services concluded that national implementation of an effective programme which cost \$220 per pupil could in the long term save \$18 for every \$1 invested.²¹¹

²⁰⁶ EMCDDA (2012). EMCDDA trend report for the evaluation of the 2005–12 EU drugs strategy. EMCDDA

²⁰⁷ Social Research Unit (2012) Investing in Children, Youth Justice <http://bit.ly/IEA6w1>

²⁰⁸ <http://www.mentoruk.org.uk/2011/11/prevention-expenditure-in-england/>

²⁰⁹ Foxcroft, D and Tsertsvadze, A (2011). Universal school-based prevention programs for alcohol misuse in young people. Cochrane Database of Systematic Reviews

²¹⁰ Nherera, L and Jacklin, P (2009). A model to assess the cost-effectiveness of alcohol education developed for NICE public health guidance on personal, social, health and economic (PSHE) education. NICE

²¹¹ Miller, T R and Hendrie, D (2009). Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis. Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

5.4 The Social Research Unit at Dartington are carrying out detailed cost-benefit analysis of a range of children's services interventions in a UK context: the latest reports are available from www.dartington.org.uk/investinginchildren

6. A CASE STUDY: THE GOOD BEHAVIOUR GAME

6.1 The GBG is a way of managing class behaviour during lessons by dividing young children into teams which during short periods of the day are given the chance to earn prizes and praise by keeping to simple rules for good behaviour.

6.2 A trial in Baltimore showed a 50% reduction in the likelihood of later drinking problems at follow-up aged 19 or 20. The programme had other pro-social benefits; reducing the chances of drug dependence, dropping out of education, and antisocial behaviour, particularly among boys. A feasibility study of the GBG in the UK with six primary schools in Oxfordshire has shown promising results with regard to behavioural impact.²¹²

6.3 Economic modelling by the Washington State Institute for Public Policy estimated every dollar spent on the GBG resulted in total benefits valued at \$31.²¹³ In a UK context, the Social Research Unit recently estimated a more conservative benefit-cost ratio of £8.26 for every £1 invested.²¹⁴

7. IMPLEMENTATION

7.1 Mentor's Chief Executive is co-chair of the Education Committee for the Department of Health's Responsibility Deal. This offers a valuable opportunity to assess the impact that some of the programmes described above can have in the UK. However, it is clearly not the role of the alcohol industry to fully fund appropriate health education and prevention. If these programmes are cost effective and attractive options to policymakers we would want and expect them to be funded by the state.

7.2 If the Committee would like more information on any of the points raised in this submission, we would be very glad to provide it.

May 2012

Written evidence from the Family Planning Association (GAS 41)

1. EXECUTIVE SUMMARY

1.1 FPA is one of the UK's leading sexual health charities, with over 80 years' experience of providing the UK public with accurate sexual health information, education and advice services.

1.2 FPA represents a national voice on sexual health, working with and advocating for the public and professionals to ensure that high quality information and services are available for all who need them.

1.3 We know, through research published in 2009 as part of FPA Sexual Health Week, that sometimes people take risks with their sexual health when they have been drinking alcohol.

1.4 Integrated service delivery is vital to address the issue of alcohol and sexual health. We welcome the commissioning of community contraception, sexually transmitted infection (STI) testing and treating, sexual health prevention and alcohol services as part of Public Health in Local Authorities. However, we have concerns that the commissioning of sexual health services will be fragmented with Clinical Commissioning Groups commissioning abortion services and the National Commissioning Board responsible for GP provision of contraception and HIV treatment. This could make integrated service delivery with alcohol services challenging.

1.5 We believe that Personal, Social, Health and Economic (PSHE) education has a vital role to play in addressing issues associated with young people and alcohol but also believe that a high quality relationships and sex education programme will address the issue as well.

1.6 High quality and accurate information for the public has a role to play in empowering people to make informed choices. Information for professionals on creating an integrated alcohol and sexual health service is also important.

2. NHS AND PUBLIC HEALTH REFORMS

2.1 FPA campaign *One Too Many*, part of FPA Sexual Health Week 2009 commissioned a survey into alcohol and sex. It found that regretted sex and alcohol often go hand in hand, as of the 38% of all respondents who said "I have taken part in sexual activity with someone and then regretted it later", 70% of these said

²¹² Chan, G, Foxcroft, D, Coombes, L and Allen, D (2012). Improving child behaviour management: An evaluation of the Good Behaviour Game in UK primary schools. Oxford Brookes University and Oxfordshire County Council

²¹³ Washington State Institute for Public Policy (2012). Return on Investment: Evidence-Based Options to Improve Statewide Outcomes. Washington State Institute for Public Policy

²¹⁴ The Social Research Unit at Dartington (2012). Investing in Children: Early Years & Education.

alcohol was a factor (either a great deal or a fair amount) in what happened. And over a quarter of all respondents (28%) had sex with someone they normally wouldn't find attractive, with 73% of them giving alcohol as a factor.

2.2 Furthermore, the vast majority (83%) agreed with the statement "In general people are less likely to use a condom or other contraception when they have sex if they have been drinking alcohol".²¹⁵

2.3 The aim of the *One Too Many* campaign was to raise public awareness that alcohol can impact on sexual decision-making highlighting the need for more, non-judgemental information around sexual health and alcohol. The campaign also produced a briefing for professionals on integrating alcohol and sexual health consultations. It included tips such as identifying groups at risk and providing support for reducing risk taking.

2.4 We know that alcohol can impact on sexual decision-making and potentially lead to regretted sex. It is essential that commissioners of sexual health services recognise this and it will be essential for members of Local Health and Wellbeing Boards must have all information to be able to commission effective integrated sexual health and alcohol services.

3. PUBLIC HEALTH INTERVENTIONS SUCH AS EDUCATION AND INFORMATION

3.1 We believe that relationships and sex education plays a vital role in empowering people to make informed and positive choices about their sexual health and relationships. When the new commissioning structure is in place it will be essential for local Health and Wellbeing Boards to engage with education professionals in their local area to ensure that the education young people are receiving is supporting positive messages around using contraception and where to access sexual health services.

3.2 Integrated services also provide a great opportunity for professionals to talk to people about alcohol and sexual health and the impact alcohol may have on decision-making. These kind of integrated services can also offer information on further support and be able to signpost people to other services.

May 2012

Written evidence from the Medical Research Council and the Economic and Social Research Council (GAS 42)

BACKGROUND

The Medical Research Council (MRC) is one of the main agencies through which the UK Government supports biomedical and clinical research. It is dedicated to improving human health through the best scientific research. The MRC's work ranges from molecular level science to public health medicine and has led to pioneering discoveries in our understanding of the human body and the diseases which affect us all.

The Economic and Social Research Council (ESRC) is the UK's largest organisation for funding research on economic and social issues. The ESRC supports independent, high quality research which has impact on business, the Public Sector and the Voluntary Sector. At any one time, the ESRC supports more than 4,000 researchers and postgraduate students in academic institutions and independent research institutes.

The MRC and the ESRC are funded by the Department for Business, Innovation and Skills (BIS) and together invest around £953 million per annum (£750 million from the MRC and £203 million from the ESRC) in research, training and knowledge exchange across a broad spectrum of research areas.

This evidence is submitted by the MRC and ESRC and represents the independent views of these two research councils. It does not include or necessarily reflect the views of Research Councils UK or the Department for Business, Innovation and Skills. It aims to address the areas within the terms of reference of the Committee's Inquiry which are directly related to the work of the research councils. In preparing this submission evidence was sought from experts funded by both research councils who are leading major research projects and programmes as well as members of both council's advisory groups and research boards. Some of those consulted will have submitted their own independent submissions to the Committee.

EXECUTIVE SUMMARY

Both the MRC and the ESRC have provided key impacts across the full range of alcohol research from mechanistic brain science that is providing leads for new treatments, to alcohol related harms and prevention, research into socio-economic factors and contributions to the evidence base for treatment and alcohol policy. In addition to this long-standing and strong tradition of funding high quality research, since 2007 the MRC in partnership with the ESRC, has been leading a strategy to fund multidisciplinary research addressing the biological, medical, social and economic aspects of addiction and substance misuse.¹ A key outcome has been the creation of inter-disciplinary networks of researchers—addiction research clusters—that are providing a step-change in capabilities for developing new treatments and robust scientific appraisal of alcohol policy interventions.

²¹⁵ The survey was conducted among 1,002 members of Ipsos MORI's GB online panel. All participants were aged 18–30 and had had sex/taken part in sexual activity and drink/had drunk alcohol. The fieldwork was conducted between 11–18 August 2009.

The MRC and the ESRC have concluded that there is an urgent and compelling case for developing the addiction initiative further to understand alcohol use and its harms to inform targeted intervention and cost-effective policy. We welcome the aims of the Government's strategy, however, we would highlight a broader approach to alcohol misuse and its consequences across the life-course, rather than just the young and those who binge drink. Further biomedical and social research is required to deal with longer term brain and organ damage and treatments/interventions targeted to chronic use and relapse after detoxification. In consulting our academic community during the assembly of our response, several needs were highlighted:

- New treatments and preventive strategies targeted to the key components of alcohol misuse in an efficient and cost-effective way.
- Protecting existing high quality databases and using these to put in place long-term monitoring studies with strong baseline data collection; this is fundamental to regular monitoring harms and the effects of policy changes as they occur.
- Further research on how drinking harms those other than the drinker.
- Scoping tractable opportunities for research for prophylaxis of alcohol-induced organ damage.
- The effect of drinking in pregnancy and the risk this poses to the fetus, including whether more moderate drinking in pregnancy might harm the brain of the developing child.
- The effects of marketing strategies on promoting and facilitating harmful drinking.
- Further integration of effective delivery of care given recent in depth studies to establish the strength of evidence for existing interventions. It is suggested we bring these much more into real-world settings, such as the workplace.

To summarise, policy makers and the public would benefit significantly from further high quality rigorous research to deliver new treatments and to ensure policy decisions are based on the best evidence.

INTRODUCTION

1. Given the scale of harm to both society and individuals, the MRC and the ESRC believe that understanding alcohol misuse and tackling its consequences are major public health priorities. We welcome the aims of the Government's strategy, however significant gaps remain in our knowledge about the wider harms of alcohol and research is needed to develop new, effective, interventions to minimise these. There are now strong research opportunities to make significant progress which the MRC and the ESRC are pursuing through an addiction and substance misuse research strategy.

2. Both research councils have made important contributions to alcohol research. The MRC annual spend on research projects and programmes that include aims specifically addressing alcohol has increased steadily in the last five years and reached £4.1 million in 2009–10. The ESRC annual spend in this year was £0.5 million.

3. Since 2007, the MRC has been leading an addiction and substance misuse initiative which is funding cross-discipline research addressing the biological, medical, social and economic aspects of addiction and substance misuse.¹ ESRC is a partner. The initiative aims to strengthen the translation of this research into public health benefit. This initiative is led by the MRC in partnership with the ESRC on behalf of the Office for Strategic Coordination of Health Research (OSCHR).

4. The initiative is fundamental to and delivers on the priorities outlined in the MRC's Strategic Plan, "*Research Changes Lives*"², which emphasises the impact that world-class research has on improving the health and wellbeing of society. This involves developing preventative interventions, new treatments for diseases, producing well-founded policy guidance for research governance and ethics; and delivering excellence in the basic research that underpins these activities. The ESRC's Delivery Plan³ aligns strategic research investment on three priority challenge areas, two of which, *Influencing Behaviour* and *Informing Interventions*, directly relates to addiction and substance misuse through funding research which aims to better understand how and why people make decisions relating to alcohol consumption, and how these can be managed or influenced through interventions.

5. In this submission we outline what the MRC and ESRC have already achieved in terms of key impacts on the knowledge base, patient benefit and policy, from the research we have supported. We then comment on the knowledge gaps, which the MRC and ESRC are currently considering to see if there are tractable opportunities to address them. We have made little reference to levels of consumption, demographics and harm as these issues have been extensively covered in many other reports. Minimum pricing also has a strong evidence base.^{4,5}

THE MRC AND ESRC ADDICTION AND SUBSTANCE MISUSE RESEARCH INITIATIVE

6. This initiative was a strategic response by the MRC to research needs in the field and was in addition to the "normal" support for alcohol research provided by the MRC and the ESRC which is set out at paragraphs 11 to 22. A key element of the addiction and substance misuse initiative has been to create inter-disciplinary networks of researchers called addiction and substance misuse research clusters.²¹⁶ A major aim of the clusters has been to recruit relevant scientific expertise from outside the addiction field to increase capacity and

²¹⁶ <http://www.mrc.ac.uk/Ourresearch/ResearchInitiatives/Addictionresearch/index.htm>

innovation; and to engage stakeholders to ensure, where possible, relevance to treatment and public health policy needs. Four of these clusters have been awarded substantial grants, including two awards of direct relevance to alcohol misuse. One award was made to the Capacity development for Alcohol Policy Effectiveness Research (CAPER) cluster (£1 million) at the University of Sheffield (led by Professor Petra Meier); and another £1.6 million to the Imperial College, Cambridge and Manchester (ICCAM) cluster which is evaluating the mechanistic basis of potential new drugs for addiction (led by Professor David Nutt).

7. The significant funding from the MRC and the ESRC at the University of Sheffield has enabled the assembly of a multidisciplinary research team involving epidemiologists, health economists and statisticians, who together are building a sophisticated model of alcohol consumption that considers taxation, minimum pricing, outlet density and other available policy options. This involves data and evidence analyses in areas such as market response to pricing policy, relationships between heavy episodic drinking, and harms in different settings and the variability in individuals' consumption patterns over time. This model will be dynamic and not assume "steady" baseline level of consumption and harms.

KEY OUTCOMES

8. The MRC and the ESRC funding at Sheffield has facilitated various pieces of work connected with pricing policy; some of which have clearly identifiable policy impact including work for the Scottish Government,⁶ a report to the Home Office on pricing and crime,⁷ and several papers on the effectiveness of pricing policies.^{8,9} Work published during the cluster's lifespan also underpins policy recommendations by the *BMA* and *Alcohol Concern*. MRC funding and support has allowed the Sheffield team to continue disseminating the findings of the work—which started with the Department of Health report—continue engagement with key stakeholders within and outside government; and continue development of the model that we envisage should be able to develop a step-change in capabilities for robust scientific appraisal of alcohol policy interventions.

9. ICCAM is a complementary translational preclinical and clinical brain imaging study which is investigating medicines that may help in preventing alcohol and drug relapse in humans. Studies focus on people who have recently stopped using alcohol, cocaine or heroin and focus on processes affecting relapse such stress and craving. In addition, drugs with potential to dampen down these brain processes are being studied. Given that 50% of those who have stopped using drugs or alcohol relapse within three months, this is an important step in the search for much needed pharmacological therapies to help with relapse, for which no pharmaceutical products are currently available.

KEY OUTCOMES FROM THE MRC AND ESRC IN ADDITION TO THE ADDICTION AND SUBSTANCE MISUSE INITIATIVE

10. Outputs matter and the MRC and ESRC continue to support research that is not only of the highest quality but whose outcomes bring benefits to people's health and society—whether through inventing new medicines, changing clinical practice, influencing policy, creating wealth or improving our basic understanding of the human body. Exemplars are provided below.

BRAIN SCIENCE

11. Brain science is fundamental to understanding how drugs and alcohol affect behaviour. MRC supported research has made a significant contribution to our understanding of how many drugs work at the molecular level and, at least initially, in the brain. For example, funding for over 10 years for Professor David Nutt at Imperial College London has contributed to the UK's position as a world leader in the understanding of two of the key neurotransmitters involved in the actions of alcohol and to a number of reviews and policy papers.^{10,11,12,13}

12. Most alcoholic patients undergo cycles of alcohol abuse, followed by detoxification after which the patient may abstain for a period, but the relapse rate is very high. Research supported by the MRC at the University of Sussex over the past 15 years has revealed that repeated episodes of detoxification result in altered brain function leading to both increased pressure to drink, and loss of the ability to control drinking. This emphasises the need for the first detoxification to be successful and has implications for provisions of support of patients following their release from the "detox clinic" or GP supervision.^{14,15,16,17}

13. Researchers from the MRC's Laboratory of Molecular Biology in Cambridge recently described how excess alcohol can cause irreparable damage to our DNA.¹⁸ The effects of alcohol in pregnant mice resembled that in fetal alcohol spectrum disorder, so this may be one of the unwelcome mechanistic explanations for the permanent damage to the unborn child, resulting from excessive drinking by pregnant women.

SOCIAL AND PUBLIC HEALTH SCIENCES

14. *Understanding Society* is a world leading study of the socio-economic circumstances and attitudes of 100,000 individuals in 40,000 British households, funded by ESRC, and run by the Institute for Social and Economic Research at the University of Essex. The study includes questions on alcohol consumption in adults and risky behaviour, including alcohol and binge drinking in adolescents. Some examples of outputs include (briefings, working papers and research) which have used the data from the National Child Development Study,

the 1970 British Cohort Study and the Millennium Cohort Study parents (MCS). A wide body of research utilising MCS data has been produced by think tanks, particularly in relation to parenting. The Centre for Social Justice (*Family breakdown in the UK: it's NOT about divorce*) found that those experiencing family breakdown are 50% more likely to have alcohol problems.^{19,20,21,22,23}

15. The Whitehall II study was established in 1985 as a longitudinal study to examine the socioeconomic gradient in health and disease among 10,308 civil servants (6,895 men and 3,413 women). The MRC has been a major funder of the cohort study. Studies using its longitudinal data have shown substantial socio-economic variation in alcohol-related harm in the UK. The alcohol-related mortality rate for men in the routine class was 3.5 times greater than the rate among men in higher and managerial occupations, while for women the corresponding figure was 5.7 times. Admissions for alcohol-related conditions in England for 2006–08 were associated with increased levels of deprivation.²⁵ Alcohol consumption is related to risk of sickness absence due to injury with increased risk seen even at moderate levels of alcohol consumption. “Binge” drinking and alcohol dependence were also related to absence due to injury.²⁶

16. Researchers at the MRC’s Social and Public Health Research Unit in Glasgow have published 16 papers over the last 10 years on alcohol-related problems, attitudes to alcohol use and predictors of alcohol use. Findings have contributed to the evidence base for policies. For example the work using data from the *Twenty-07 Study* found that socio-economic status in early and adult life was related to an increased risk of exceeding “sensible” drinking guidelines and problem drinking in men at age 58. Understanding precursors for harmful drinking is crucial for prevention and current work in the Unit suggests that estimated exposures to film images of alcohol and drug use are related to young people’s alcohol use in both sexes, in contrast to a lack of association for smoking.^{27,28,29,30}

17. The Avon Longitudinal Study of Parents and Children³¹ is a long-term health research project based at the University of Bristol funded by both the MRC and the ESRC. More than 14,000 mothers were enrolled during pregnancy in 1991 and 1992, and the health and development of their children has been followed in great detail ever since. It has provided a vast amount of genetic and environmental information over the years and this resource is assisting scientists all over the world with research into a wide range of health problems including alcohol use. Recent data shows boys and girls with early persistent or adolescent onset of antisocial behaviour are at three-fold risk of drinking heavily in mid-adolescence and nearly two-fold risk of drinking hazardingly at 16–18.

PREVENTION RESEARCH

18. The MRC and the ESRC support Professor Gerard Hastings at the University of Stirling through the National Prevention Research Initiative (NPRI) to investigate whether advertising encourages consumption. The study has had an impact at a European level through the alcohol platform of the European Commission’s Directorate General for Health and Consumer Affairs (DG Sanco); and in Scotland, through the Holyrood alcohol team and Alcohol Focus. The BMA has commissioned Professor Hastings to report on alcohol marketing.

19. A series of studies led by Dr Simon Moore from the Violence and Society Research Group in Cardiff has examined alcohol-related harm in the night time economy and demonstrated robust relationships between premises servicing practices and violence, and alcohol promotions and violence. Dr Moore has formed a strong collaborative partnership with Environmental Health Officers (EHOs) and expects to deliver a cost-efficient “All-Wales” alcohol-related harm reduction intervention that can be delivered by EHOs in normal practice.³²

TREATMENT DELIVERY

20. Professor Colin Drummond at King’s College London has informed NICE guidelines on the further development of assertive community treatment based on a literature review and pilot research funded by the MRC.

21. Other on-going MRC and ESRC investments are listed at Annex 2.

FUTURE PLANS; RESPONDING TO GAPS IN KNOWLEDGE AND EXPLOITING SCIENTIFIC OPPORTUNITY

22. The MRC and the ESRC have concluded that there is a compelling case for developing the addiction initiative further in the area of alcohol and its harms. A workshop will be held in October 2012 which will bring together researchers, funders and key stakeholders to reach a consensus on the tractable priorities for research on alcohol misuse. The following sections highlight some of the gaps and opportunities in this area that have been highlighted by our expert advisors and some of these may be explored at the workshop.

THE NEED FOR NEW TREATMENTS AND ENHANCING THE EXISTING EVIDENCE BASE

New treatments

23. Alcohol misuse and its consequences involve complex, often intertwining psychosocial and biological processes influenced by a range of environmental and economic factors. New treatments and preventive strategies are needed that target the key mechanistic components, such as impulse, relapse and bingeing.

Knowledge of brain mechanisms is offering a way forward and to this end MRC is supporting and encouraging experimental medicine research. We will also continue to support ICCAM as well as explore opportunities to target drugs to the specific aspects of alcohol misuse—there are several drugs of potential promise which require proper mechanistic evaluations. These and other issues, including the broader context of therapies and prophylaxis for alcohol-induced organ damage, will also be explored at the workshop.

Existing treatments—enhancing the evidence base

24. With three sets of NICE guidance on alcohol published in the last five years as well as a series of systematic reviews, there is now a body of evidence on the effectiveness of existing behavioural and cognitive approaches (such as intensive case management, motivational enhancement therapy and social network based therapies) as well as certain pharmacological interventions (eg acamprosate and disulfiram). Nevertheless, many of our advisors highlighted the lack of joined-up effective delivery and available appropriate expert services for drinkers, especially in “real-world” settings. This is a key element of support that they felt was not fully addressed in the Government’s alcohol strategy.

RESEARCH TO INFORM PREVENTION

25. One area where the UK has world-leading strengths is in epidemiological studies based on high quality and well maintained administrative datasets and patient and population based cohorts. The MRC and the ESRC continue to provide substantial investment into the policy modelling work at the University of Sheffield which uses sensitive and reliable methodology to build on existing evidence. However, there are still gaps in the evidence base where more robust modelling resources would inform future policy. Some of the research objectives advisors have suggested include, protection and continued investment of existing databases and cohorts, the development of a comprehensive longitudinal dataset recording price paid for alcohol, consumption of alcohol (average and single-occasion) and resulting experiences of harm; as well as better data linking levels of consumption with criminal offences committed.

26. In order to inform future policy decisions it is necessary to maintain the current resources and develop these to ensure that data relevant to alcohol harm is collected as a resource for the ingenuity of the UK science base. Long-term monitoring with strong baseline data collection could also be a more efficient and cost effective way of monitoring responses to policy changes as they occur.

27. In the neurobiological domain, the MRC will continue to fund research on alcohol alongside other forms of impulse control disorders such as gambling. Understanding how “impulse” triggers addiction and longer term use of harmful substances is likely to be particularly helpful for the prevention and treatment of alcohol addiction.

HARM

Secondary effects of drinking

28. Despite studies of individual areas such as domestic violence and drink driving, there has been little systematic study of how drinking harms those other than the drinker. For example, little is known of the health economics and other impacts of a drinker on family members, workplace absences, work accidents and lower performance. Such research is needed to inform interventions to minimize these.

Adolescent bingeing—behavioural influences and harms

29. It is of paramount importance to understand how drinking and group processes (such as social influence, aggression, competition) combine if we are to design drinking situations and environments that are safer. This requires a focus on the social and behavioural outcomes such as risk-taking, expressions of prejudice, decision making (and subsequent commitment to decisions), that leads to the anti-social behaviour that can arise in groups that are drinking socially. Although there is observational and survey evidence about social drinking there is very little experimental evidence. It is also important to consider the social and behavioural aspects of interventions targeted at groups such as in management strategies in bars and pubs and police management of large groups of drinkers.

Long-term brain and organ damage caused by excessive drinking

30. Liver disease is currently increasing in frequency in the UK due to alcohol³³ while in the rest of Europe chronic liver disease mortality is falling. Evidence is starting to emerge of other longer-term medical problems associated with drinking such as other gastro-intestinal disorders and cancers and an outcome of the work from the MRC 1946 Birth cohort study and others is a demonstrated link with colorectal cancer.³⁴ A European-wide epidemiological survey indicated that alcohol misuse is now the most common factor underlying brain disorder in men³⁵ based on harm. The possibility of longer-term brain damage resulting in a range of cognitive impairments is a major concern and little understood. We will explore this in the workshop in October to see if there is a need for further knowledge about these harms and/or any tractable opportunities for research for new therapies for alcohol-induced organ damage.

31. A huge, unresolved question is the effect of drinking in pregnancy and the risk this poses to the fetus. We know that women who drink at above recommended levels, particularly in binges, will consume harmful amounts of alcohol during the pre-pregnancy recognition period. This leads to the *Fetal Alcohol Spectrum Disorder* recently highlighted by the European College for Neuropharmacology as possibly the leading cause of brain damage in children. We clearly have to understand this better and also explore whether more moderate drinking in pregnancy might harm the brain of the developing child.

Drinking in middle age and older people

32. Public debate understandably focuses on the young and the growth over the long-term in binge drinking amongst young people clearly raise particular health concerns because of the likely link between regular and excessive alcohol use in adolescence and alcohol dependence in adulthood and chronic health problems in later life. However, survey data also suggests that those aged 45–64 are more likely to drink, drink more, and be more likely to suffer health harms from drinking than their younger counterparts.^{36,37,38} The scale of harm is unknown and more sophisticated research is needed in this area.

Marketing strategies and outlet density

33. A major question is what effects do marketing strategies have on harmful drinking and whether vulnerable groups are being targeted through unregulated media channels such as social networking sites. There is also an increasingly compelling body of evidence demonstrating a relationship between the number of outlets and hours of sale in an area, and factors such as violence³⁹. Further exploration of this relationship is warranted so that licensing decisions are evidence-based.

MRC AND ESRC RESPONSE TO COMMITTEE'S SPECIFIC QUESTIONS

Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol

34. The main government departments responsible for alcohol policy have been co-ordinated for several years—although not as well as in the area of illicit drugs—and the new alcohol strategy shows that the Treasury is now integrated within this, which is welcomed. The MRC has brought stakeholders together from Government departments in England and Scotland on a number of occasions, including the Ministry of Justice, Home Office, Department of Health, National Treatment Agency and Scottish Office (including their Alcohol Evidence Group). Given the significance of the public health and societal problems arising from alcohol misuse, there is case for increasing coordination between England and the devolved administrations, particularly Scotland where there is a major policy drive. Promising results from policy initiatives undertaken in one administration can subsequently be used to guide policy more widely in the UK and reduce duplication.

The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing

35. There is robust evidence linking changes in the price of alcohol to changes in consumption and harm and detailed modelling by the School of Health and Related Research in Sheffield (ScHARR) and evaluation work in Canada has demonstrated the effectiveness of minimum pricing as an effective and targeted pricing policy. Evaluation of these policies if and when implemented across the UK and Ireland will be crucial in further demonstrating the effectiveness of such policies. Projects are being developed in Scotland for this purpose and similar projects will be needed in the rest of the UK to provide a comprehensive evaluative evidence base. Setting the level is the subject of a public consultation, but many are calling for impact and the committee will be aware that a 10p difference in value, in the range under discussion is significant in terms of public health benefit (see NICE guidelines). It has been calculated that the impacts of a minimum price of 40p would "...include a reduction in the mean alcohol consumption per drinker of 2.4%, in deaths of 1149 annually, and in hospital admissions of 38,900 annually".⁴⁰

CONCLUDING REMARKS

36. The Government's strategy highlights the social and crime aspects effectively, however the lack of emphasis on treatment and research means that the strategy does not fully address the complexities of the issue and may underestimate harm and the potential to address it. The introduction of minimum pricing, which will need to be scrupulously evaluated, could have a major impact depending on the value per unit agreed. The MRC and the ESRC support this. However, there is an opportunity to build on the UK's excellent brain research to develop new treatments and to address the gap in social and psychological research on the very strong role of social norms and group processes that can either elevate or moderate alcohol consumption. Health Services Research is needed to add value to existing knowledge by ensuring delivery of the most effective care. Heavy drinking among the middle-aged—where the real burden of adverse health effects is seen—and the need to study the broader harm to others that arises from the adverse effects of heavy drinking on other family members, remain important issues to address.

billion per annum, and the British Crime Survey reveals that there are one million alcohol-related assaults in England and Wales annually. In many communities, the high street has been taken over by episodes alcohol-fuelled aggression on Friday and Saturday nights, thereby depriving other local citizens of the freedom to feel that they can go out in safety. In both human and fiscal terms, the current situation is untenable for the future.

2. Extremely inexpensive alcohol is a major contributory cause to these problems. Epidemiological research demonstrates that problem drinkers spend about 80% less per unit of alcohol than do moderate drinkers. This reflects the fact that problem drinkers tend to favour the low-cost, high-strength alcoholic drinks that are sold in many off-licences and supermarkets. Minimum pricing is thus a policy specifically tailored to the problem at hand: the heaviest drinkers will face higher prices than they are used to, whereas moderate drinkers will probably not even notice the change because they already tend to pay prices well above the proposed minimum.

3. The increase in cost from a minimum pricing policy would impact on alcoholic beverages in the lower price bracket. This is important because research shows that even heavy drinkers are price-sensitive: they consume less alcohol when the cost rises. Canada's experience with minimum pricing, for example, has shown that even a modest increase in minimum price reduces alcohol consumption. We believe the same should prove true in England and Wales.

4. Some critics have incorrectly portrayed minimum pricing as an anti-pub measure being contemplated when many pubs around the UK are closing. Just the reverse is true. Pubs are losing business because they are being undersold by extremely cheap alcoholic beverages available in off-trade. A minimum pricing policy should actually help protect pubs, allowing them to continue their valuable role as a centre of social life in many towns and cities.

5. We suggest that, although the government's proposed minimum price of 40p per unit should deliver substantial public health and safety benefits, a strong case could be made for starting instead with a minimum price of 45p per unit, for two reasons. First, research recently published by Dr. Robin Purshouse and colleagues in *The Lancet* (*Lancet* 2010; 375: 1355–64) demonstrates that the health and safety benefits of a minimum price policy is greater at 45p than at 40p per unit (eg. conferring a further £60 million in health care cost savings annually). Second, 45p per unit is the minimum price being seriously considered in Scotland; for many reasons there are advantages in applying a consistent policy on both sides of the Scottish border.

6. In conclusion, setting a minimum price for alcohol in England and Wales is likely to reduce problem drinking and its consequences while troubling neither the pub trade nor the millions of citizens who drink alcohol in moderation. We applaud the government for proposing a minimum pricing policy and hope that it is swiftly enacted.

May 2012

Written evidence from the Royal College of Psychiatrists (GAS 44)

This submission has been led by Dr Peter Rice, Chair of the Royal College of Psychiatrists in Scotland and member of the Addictions faculty, with contributions from the Addictions faculty, the Neuropsychiatry section, the Royal College of Psychiatrists in Northern Ireland and the Royal College of Psychiatrists in Wales.

1. Summary

1.1 The Royal College of Psychiatrists (RCPsych) is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

1.2 The RCPsych Faculty of Addictions comprises medical doctors who have completed extensive training in psychiatry and addiction, and service users with lived experience of addiction and addiction services. It thus has expertise in all aspects of addiction, including individual brain mechanisms, behaviour, and its overall effect on the family, society and the economy. It has unique expertise in the management of addiction problems in complex cases, particularly co-morbid mental health problems.

1.3 The Faculty supports a holistic approach that considers how biological, psychological and social factors impact on a person's life and recovery journey.

1.4 The RCPsych welcomes the Government's Alcohol Strategy. The strategy recognises the broad range of effects of alcohol and that there are many opportunities for Government at all levels to influence rates of alcohol-related harm. The recognition of the relationship between price, particularly of the cheapest alcohol, and alcohol-related harm, is a major development. There is very good evidence which leads us to expect that the introduction of a minimum unit price that is set, monitored and adjusted on the basis of good information on trends in price, consumption and harm, will make a major contribution to improving public health, including public mental health. We believe that the potential health benefits have been understated in the strategy, and that these are at least equivalent to the community safety benefits to which the strategy gives greater emphasis.

1.5 The emphasis on public health in the operation of the Licensing system is welcomed; if fully implemented, this will be a major step forward.

1.6 There is less innovation evident in the strategy's approach to the development of treatment services, including Screening and Brief Intervention (SBI), and this issue will require continued work to be resolved. There needs to be action to ensure that screening and brief intervention becomes a mainstream part of Primary Health Care and to secure the much-needed expansion of treatment services.

Another important area requiring service development is that of assessment and management of brain damage or cognitive deficits associated with alcohol use. Improved management of alcohol problems in prison populations and rehabilitation of people with established cognitive damage also merits urgent service planning.

1.7 We are concerned that there is little prospect for progress in the proposals controlling the promotion and advertising of alcohol. We do not believe that an approach based on self-regulation will be effective.

2. Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role

2.1 Alcohol is an issue where policy coordination is vital to the effectiveness of National Policy. There is a wide range of Government Departments involved in prevention of alcohol harm. Over the 20 years from 1991, alcohol death rates in the UK doubled (ONS 2011), indicating the lack of an effective co-ordinated approach by Government and other bodies and a relative lack of attention to the many individual, family and societal harms caused by alcohol, when compared to the sustained government focus on illicit drug use. In 2008, Patricia Hewitt MP was reported as saying that she had "pleaded with the Treasury for higher alcohol duty at every budget" while Health Secretary (<http://www.dailymail.co.uk/health/article-517930/Now-middle-aged-women-targeted-anti-drink-campaign.html>).

2.2 The recognition of the need for inter-departmental co-ordination is a strength of the Government's alcohol strategy. The College has no view on which Department should lead policy, but there is a clear need for leadership on this complex issue.

3. Coordination of policy across the UK with the devolved administrations and the impact of pursuing different approaches to alcohol

3.1 Rates of alcohol-related harm vary across the UK. The longstanding higher rates of harm in Scotland than the rest of the UK are widely recognised, but the considerable variation in rates of harm within England, less so. In Wales, it is estimated that 15% of hospital admissions are alcohol-related and the overall cost to the NHS is around £70 million. The trends in alcohol harm show similar patterns in the UK, supporting the importance of price in determining rates of change in mortality and morbidity (ONS 2011).

3.2 There have been different approaches in alcohol policy across the UK for many years. For instance, the restriction of alcohol to designated areas within supermarkets which was introduced in Scotland in 2010 and has been called for by Alcohol Concern in England and Alcohol Concern Cymru, has been in place in Northern Ireland since the introduction of alcohol to supermarkets in the province in 1997. The work of Dr James Nicolls of Bath Spa University on the many historical differences between Scotland and England is summarised in the report *Rethinking Alcohol Licensing* (SHAAP/AFS 2011).

3.3 The Northern Ireland Assembly has announced its intention to reduce the drink-drive limit to 50mg/100ml and the Scotland Bill will give the Scottish Government the opportunity to fulfil its wish to do likewise. The Scottish, Northern Irish and Welsh jurisdictions all expressed their wish to introduce minimum alcohol pricing prior to the UK government's announcement in 2012.

3.4 The UK has thus been familiar with different approaches to alcohol policy throughout its history. In recent times, the UK Parliament and English alcohol strategies have been characterised as being both weak on public health policy and influenced by alcohol industry interests, to the detriment of public health. (Drummond 2004, House of Commons Health Committee 2010). The 2012 strategy has been more positively received by health organisations, particularly because of the recognition of the links between price and harm, and the commitments to introducing a minimum price per unit and to exploring the introduction of a multi-buy discount ban.

4. The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group

4.1 The involvement of Business Interest Non Governmental Organisations (BINGOs) in health promotion and harm reduction is a controversial issue recently highlighted by the Non Communicable Disease (NCD) Alliance in their response to the UN Draft Resolution on NCDs (Lincoln et al 2011). In brief, the NCD Alliance, which includes UK alcohol charities, shares the view of the Strategy that "industry needs and commercial advantages have too frequently been prioritised over community concerns" in a range of health issues. (Alcohol Strategy para 1.4, p12).

The College encourages the Health Committee to consider this issue from first principles.

We believe that BINGOs should not be part of Government policy fora. In our view, their role should be to influence the practice of their members, and their relationship with Government should be restricted to implementation of Government policy.

5. *The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing*

5.1 The evidence base for the effectiveness of different pricing mechanisms has been reviewed by the University of Sheffield in a series of reports for the UK and Scottish Governments. This work has been peer reviewed and published in the leading academic journals in the field; the Committee will be familiar with its findings. In brief, minimum alcohol price is the most effective and selective mechanism to reduce heavy drinking and alcohol-related harm. The modeling suggests greater benefits at a higher minimum price. The most recent report estimates that a 40p per unit price will reduce deaths cumulatively by 5.4% per annum. A 50p price produces a 17.2% annual reduction and 60p price a 33.2% reduction. The estimated crime reduction at 60p (3.7%) is more than five times that at 40p (0.6%) (University of Sheffield 2012).

5.2 The minimum price should not be permanently fixed, but will require regular review based on accurate and timely data on consumption, sales, health and crime. We support a minimum price of at least 50p per unit and suggest the price should be reviewed and adjusted as necessary at least annually.

5.3 With regard to legality, the Medical Royal Colleges commissioned a legal opinion in Scotland in 2007 which concluded that setting a minimum price would not be illegal under UK or EU law as long as the alcohol industry was not involved in setting the price. While industry bodies have repeatedly asserted that price measures are illegal, we remain of the view that this is not the case. We are encouraged that the UK government appears to share our view.

6. *The effects of marketing on alcohol consumption, in particular in relation to children and young people*

6.1 The issue of marketing was fully reviewed by the House of Commons Health Committee in 2009–10 (House of Commons Health Committee 2010). The Committee concluded that “The current system of controls on alcohol advertising and promotion is failing the young people it is intended to protect” and recommended that regulation should be completely independent of the alcohol and advertising industries. The College agrees with this position and therefore we fully supported Dr Sarah Wollaston MP’s Private Member’s Bill on alcohol advertising in March 2011. The 2012 strategy does not propose the sort of step change on advertising and promotion we believe to be necessary. This is one of the most disappointing elements of a strategy which in many other areas shows welcome courage and vision.

7. *The impact that current levels of alcohol consumption will have on the public’s health in the longer term*

7.1 Sheron, Gilmore and colleagues have estimated that, over a 10-year period, well over 200,000 alcohol-related deaths could be prevented by effective alcohol policies (Sheron *et al* 2012). This would include prevention of many thousands of suicides because of the impact of alcohol on mental health. The Sheffield series of studies similarly estimates considerable health benefits of the reduced consumption which would result from effective pricing policies. All deaths and other harm linked to alcohol should be regarded as preventable.

7.2 The impact of alcohol on mental health is substantial due to its effects on mood, cognition and behaviour, as well as its neurotoxic effects. The recognition of this impact will be crucial to success in the implementation of the “No Health Without Mental Health” mental health strategy in England.

7.3 Parental misuse of alcohol can have harmful effects on children, and while the Strategy acknowledges this, the issue is not given the emphasis it merits. Parental alcohol misuse is associated with child abuse and domestic violence, which can lead to children developing emotional, behavioural and mental health problems. Parental substance misuse, most often involving both alcohol and illicit drugs, is a significant factor in many child protection cases, including in cases of serious injury and death. It has been described as “a formidable social problem” and is a factor in up to two thirds of care cases (Harwin, Ryan and Tunnard, 2011).

8. *Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services*

8.1 Our comments focus on service use issues in substance misuse treatment services and wider mental health services, though we recognise that the increasing demand on hepatology services has been very considerable.

8.2 Interventions for alcohol problems, including dependence, are effective and cost-effective (NICE 2011); these range from brief interventions in some settings to more intensive treatment programmes for those with dependence. Good quality UK research has shown that investment in treatment produces five-fold savings in Health and Social Care costs alone (UKATT 2005).

8.3 The Health Committee described the state of alcohol treatment services in England as “dire” in 2010 and concluded that this was a disincentive for early detection of alcohol problems in Primary Care and other settings. This is consistent with the findings of the Alcohol Needs Assessment Research Project which found capacity in treatment services for 5.6% of the need. It was estimated that 1 in 18 people with alcohol dependence were in contact with treatment services. In some parts of England the figure was close to one in 100 (Drummond *et al* 2004).

This unmet need for treatment requires urgent attention.

8.4 Responses to parents with substance misuse problems whose children are at risk should include further development of the Family Drug and Alcohol Court model, which involves multi-disciplinary input from family justice, social care and health services. This should build on the positive findings of the piloting of this service and be attentive to the recommendations made in the evaluation report (Harwin, Ryan and Tunnard, 2011).

8.5 Another important area requiring service development is that of assessment and management of brain damage or cognitive deficits associated with alcohol use. There is a need for coordinated effort involving public health education measures, and improved alcohol misuse and cognitive deficits screening in Accident & Emergency, Acute Medicine, Trauma, Gastroenterology, and Mental Health Units. Improved management of alcohol problems in prison populations and rehabilitation of people with established cognitive damage also merits urgent service planning.

9. Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm

9.1 The proposed reforms do offer the potential to improve the development of services. The development of Health and Wellbeing Boards and Public Health England offers the opportunity to better integrate the work of the NHS and Local Authorities. This could bring together strands such as Licensing, Criminal Justice, Community Action, Trading Standards, Primary Health Care, Family Justice, Mental Health and specialist Addiction services to produce effective change. This depends on strong leadership focused on alcohol issues. Otherwise there is a risk, perhaps because of the size of the issue that alcohol becomes everyone's concern, but no-one's responsibility. Alcohol should be identified as a high priority by Health and Wellbeing Boards. It is estimated that alcohol costs the NHS £2.7 billion. The National Audit office showed that spending on alcohol treatment is £217 million. The new planning arrangements for alcohol should allow for whole-system redesign using a wide range of funding sources.

9.2 The transfer of the National Treatment Agency (NTA) to Public Health England should be managed to ensure that the plans to expand the NTA function to cover some elements of alcohol misuse rest in Alcohol services achieving parity with Drug services.

9.3 There is now a well developed consensus on what a good alcohol treatment system looks like. The conclusions and recommendations at the end of Chapter 5 of 2010 Select Committee report are a good plan for action for the development of early intervention and treatment services. These have been supported by the subsequent NICE guidance on alcohol use disorders (NICE 2011).

9.4 A key test for the development of an effective response to alcohol will be the development of systematic Screening and Brief Intervention (SBI). The effectiveness of this has been recognised for decades and has recently been advocated by NICE, and the evidence base further developed by recent findings from the Department of Health-funded Screening and Intervention Programme for Sensible Drinking (SIPS) project (<http://www.sips.iop.kcl.ac.uk/>)

9.5 Difficulties in establishing Alcohol SBIs, most notably in Primary Health Care, suggests that this requires a national screening programme approach. The Scottish SBI programme, which has delivered 200,000 Brief Interventions over past four years was built on a health improvement target for which local commissioners (Health Boards) were held nationally accountable.

We recommend inclusion of alcohol SBI in the Quality Outcomes Framework.

10. International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking, such as Public health interventions such as education and information:

- *Reducing the strength of alcoholic beverages;*
- *Raising the legal drinking age; and*
- *Plain packaging and marketing bans*

10.1 NICE published its review of preventing harmful drinking in June 2010 (NICE 2010). The recommendations were:

- To consider introducing a minimum price per unit.
- To regularly review the minimum price per unit.
- To regularly review alcohol duties.
- To consider revising licensing legislation to ensure:
 - links between the availability of alcohol and alcohol-related harm are taken into account when licence applications are considered;
 - immediate sanctions can be imposed on premises in breach of their licence; and
 - health bodies are “responsible authorities”.
- To consider a review of the advertising codes, to ensure that:
 - limits set by Advertising Standards Authority for the proportion of the audience under age 18 are appropriate;

- children and young people are adequately protected where alcohol advertising is permitted; and
- a stringent regulatory system covers all alcohol marketing, particularly via new media.
- To prioritise alcohol-use disorder prevention as an “invest to save” measure.
- To conduct a local joint alcohol needs assessment.
- To include screening and brief interventions in commissioning plans.
- To provide resources for tier 2, 3 and 4 alcohol services to accommodate a likely increase in referrals.

NICE did not find that education and information approaches were effective as stand-alone measures to reduce alcohol-related harm. However, these activities may be effective for building public support for effective measures, similar to the linkage between awareness campaigns and the introduction of seatbelt legislation. A similar mix of awareness-raising and regulation was also effective in tackling drink driving.

10.2 Measures to increase the attractiveness of lower strength alcohol should be implemented. There are many international examples of success in this area, most notably in Australia. In evidence to the Scottish Parliament Health Committee in January 2012, Tesco reported that sales of low alcohol beer have doubled since the introduction of lower duty for beers with a strength of less than 2.8% ABV. We welcome the statement in the strategy that the UK government would support EU action to revise duty on wine so that it increases with alcoholic strength. We were surprised and disappointed that a similar statement was not made in relation to cider, which is the drink of choice of many alcohol-dependent patients due to its low alcohol duty at higher strength.

We recommend that revision of the cider duty arrangements should be a high priority.

10.3 The international evidence of the harm reduction benefits of a higher legal purchase age are mainly from the USA and the benefits are mainly seen in reductions in Road Traffic Accidents. The possible benefits of a split legal purchase age was raised in the New Zealand Law Commission’s report *Alcohol in Our Lives*. The suggested advantages of a legal purchase age of 18 in on-licence premises and 20 or 21 in the off-licence environment are:

- Moving alcohol use by young people into the supervised on-licence sales environment.
- Reducing “pre-loading” at home, thus reducing overall consumption.
- Reducing third-party agent purchase by 18/19 year olds, which is a major source of alcohol supply for children.

We recommend that the Committee consider this proposal for England and Wales.

10.4 The Independent Review of Prices and Promotions commissioned by the Department of Health in 2008 found a small but consistent effect of advertising on alcohol consumption, including by young people. The Health Select Committee in 2010 made a series of recommendations on the regulation of advertising, including restriction of cinema advertising to 18 certificate films, a 9 o’clock watershed for TV advertising, and a ban on advertising or sponsorship if more than 10% of the audience is under 18.

We endorse these recommendations.

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May 2012

Written evidence from the Institute of Alcohol Studies (GAS 45)

SUMMARY

The main points the Institute of Alcohol Studies (IAS) would like to highlight are:

- *IAS welcomes the Government's Alcohol Strategy, in particular the proposal to introduce a minimum unit price for alcohol. We applaud the recognition that affordability of alcohol is a major driver of alcohol related harm and support a minimum price of at least 50p per unit in the first instance.*
- *The commitments made in the strategy are a significant step forward in the battle to reduce problems caused by alcohol. However, in order to be meaningful, these commitments must be supported with measurable targets and indicators over established time periods. They must also be subject to robust monitoring and evaluation.*
- *Alcohol harm is ubiquitous and covers many policy areas. IAS recommends that a cross-departmental alcohol coordination committee is established to ensure the Strategy is successful in reducing health and social harms caused by excessive drinking.*
- *IAS is concerned that the Strategy reinforces and indeed enhances existing roles and structures for alcohol industry involvement in alcohol policy and calls for robust monitoring and independent evaluation of industry initiatives.*
- *IAS is concerned about the lack of reference to drink driving policies within the Strategy, and calls for the introduction of unrestricted police powers to breathalyse drivers and a lowering of the legal BAC limit to 50mg in line with the majority of European countries.*
- *IAS is concerned that although there is significant emphasis on the use of screening and brief intervention to moderate drinking behaviour within the Strategy there is no provision for the early detection of the health problems associated with alcohol misuse.*

INTRODUCTION

The Institute of Alcohol Studies (IAS) welcomes the opportunity to respond to the Health Select Committee inquiry into the Government's Alcohol Strategy. *It is clear that the UK is faced with a rising tide of alcohol harm: Each year, alcohol causes the admission of over a million people to hospital, death rates from alcohol-related liver disease are amongst the highest in Europe and alcohol is linked to 13,000 new cases of cancer and is associated with one in four deaths among young people aged 15 to 24.*

IAS sees the Government's Alcohol Strategy as a step in the right direction. However, the major focus of the strategy is on binge drinking and alcohol-related crime with little direct emphasis on the far greater problems of the health issues associated with long-term misuse of alcohol reflecting, perhaps, its Home Office remit. Many of the commitments made to reduce consumption are to be applauded, especially the introduction of a minimum unit price for alcohol. However, in order to be meaningful, the commitments made in the Strategy must be supported with *measurable targets and indicators* over established time periods. They must also be subject to *robust monitoring and evaluation*.

IAS RESPONSES TO TERMS OF REFERENCE

1. *Establishing who is responsible within Government for alcohol policy writ large, policy coordination across Whitehall and whether the Department of Health should take a leading role*

Alcohol harm is ubiquitous and spans across a wide range of policy areas, including health, justice, transport, culture, education, economics and many more. In order to be effective this Strategy requires a *cross-departmental alcohol coordination committee*, which will in turn need to connect effectively with research and public health bodies.

It is however vital that one Department takes overarching responsibility. Given that there is a need for an alcohol strategy to address public health concerns at its core, it would be sensible for the Department of Health to take the leading role.

2. *Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol.*

While health and law are devolved within the UK, taxation and several other fiscal powers are not. England and the devolved administrations have differing approaches to alcohol policy, illustrated by the Scottish ban on multi-buy discounts and the Northern Ireland commitment to changes in the drink drive levels.

In pursuing different policy approaches, the UK administrations are able to cater for individual health needs and cultural sensitivities. However, some policies may be at risk of being undermined if they differ from neighbouring territories. This is particularly true with pricing policies. For example, the introduction of a ban on bulk discount purchases for alcohol in Scotland led a leading supermarket to contact customers north of the border to reassure them that they could still access bulk discount offers online because the location of the distribution warehouse was in England.

In order to avoid problems associated with cross-border trading, administrations must work together to coordinate, where appropriate, policy responses and share evidence and best practice examples. *An alcohol policy working group*, with representatives from England and each of the devolved administrations, could be established to perform this function, which could report to the cross-departmental alcohol coordinating committee.

Alongside the devolution of UK administrations, there is an important need to remember the European context within which UK policy sits. Much of our domestic alcohol policy is governed by European Directives for example taxation and marketing regulations. The UK Government must be strong in Europe and represent our domestic public health interests.

3. *Impact of alcohol industry lobbying on changing or influencing alcohol policy of successive governments, and the potential impact on minimising regulation in the future*

IAS has repeatedly expressed concerns about the involvement of the alcohol industry in public health policy through partnerships developed by the previous Labour administrations and the Coalition Government. Indeed IAS joined other leading health bodies in boycotting the Public Health Responsibility Deal for Alcohol in March 2011, which was seen as a culmination of inappropriate relations between government policymakers and industry officials that represented a direct conflict of interest between public health goals and economic objectives. Thus, despite acknowledgement in the strategy that *“industry needs and commercial advantages have too frequently been prioritised over community concerns”* many of the Strategy’s proposals rely strongly on industry patronage and support.

IAS is concerned that the Strategy reinforces and indeed enhances existing roles and structures for alcohol industry involvement in alcohol policy through initiatives such as the Public Health Responsibility Deal and Drinkaware, in the absence of independent evaluation of their effectiveness. Furthermore, there is evidence that industry-led “social responsibility” initiatives are ineffective: findings of a report commissioned by the Home Office in 2008 on the efficacy of industry self-regulation in the pursuit of effective alcohol policies identified the persistence of “many irresponsible and harmful practices” despite the establishment of the drink’s industry Social Responsibility Standards in 2005.²¹⁷

IAS believes it is not the role of the alcohol industry to define public health policy or to be responsible for the creation of public health information, as in many cases this is in direct conflict with their interests and responsibilities to shareholders and employees. To ensure policies relating to alcohol are developed and implemented with the maximum public health benefit, they must be subject to rigorous evaluation and monitoring, by agencies free from alcohol industry interests.

²¹⁷ KPMG. Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks. Home Office, 2008

4. *The evidence base for and economic impact of introducing a fixed price per unit of alcohol, including the impacts on moderate and harmful drinkers. The legal complexities of introducing fixed pricing should also be explored*

The IAS strongly supports the Strategy's commitment to introduce a minimum price per unit of alcohol. We applaud the recognition that affordability of alcohol is a major driver of alcohol related harm and congratulate the Government for taking a significant step forward in the fight against alcohol harm.

Numerous studies across the world have shown public health benefits as a result of alcohol price increases and taxation policies: increasing the cost of alcohol is associated with sustained reductions in all-cause mortality, liver related deaths; suicide rates; hospital admissions; road traffic accident rates and youth fatality rates.²¹⁸ Alcohol price increases have also been directly linked to reduced rates of homicides, rape, robbery, assaults, motor vehicle theft, domestic violence and child abuse.²¹⁹ Young people and harmful drinkers are the two groups that are the most responsive to pricing policies and would be the most affected by the introduction of a minimum price policy, as they consumer cheap alcohol. "Moderate" drinkers however will be less affected by the price changes.²²⁰

A study by the University of Sheffield conducted as part of the NICE review estimated that on average, hazardous drinkers drink 15 times more alcohol than moderate drinkers, yet pay 40% less per unit. The modelling used as part of the report showed that as the minimum unit price increased, public health gains also increased, as outlined in Table 1:

Table 1
ESTIMATED EFFECTS OF MINIMUM UNIT PRICING POLICY IN ENGLAND²²¹

<i>Outcome</i>	<i>40p</i>	<i>45p</i>	<i>50p</i>
Alcohol-related deaths prevented after 1 year	157	268	406
Alcohol-related deaths prevented after 10 years	1,381	2,288	3,393
Hospital admissions prevented after 1 year	6,300	10,800	16,400
Hospital admissions prevented after 10 years	40,800	66,600	97,000
Crimes prevented after 10 years	16,000	28,900	45,800
Violent crimes prevented after 10 years	3,200	6,200	10,300

IAS therefore supports the introduction of a minimum unit price of *at least 50p*, which the modelling suggests would save 3,393 lives, prevent 97,000 hospital admissions and 45,800 crimes each year when the policy has reached its full affect.

Concerns have been raised that minimum price may be illegal under EU competition law. The Scottish Government, which has examined this issue thoroughly, strongly disagrees and argues EU Competition Law does provide for a public health exemption. This exemption has been successfully used by the French Government to ban alcohol advertising and sponsorship in certain circumstances (the *Loi Evin*), winning a number of cases in the European Court of Justice (ECJ) after challenges on its legality.

5. *The effects of marketing on alcohol consumption, in particular in relation to children and young people*

There is extensive evidence that exposure to alcohol marketing encourages children to drink at an earlier age and in greater quantities than they otherwise would. The Health Select Committee reported in 2010 that the current regulatory framework for alcohol marketing in the UK was inadequate:

*"The current system of controls on alcohol advertising and promotion is failing the young people it is intended to protect. The problem is more the quantity of advertising and promotion than its content. This has led public health experts to call for a ban. It is clear that both the procedures and the scope need to be strengthened."*²²²

Whilst the Strategy recognises the link between marketing and consumption, the proposed actions outlined focus on working within the current structures and do not go far enough to curb children's exposure to alcohol advertising.

A framework exists in France to protect children and young people from exposure to alcohol marketing and promotion. The *Loi Evin* allows alcohol marketing and promotion in media that is used by adults, but not where a large proportion of children and young people make up the audience. Given the complexities of marketing regulation in the UK and the ease at which alcohol promoters are able to advertise their products to

²¹⁸ Babor, T, Caetano, R, Casswell, S, Edwards, G, Giesbrecht, N, Graham, K, Grube, J, Hill, L, Holder, H, Homel, R, Livingston, M, Osterberg, E, Rehm, J, Room, R, Rossow, I. Alcohol, No Ordinary Commodity, Oxford, second edition, 2010

²¹⁹ Wagenaar A C, Salois M J, Komro K A. Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction* 2009; 104: 179–90

²²⁰ Purhouse, R *et al*, 2009. Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group.

²²¹ *ibid*

²²² Health Committee, First Report of Session 2009–10, *Alcohol*, House of Commons 151-I Back. 2010.

children within the current codes of conduct, for example in cinemas for under-18 films, music festivals and football sponsorships, the *Loi Evin* model provides a simple framework that can offer clarity on what marketing practices can and cannot be implemented whilst ensuring that children and young people are protected from an exposure that poses a risk to their health and wellbeing.

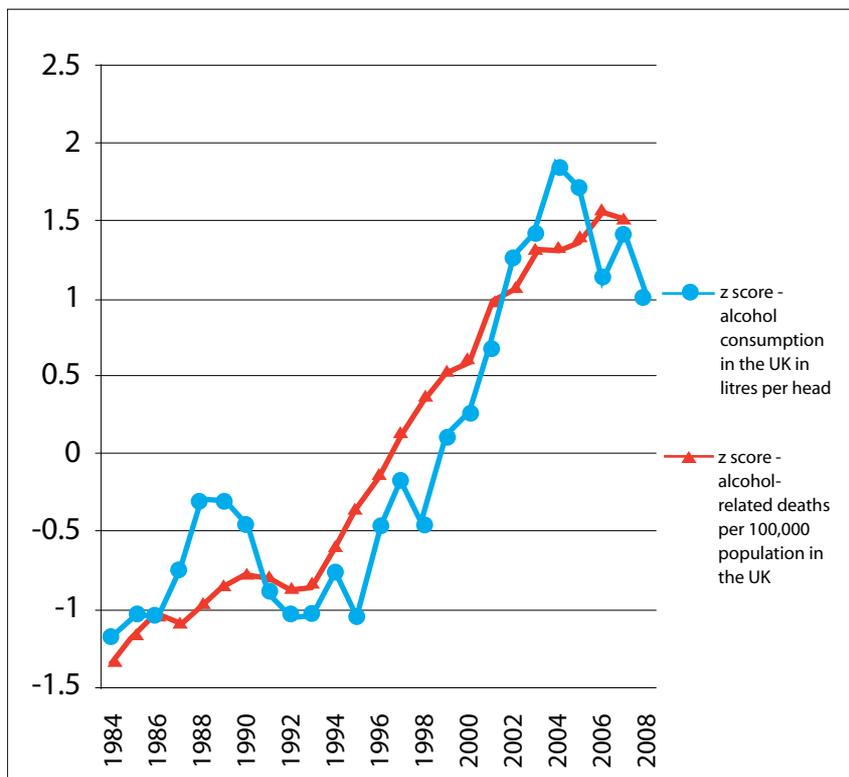
IAS would support a UK adapted version of the *Loi Evin*. The *Loi Evin* has been challenged in the French courts upheld in the ECJ, which found in 2004 that the measure is proportionate, effective, and consistent with the Treaty of Rome.²²³

6. *The impact that current levels of alcohol consumption will have on the public's health in the longer term*

Making future projections on the health impacts of alcohol is a difficult task, especially for a population that is subject to increasing demographic change. However, it is clear that alcohol-related harm increases when population consumption levels increase (Figure 1).

Figure 1

TRENDS IN PER CAPITA ALCOHOL CONSUMPTION AND ALCOHOL-RELATED DEATHS FOR THE UK 1984–2008



Source: “Future Proof: Alcohol Consumption, Mortality and Morbidity—Key Findings” Professor Martin Plant 2009²²⁴

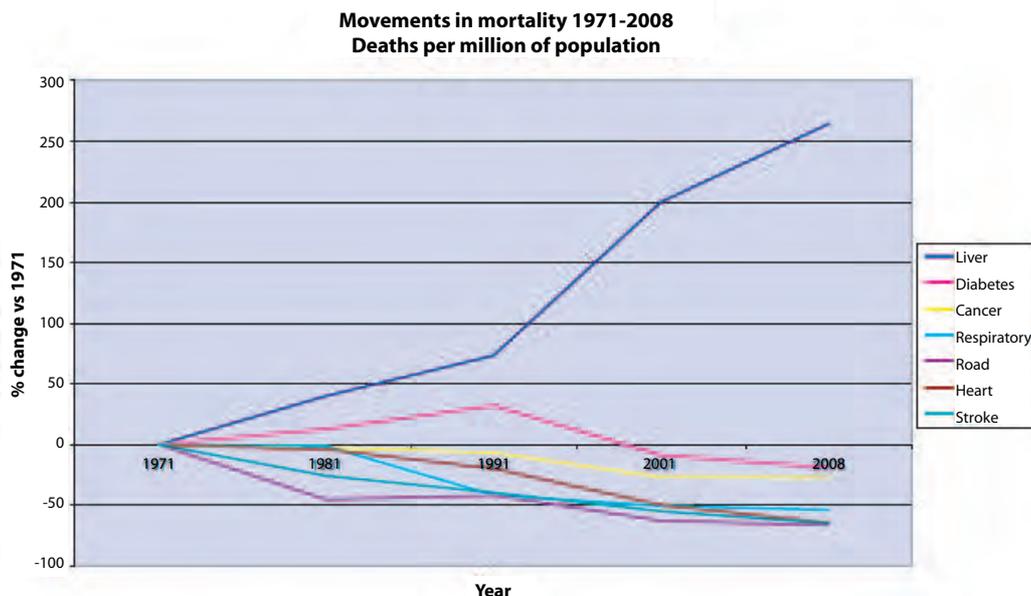
At present, death rates from liver disease in the UK are increasing at a time when the mortality rates from many other diseases such as cancer, heart disease, stroke and respiratory disease have fallen since the early 1990s (Figure 2):

²²³ Commission of the European Communities v French Republic, 2004

²²⁴ Coghill, N, Miller, P, Plant, M, Future Proof: Can we afford the cost of drinking too much? Mortality, morbidity and drink driving in the UK, report by Alcohol Concern, 2009

Figure 2

CHANGES IN MORTALITY RATES PER MILLION POPULATION FOR SELECTED DISEASES IN ENGLAND AND WALES 1971–2008 (1970 = 100%)



Source: British Liver Trust, 2010²²⁵

Alcohol consumption levels have fallen in recent years most likely because of the current economic climate and the reduction in disposable income. It is likely that this reduction in consumption levels, if sustained for whatever reason, may be reflected, after a lag time of about 18 months, in a reduction in the levels of alcohol-related harms.

The IAS would recommend that the Department of Health commissions research into future projections for alcohol health harms, paying particular attention to the impact on different demographic groups and communities. We would also recommend that attention be drawn to the health (and social) *harms to others* caused by alcohol, as well as to individual drinkers.

7. Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services (presumably as specified in the national liver strategy but not spelt out in the Strategy document)

The Strategy focuses strongly on binge drinking and alcohol-related crime with little if any recognition of the appalling personal, societal and fiscal costs associated with the health consequences of long-term alcohol misuse. Clearly measures taken to reduce alcohol consumption, such as minimum unit pricing, will impact on the heaviest drinkers but will not in the short to medium term have any effect on the health burden imposed by those already damaged. Reductions in population consumption levels, if sustained, will be followed, after a lag time of approximately 18 months, by a fall in mortality rates from alcohol-related cirrhosis. This, however, simply reflects the fact that survival improves if patients reduce their alcohol intake but does not detract from the fact that these individuals still have a serious chronic condition that will continue to incur significant health-related costs.

Many of the chronic health problems associated with long-term alcohol misuse take 10 to 15 years to develop and often do so silently. *There is no provision within the Strategy for the early detection of the health problems associated with alcohol misuse.* Thus, although much is made of the opportunities within the health services to identify individuals drinking excessively and to provide a brief intervention there is nothing about screening for the health consequences. It is well established that the more information individuals receive about the damage they may be causing themselves the more likely they are to change behaviour. Thus, alcohol identification and brief advice is simply not enough; those who have an established pattern of heavy drinking should be screened further to identify alcohol-related damage at an earlier and potentially reversible stage.

As there are no clear plans within the Strategy to specifically target and hence reduce the health consequences of alcohol misuse it is unlikely that the burden of alcohol-related problems on health and social services will be alleviated significantly within the foreseeable future.

²²⁵ data accessed at <http://www.britishlivertrust.org.uk/home/about-us/media-centre/facts-about-liver-disease.aspx?searchId=682> 2/5/2012

8. *Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm*

The availability and quality of services for people with alcohol-related harm vary widely across the country. Services are provided by a variety of statutory and non-statutory agencies. Within the statutory sector there is a tendency for services to be commissioned from private agencies many of whom do not employ clinical staff but rely on ex-service users. There are some examples of good practice but very few integrated services. Many health authorities combine Drug and Alcohol Services and invariably the provision for alcohol come a poor second despite the much greater need. General practitioners have not embraced the problems of alcohol misuse as well as they should have done evidenced by the fact that any screening etc, is only undertaken, and then not particularly effectively if it attract additional payment via Quality and Outcome Framework initiatives.

Given the above *it is difficult to see how the proposed reforms of the NHS and public health systems would facilitate let alone help integrate services for people who experience alcohol-related harm.* From April 2013 upper tier and unitary local authorities will receive a ring fenced public health grant, including funding for alcohol services. However, unless a proportion of these funds are in turn ring-fenced for alcohol services there will be no guarantee of proportionate funding analogous to the situation with Drug and Alcohol Services mentioned above. The situation relating to the Health Service reforms is less clear: much of the commissioning will be in the hands of the GPs and it is difficult to be clear about where on their landscape alcohol services will figure. What is clear is that these lines of commissioning will do nothing to ensure uniformity in the availability and quality of services for people with alcohol-related problems.

Clearly there should be dialogue between the various sectors responsible for commissioning of alcohol services in a given area if not nationally. Of value would be a series of directive on service provision from central Government better still with identification of ring-fenced funding.

9. *International evidence of the most effective interventions for reducing consumption of alcohol*

There is a substantial evidence base on the effectiveness of different policies in reducing the harm done by alcohol (Table 2). Effective policies include those that (i) regulate the environment in which alcohol is marketed (economic and physical availability) (ii) reduce drinking and driving and (iii) are individually-directed at already at-risk drinkers. On the other hand, the evidence shows that information and education-type programmes do not reduce alcohol-related harm, although they have a role in providing information, reframing alcohol-related problems, and increasing attention to and acceptance of alcohol on the political and public agendas.²²⁶

Based on a WHO report in 2009, *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*, Table 2 summarizes the evidence to support policy measures that reduce alcohol-related harm:

Table 2. Summary of the evidence of the effectiveness of alcohol policies

Degree of evidence	Evidence of action that reduces alcohol-related harm	Evidence of action that does not reduce alcohol-related harm
Convincing	Alcohol taxes Government monopolies for retail sale Restrictions on outlet density Restrictions on days and hours of sale Minimum purchase age Lower legal BAC levels for driving Random breath-testing Brief advice programmes Treatment for alcohol use disorders	School-based education and information
Probable	A minimum price per gram of alcohol Restrictions on the volume of commercial communications Enforcement of restrictions of sales to intoxicated and under-age people	Lower taxes to manage cross-border trade Training of alcohol servers Designated driver campaigns Consumer labelling and warning messages Public education campaigns
Limited-suggestive	Suspension of driving licences Alcohol locks Workplace programmes Community-based programmes	Campaigns funded by the alcohol industry

²²⁶ WHO, *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*, Geneva, 2009

Source: Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm, WHO report, 2009²²⁷

DRINK DRIVING

IAS is concerned about the omission in the Strategy of drink drive policy commitments. Despite the gradual decline in drink drive accidents over the last 25 years, drink drivers still kill and injure thousands of people each year. *In 2010 250 people were killed and 9,700 were injured in drink drive accidents in Britain.*²²⁸

A person's ability to drive is affected if they have any alcohol in their blood. Drivers with blood alcohol concentrations of between 20–50mg/100ml have at least a x3 greater risk of dying in a vehicle crash. This risk increases x6 with blood alcohol concentrations of 50–80mg %, and x11 at 80–100mg%.²²⁹

IAS supports a reduction in the legal blood alcohol limit for drivers to 50mg in line with the majority of European Countries. Lowering the legal blood alcohol level to 50mg/100 ml in Great Britain would save up to 303 lives during the first six years of implementation.²³⁰ *Implementation of this scheme in Northern Ireland should be carefully monitored.*

There is ample evidence that high profile police breath testing of drivers cuts casualty rates²³¹ and there is a clear inverse relationship between the number of breath tests carried out and the number of drink-drive casualties. *IAS supports the Association of Chief Police Officers (ACPO) in their request for the removal of restrictions on Police powers to breath test drivers.* This would help the Police to use their powers more effectively both as a deterrent and also to target drinking drivers who remain undeterred.

May 2012

Written evidence from Drink Wise North West (GAS 46)

ABOUT DRINK WISE NORTH WEST

Drink Wise North West gives a voice and support to public sector professionals and community members who want to end alcohol harm. We work with the NHS, Local Authorities, the voluntary sector and communities to reduce the negative impact of alcohol—saving lives, reducing crime and cutting the financial and social costs of alcohol. We work on behalf of all 24 of the Directors of Public Health across the North West of England, Local Authority Chief Executives and we have more than 200 Drink Wise North West alcohol champions, who include clinicians, academics and senior police officers. We are hosted by the social enterprise, Our Life, which ensures people are given the opportunity to influence and deliver change on a range of issues to support their community's wellbeing. www.drinkwisenorthwest.org and www.ourlife.org.uk.

1. Summary

- Drink Wise North West welcomes the publication of *The Government's Alcohol Strategy* (2012), particularly the proposal to introduce a minimum price for alcohol.
- We urge the Government to set the minimum unit price at 50p per unit, and to introduce a “public health levy” to offset any potential profit made by retailers or producers.
- We welcome the Government's acknowledgement that “the alcohol industry has a direct and powerful connection and influence on consumer behaviours”,²³² especially that “marketing and advertising affect drinking behaviour.”²³³
- However, we are concerned that there is a need for greater independence from the industry when regulating alcohol advertising, marketing and promotion.
- We also recommend stronger proposals to protect children and young people through a *Loi Evin* approach and greater powers to regulate the newer forms of alcohol promotion and marketing, like social media.
- We remain concerned that the Responsibility Deal is given prominence in the alcohol strategy, but industry is actively undermining this work by lobbying against evidence based measures like minimum unit pricing.
- The ongoing involvement of industry in public health campaigns is also of concern as it represents a conflict of interest.

²²⁷ *ibid*

²²⁸ Department for Transport. Reported Road Casualties Great Britain. DoT, 2009.

²²⁹ NICE, Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths, March 2010

²³⁰ Department for Transport, Report of the Review of Drink and Driving Law, June 2010

²³¹ *ibid*

²³² *The Government's Alcohol Strategy*, page 17, para 4.4

²³³ *Ibid*

- Whilst we welcome the emphasis on local action, we believe this should be underpinned by a framework of national leadership, support and advice to support local areas to develop cost effective and best practice based treatment and prevention.

RESPONSE TO AREAS OF INTEREST OUTLINED BY THE INQUIRY TERMS OF REFERENCE

2. Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role

2.1 Harmful alcohol consumption is a population level issue which has enormous societal consequences, including lost life, chronic illness, crime and antisocial behavior.

2.2 Recent research shows that addressing the negative impacts of alcohol costs the North West of England at least £3 billion per year (this includes the burden on the NHS, Police, Social Services, as well as the cost to the economy, for instance through lost productivity).²³⁴

2.3 The sheer scale of the challenge that excessive alcohol consumption poses, means that alcohol policy necessarily falls under a range Government departments. These include: the Department of Health, Home Office, the Treasury, the Department for Education and the departments of Culture, Media and Sport, Transport, Communities and Local Government and the Ministry of Justice.

2.4 This can mean that co-coordinating alcohol policy effectively is a challenge. We recommend therefore a cross departmental alcohol unit, which could report to the Home Affairs (Public Health) Cabinet sub-committee. The unit could be led by the Chief Medical Officer, who would be well placed to mitigate the differing concerns of various departments.

3. Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol

3.1 Alcohol policy should be coordinated across the UK where possible and be based on sound, independent evidence.

3.2 The level at which minimum unit price is set should be coordinated across the UK jurisdictions. The Scottish Government is committed to introducing a minimum unit price for alcohol, which we expect to be set at no lower than 45p per unit. It would be counterproductive if there was a differential minimum unit price in England and Wales.

4. The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group

4.1 Drink Wise North West welcomes the acknowledgement in the strategy that “industry needs and commercial advantages have too frequently been prioritised over community concerns.”²³⁵

4.2 The alcohol strategy relies heavily on organisations, which are totally funded by the alcohol industry such as the Portman Group and Drinkaware.

4.3 We are concerned about the involvement of industry in educating the public about the risks of alcohol. This is a clear conflict of interest because the alcohol industry has a responsibility to their shareholders to maximise profit by selling more alcohol.

4.4 Even when there is public health involvement in such organisations (such as Drinkaware), the involvement of industry leads to an inherently specific remit and limited role in public health strategy and action. This is reflected for instance in Drinkaware’s primary focus on young people and binge drinking, which we believe excludes other groups who are at risk of alcohol related death or illness.

4.5 We are also sceptical about the commitment of industry to play a full role in rebalancing the UK’s drinking culture, because many alcohol companies and representative organisations are active in undermining the international evidence base for policies such as minimum unit pricing.

4.6 We argue that any organisation undertaking the important role of public education should be completely independent of the alcohol industry.

4.7 We recommend instead using independent public health experts and evidence when setting behaviour change agendas, or running education campaigns, in line with WHO recommendations.

4.8 If funding is to be leveraged from industry (which we believe is a good idea), then industry should have no say in how this is spent. Instead we would support the establishment of a truly independent charity or blind trust to oversee this work.

4.9 We also believe that education should be reinforced by a regime of national action to tackle price, promotion, product and placement so that it becomes easier for people to drink less, rather than more.

²³⁴ *The Cost of Alcohol to the North West economy*, (March 2012), Drink Wise North West

²³⁵ *The Government’s Alcohol Strategy*, page 3, para 1.4

5. The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing

5.1 Drink Wise North West strongly supports the introduction of a minimum price per unit and congratulate the Government on this intention.

5.2 This step acknowledges the clear relationship between price and harm. Alcohol is 44% more affordable than it was in 1980,²³⁶ and a survey conducted in the North West found that 80% of people said that low prices and discounting increase their alcohol consumption.²³⁷

5.3 The Sheffield University study indicates that the introduction of a minimum price would reduce consumption amongst harmful drinkers and young drinkers while having a minimal effect on those drinking within the guidelines.²³⁸

5.4 Drink Wise North West strongly supports a level of 50p per unit because this will save more than twice as many lives and avoid an additional 30,000 crimes and more than 50,000 hospital admissions per year than 40p.²³⁹ Table A below shows the benefits (per year) after ten years:

Table A

COMPARISON OF THE EFFECTS OF A MINIMUM UNIT PRICE OF 50P AND 40P²⁴⁰

	<i>Deaths</i>	<i>Hospital admissions</i>	<i>Days absent from work</i>	<i>Crimes</i>
Minimum unit price at 40p	1,380 lives saved	40,800 reduction	100,000 less	16,000 avoided
Minimum unit price at 50p	3,400 lives saved	98,000 reduction	300,000 less	46,000 avoided

5.5 We also recommend that a minimum price should be closely linked to general inflationary pressures, and should increase in line with official rates of inflation each year. The experience of some Canadian provinces which have minimum unit pricing, shows us that the price level needs to be regularly reviewed to maintain its effectiveness.

5.6 Drink Wise North West supports the introduction of a “public health levy” on retailers and/or producers should they accrue additional profits due to the introduction of a minimum unit price. This levy could be used to directly fund alcohol health services and we suggest that there is a precedent for this type of approach in Scotland’s Public Health levy.

5.7 We are aware that industry is claiming that a minimum price per unit will lead to an increase in illegal activity. We refute this claim based on evidence given during the passage of the Scottish Bill.²⁴¹

5.8 However we do support the proposals for improving methods to deter and catch illegal sales of alcohol, such as introducing fiscal marks for beer, supply chain legislation, and a licensing scheme for wholesale alcohol dealers is to be welcomed. In WHO Europe’s recent report “Alcohol in the European Union: Consumption, Harm and Policy Approaches” it says “the level of illegal trade and smuggling predominantly depends on the level of Government enforcement.”

5.9 We also support the proposed ban on multi buys as an effective and complementary policy alongside minimum unit pricing.

6. The effects of marketing on alcohol consumption, in particular in relation to children and young people

6.1 In the BMA’s *Under the Influence* report it states that: “a substantial body of research has found that alcohol advertising and promotion influences the onset, continuance and amount of alcohol consumption amongst young people.”²⁴²

6.2 The Health Select Committee (2010) also found that the current regulatory framework for alcohol marketing is not adequate.²⁴³

²³⁶ *Statistical Handbook* (2007), Tighe A (Ed) Brewing Publications Ltd

²³⁷ *Big Drink Debate* (2008) (a survey of 30,000 people in the North West), Department of Health North West, Our Life and Liverpool John Moores University.

²³⁸ *Independent Review of the Effects of Alcohol Pricing and Promotion* (2008) University of Sheffield

²³⁹ *Ibid*

²⁴⁰ *Ibid*

²⁴¹ Senior police officers indicated that across all eight forces in Scotland there was no evidence that illegal sales of alcohol were an issue nor did they consider that it was likely to become one. *Evidence to the Health and Sport Committee* (2010)

²⁴² *Under the Influence*, BMA (2009), page 18, para 4.1

²⁴³ Health Committee, First Report of Session 2009–10, Alcohol, HC151-I, 2010

6.3 Therefore, we are concerned that the strategy does not, in our view, contain robust proposals to reduce children's exposure to alcohol advertising and marketing.

6.4 Instead, it relies on working with a partially self regulatory system, which again is constrained by the conflict of interest that industry's overwhelming aim to make profit by encouraging people to drink more poses.

6.5 We also believe that the current system has not evolved adequately to take account of the decline in "traditional" advertising to other forms of marketing such as football sponsorship, promotions, musical festivals and viral and social media marketing where the potential exposure of children is even more problematic.²⁴⁴

6.6 We argue, in line with WHO and BMA that all regulation of alcohol advertising and marketing should be wholly independent of the alcohol industry. An independent body should be set up to perform this function and it should have sufficient resources and expertise to be able to look at the newer forms of alcohol marketing and promotion, as well as more traditional advertising routes.

6.7 To protect young people, Drink Wise North West also supports an approach to alcohol advertising similar to that taken in France via the *Loi Evin*, whereby the promotion of alcohol would be restricted to media that adults use.

7. *The impact that current levels of alcohol consumption will have on the public's health in the longer term*

7.1 Someone is admitted to hospital every four minutes in the North West.²⁴⁵

7.2 The Office for National Statistics estimated that in the UK there were 8,664 alcohol-related deaths in 2009, which is more than double the 4,023 recorded during 1992.²⁴⁶ By way of a comparison 1,738 people died due to drug misuse in 2008.²⁴⁷

7.3 In its publication "reducing alcohol harm" the British Liver Trust states "The challenge of alcohol misuse is reaching epidemic proportions in the United Kingdom; with the average intake of alcohol rising steadily, NHS admissions from alcohol increasing" and cites the research that suggests that the current death toll from alcohol is equivalent to "a jumbo jet crashing every 17 days."²⁴⁸

8. *Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services*

8.1 A recent report found that in the North West the costs of alcohol to the NHS were almost £650 million per year and costs to social services were more than £231 million per year.²⁴⁹ This shows that huge savings can be made if we can reduce alcohol consumption and correlating harm.

8.2 Local leaders and professionals across the North West are all keen to make sure that they tailor services for local need but with the best national advice, guidance and support.

8.3 For this reason local areas in North West have invested in Drink Wise North West to help them to "scale up" interventions that are effective and to help them to identify where it is more cost effective to work together. This work has for instance led to an identified £36 million of NHS savings in the next two years in the North West. We believe there is merit in this model being explored nationally.

8.4 We also contend that Public Health England and the NHS Commissioning Board should play a role in developing a shared national framework for tackling alcohol harm, which provides the leadership, support and advice that local areas need to develop cost effective and best practice based local treatment and prevention plans.

9. *Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm*

9.1 As public health responsibilities, including alcohol services, are moving from the NHS into local government we believe that this presents a revitalised opportunity to develop robust alcohol-harm-reduction programmes across a range of partners.

9.2 However, we recommend that there is clearer guidance/leadership around the role of GPs and others in commissioning alcohol related services in particular.

9.3 There is a real danger that CCG's and other commissioners (like the Police) assume that alcohol is covered entirely by the public health budget.

²⁴⁴ *Ibid*

²⁴⁵ Drink Wise North West analysis of hospital admissions data (HES) Department of Health 2010

²⁴⁶ Office for National Statistics Alcohol-related deaths in the United Kingdom, 2000–2009 January 2011; Burki T Changing drinking patterns: a sobering thought *Lancet* 2010;376:153–4

²⁴⁷ Health and Social Care Information Centre Statistics on Drug Misuse: England, 2010 January 2011

²⁴⁸ Reducing alcohol harm report: recovery and choice for those with alcohol related health problems, British Liver Trust

²⁴⁹ *The Cost of Alcohol to the North West economy*, (March 2012), Drink Wise North West

9.4 We appreciate that it is primarily up to local leaders to make the case through effective local advocacy and partnership working, however we believe the government, as well as Public Health England and the NHS Commissioning Board, can provide an essential leadership role to promote the pooling of resources.

May 2012

**Written evidence from the Royal Geographical Society (with the Institute of British Geographers)
(GAS 47)**

1. INTRODUCTION

1.1 The Royal Geographical Society (with the Institute of British Geographers) welcomes this opportunity to comment on the inquiry on the government's alcohol strategy.

1.2 Formed in 1830, the Society's Royal Charter is for "the advancement of geographical science". We are a charity that seeks to develop, promote and support the discipline of geography and its practitioners in the areas of research and higher education, teaching and fieldwork, policy and wider public engagement. The Society has more than 16,000 Fellows and members, of whom a substantial number are academics and other researchers whose work we support through a range of activities. These include holding the largest geographical research conference in Europe, publishing three of the leading international peer-reviewed geography journals in the world (including Transactions of the Institute of British Geographers which is often ranked first), co-ordinating twenty seven specialist research groups, and providing small grants for researchers at all career stages. We work very closely with all Higher Education (HE) geography departments in the UK.

1.3 The Society's policy work aims to raise the level of understanding of the contribution of geography to policy making. As part of this work a one-day policy conference was held in February 2010 as part of our Environment and Society series to discuss issues around alcohol policy in the UK linked to research being undertaken by geographers based in UK academic institutions. This led to the publication of a policy briefing *Consumption Controversies: Alcohol Policies in the UK* in late 2010 presenting an overview of research relating to the debate. This consultation submission summarises the main points from this briefing relevant to the inquiry. A key theme of both the conference and publication was that policies cut across departments including the department of Culture Media and Sport who deal with licensing and were responsible for the Licensing Act of 2005, Home Office, Communities and Local Government, and the Department of Health.

2. THE GEOGRAPHY OF ALCOHOL CONSUMPTION

2.1 Analysis has shown there is a marked regional difference in levels of alcohol consumption and the propensity for "binge drinking", particularly between north and south, with those adults who "binge" at least once a week ranging from one-third of male alcohol drinkers in London, southern England and the Midlands, up to almost half in the North East. Women drinkers follow this same pattern, from less than one quarter of drinkers, up to more than one third. Regional patterns of alcohol consumption also demonstrate much higher rates of abstinence in London than anywhere else in the UK [i;ii]. Patterns relating to differences in "binge drinking" are not solely confined to regional differences, and analysis has shown that other factors are also significant. For example, the health survey data for England demonstrates that managerial and professional workers are much more likely to drink alcohol (79% of men and 67% of women) than manual workers 5 (64% and 46% respectively), and are more likely to exceed recommended limits (38%, compared with 29%).

2.2 National analysis has also shown that people of Pakistani or Bangladeshi origin were much less likely to drink alcohol (just 4% and 5% respectively), than white British (68%) [i]. However the experience of survey work undertaken in Stoke-upon- Trent by a team led by Professor Gill Valentine, School of Geography, University of Leeds [iii] found that whilst drinking amongst Pakistani Muslims appears to be low in the survey results, this may be hiding significant levels of drinking within the group that simply isn't being reported, with official statistics actually under-recording consumption levels.

3. DRINKING SPACES: ALCOHOL CONSUMPTION WITHIN THE HOME

3.1 Research carried out by a team of geographers (Professor Sarah Holloway, Loughborough University; Professor Gill Valentine, University of Leeds; and Dr Mark Jayne, University of Manchester) has led to a conclusion that public and policy debates about alcohol, focusing on regeneration and fears of drunken disorder/ binge drinking within the night-time economy, are overly biased towards framing the debate around "problem" drinking in public spaces. Their research found that it is regular "home drinkers" who may be at greater risk of longer term alcohol-related ill health and conditions and of developing increased alcohol dependency. They found that a large number of these can be identified as "de-stress" drinkers who are typically middle class, have a stressful home life or pressurised job, and "drink to calm down and regain control of their life". Many continue to regard their own practices as unremarkable and find themselves insulated from concern.[iv]

3.2 These same researchers have carried out a number of other research projects around alcohol consumption, much of which has been funded by the Joseph Rowntree Foundation. One project compared drinking practices in urban Stoke-upon-Trent, and rural Eden in Cumbria [v;vi;vii] and found that across all age groups the home is the most popular venue for consuming alcohol, followed by friends' homes. This finding has been supported

by market research from Mintel which showed a rapidly growing off-trade with a strong shift in consumption away from pubs and bars, 1.8 million more people now drinking at home than in 2004 [viii;ix]. This means that “at home” is now the most important place to drink for nearly half of all drinking adults and volumes of alcoholic drinks purchased from for consumption outside the home (ie in pubs and bars) decreased by 31% between 2001–02 and 2007 affected by sales in supermarkets and other retailers. The increasing volume of sales for home drinking is attributed to women, managerial or professional occupations, with higher earners shown to be most likely to have drunk on five or more days in the last week and the most likely to have exceeded the recommended weekly guidelines.[x]

4. UNDERAGE DRINKING

4.1 Evidence from Elizabeth Fuller, Research Director for the Survey of Smoking, Drinking and Drug Use among Young People In England at NatCen, shows that on average more than half of children (11–15 year olds), both boys and girls, have tried at least one alcoholic drink, the relative proportion increasing with age from 16% of 11year olds to 81% of 15 year olds [xi]. Survey data for England [xii] has revealed how 18% of 11–15 year olds reportedly drink alcohol every week, with these children consuming an average of 14.6 units per week. The proportion drinking alcohol every week also increases with age, from 3% of 11year olds to 38% of 15 year olds. The types of alcohol being consumed also vary, with boys more likely to drink beer, lager or cider, and girls tending towards alcopops or wine. Regional variations in consumption levels match the national picture for adults in England. In London just 37% of children have tried alcohol, whereas in all other regions this varies between 51 and 63%, the highest also being in the North East region as for adults [i; xi].

4.2 Studies have found a strong relationship between family attitudes and drinking, with much lower levels of alcohol consumption by children where their family does not approve. Children who drink usually do so with friends of their own age rather than with their parents and in a mixture of locations. The main locations are their own home, at someone else’s home, at parties with friends, or out of doors (such as on the street or in parks), but only a very small proportion in either pubs or bars [xi].

4.3 Research has also revealed however that pupils are actually becoming less tolerant of drinking and drunkenness by their peers. The proportion of children agreeing it is “ok for someone of their age to drink alcohol” fell from 46% in 2003 to 35% in 2008, and the proportion who thought it was “ok for someone of their age to get drunk once a week” also fell over this same time, from 20% to 12%. [xii] Evidence also points out that teenagers in better-off areas are more likely to consume alcohol, with higher numbers of pupils drinking at schools where lower proportions of students were eligible for free school meals and from ethnic minorities. Young white people were the most likely to have tried drink, followed by mixed-race teenagers and those from black Caribbean backgrounds. Young people of Pakistani and Bangladeshi origin were amongst the least likely to have done so, as were those with parents who were unemployed, and those whose mothers had no qualifications.[xi]

4.4 Further research led by Professor Gill Valentine of the University of Leeds[xiii] examined adults’ recollections of drinking patterns in childhood. While there are different stories and perspectives on how, when and where children should be allowed to drink, for many adults looking back it remains a very important “rite of passage” in their lives and they view their own experiences (both positive and negative) as an important part of “growing up”. [xiv]

5. THE USE OF “UNITS” TO MEASURE ALCOHOL CONSUMPTION

5.1 Medical experts tried to define safe levels of consumption, establishing drink as a matter of personal health and responsibility. Dr James Kneale, Department of Geography, University College London has undertaken extensive work on the historical background and culture of alcohol consumption. From his work he found that whereas today’s “alcohol unit” is often treated with suspicion, but at the start of the twentieth century a glass of wine or pint of stout was suggested as a safe daily limit.[xv] What may be seen as current “problems” actually closely resemble the “old” ones: the Victorian “habitual inebriate” has become “the alcoholic”, but notes there is still little agreement about what “problem” drinking means and how it is defined.[xvi;xvii]

5.2 The research from a team led by Gill Valentine [xiii] found that very few people acknowledge the use of “units” as a way of either measuring, and hence controlling, their own levels of drunkenness, or of monitoring the health impacts of alcohol consumption. In a survey of drinkers in urban Stoke-on-Trent and rural Eden, Cumbria, not one single person surveyed said that they used units in their day to day life and that measuring “units” simply did not work. However what the study did find was that people tend to consider the impact of drinking on their health in terms of how they felt, with their level of drunkenness determined by a number of factors including their mood, food intake, level of tiredness, and their own personal (often changing) tolerance to alcohol.

5.3 The conclusions is that a whole range of factors, including cultural norms and peer pressure, are what are important in determining what, and how much, people drink.[xviii] This suggests the use of “units” in alcohol policy may not resonate as a useful public health tool: first, “units” do not always correlate to the actual negative health effects of alcohol on our bodies; second, under current government guidance, a majority

of drinkers are being classified officially as “bingers”. In practice, however, these same drinkers may experience little or no harmful (immediate) health issues because of their alcohol consumption.[vii]

5.4 Research by Dr Liz Twigg, Reader in Human Geography, University of Portsmouth, and Professor Graham Moon, Centre for Geographical Health Research, University of Southampton, has also focused on issues around alcohol consumption. Their work concludes that in the UK people have tended not to worry about their consumption, even when reporting excess consumption.[xvii] People living in social housing tend to report lower levels of drinking, yet worry more about their consumption.[xx] At the same time, evidence shows that the amount of alcohol consumed reported in surveys is considerably (about one third) less than that sold.[xxi]

6. TREATMENT

6.1 Policy responses to ameliorate “problem” drinking have tended towards harm reduction strategies grounded in the influence of positive, responsible drinking in family life[xxii] alongside an alternative, usually sporting, lifestyle. But recent work on rural drinking questions this approach in the countryside where drinking is viewed as a normal part of life with research from Dr Michael Leyshon, Geography, University of Exeter, showing how family members invariably introduce rural youth into a drinking culture whilst many rural parents find it difficult to discuss harm reduction strategies with their children.[xxiii]

6.2 Research carried out by geographers Dr Nicola Shelton, based at the Research Department of Epidemiology and Public Health at University College London and Emily Savell, University of Bath has found that binge drinkers are much more likely to feel it is acceptable to be drunk, say that it is easier to enjoy a social event if drinking, and be of the view that they would be thought of as odd if they did not drink. The acceptability of “binge drinking”, and the desire to do something about it, both collectively and individually, also shows significant regional variations, with a very close relationship with the pattern of overall levels of drinking in each area: a higher proportion of binge drinkers in London and the South want to reduce consumption.[xxiv] Binge drinkers are also much less likely to support government proposals for increasing alcohol taxation. Despite this over a quarter of adults who are binge drinkers say in national health surveys that they wanted to reduce their levels of drinking.[xxiv] Generally, people who say they want to drink less, or reduce drinking when older, view alcohol as the main way to relax and unwind after a stressful day. Though their “best intentions” are to lower consumption, the reality is that most do not actually want to reduce their consumption at all.[v]

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Further information from the one-day policy conference *Drinking Spaces and Places*, held at the Royal Geographical Society (with IBG) in London on 20 February 2010 can be found at <http://www.rgs.org/drinkingspacesandplaces>. This includes links to a number of the presentations. The policy document “*Consumption controversies: Alcohol policies in the UK*” was published in late 2010 by the Society, and is available from www.rgs.org/alcoholReferences to work specifically highlighted in the submission are as follows:

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May 2012

Written evidence from DrugScope (GAS 48)

DrugScope is the national membership organisation for the drugs field, with over 400 members. Many work with people affected by alcohol problems. In March 2009 we incorporated the London Drug and Alcohol Network (LDAN), which supports drug and alcohol services in London. Recently we announced plans to merge with eATA, a representative organisation with a particular focus on drug and alcohol residential rehabilitation services.

We are concerned that the Committee's inquiry should give careful consideration to the inter-relationship between drug and alcohol issues, which are relevant to a number of the issues in the terms of reference. We would draw attention to eight key areas where the relationship between drug and alcohol policy is important.

1. *Trends and approaches.* In 2009, the Annual Report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) concluded that "in Europe today, poly-drug patterns are the norm, and the combined use of different substances is responsible for, or complicates, most of the problems we face", this includes the combined use of alcohol and drugs. This is an under discussed issue for the current debate about the night time economy. Recent figures from the National Treatment Agency suggest that the numbers of people presenting to specialist services with heroin dependency fell by around 10,000 in the two years to 2010–11. However, there is unmet need among people with other kinds of substance misuse problems, including poly-drug use and alcohol dependency.
2. *Education and prevention.* Investment in drug and alcohol education has fallen sharply, less than half of schools deliver drug education more than once a year and this number is declining.²⁵⁰ Evidence-based education and information resources for young people should be a priority for both drug and alcohol policy.
3. *Specialist services for young people.* Nine out of 10 of the 22,000 young people in contact with young people's specialist substance misuse services in 2010–11 had alcohol and/or cannabis problems. The UK Drug Policy Commission report "Charting new waters" (April 2012) identified funding for young people's treatment and prevention as the most vulnerable area for local disinvestment. Fifty one% of Drug Action Teams had observed a significant decline in funding for young people's substance misuse prevention services, and 41% had observed a significant decline in funding for young people's substance misuse treatment services.
4. *Localism and the transition to public health.* Funding for drug and alcohol treatment has been largely managed through different structures and processes: a national "pooled treatment budget" for drug treatment—supported by significant local investment—with alcohol services funded primarily through local sources, including Primary Care Trusts. Following the transition to public health in April 2013 the majority of drug and alcohol funding will be combined into a new ring-fenced public health budget to be allocated locally by Directors of Public Health,

²⁵⁰ See United Kingdom, UK Focal Point (2011), Department for Education (2011) and PSHE Education: a mapping study of the prevalent models of delivery and their effectiveness.

guided by Health and Wellbeing Boards, and the Joint Strategic Needs Assessment and joint Health and Wellbeing Strategies they produce. There are positive opportunities for a rebalancing of treatment provision (including more investment in alcohol services). However, there are risks in this pooling and rebalancing—in particular, it is important that investment of local spending is in evidence-based approaches and that “population wide measures” are not at the expense of an adequate level and quality of provision for individuals and families experiencing acute and entrenched drug and/or alcohol problems. The role of Clinical Commissioning Groups also needs to be clarified.

There is a broader concern among our membership that the absorption of drug and alcohol funding into the public health budget could lead to disinvestment, given that this will be only one of 17 potential responsibilities for Health and Wellbeing Boards.

5. *Payment by results.* On 2 April the Department of Health launched eight Drug and Alcohol Recovery Payment by Results pilots (and we are aware that other localities are experimenting with their own “payment by results” approaches). Services will be paid depending on their success in achieving outcomes across three “domains”: “free of drugs of dependence”, “reduced offending” and “improved health and well-being”. It will be important to evaluate how effectively these outcomes and tariffs incentivise services to work with people with alcohol problems. We also understand that a separate payment by results scheme for alcohol treatment has been under development within the NHS. It would be helpful to have clarification of the relationship between these two programmes. People affected by alcohol problems will also be impacted by other schemes with a PbR component—including, the Work Programme, the Troubled Families initiative and PbR in prisons and criminal justice.
6. *Recovery and social re-integration.* The 2010 Drug Strategy stresses that the barriers to recovery for people with serious alcohol and drug problems (and their families) are similar. These include access to housing, employment and meaningful activity, family support and relationships and addressing issues of stigma and discrimination, which affect families as well as service users. There is concern that the removal of the ring fence from Supporting People has resulted in disinvestment in housing support for people in recovery from substance misuse problems, and that this group may be particularly vulnerable to “parking” within the Work Programme, as they are not viewed as likely to secure employment.
7. *Co-morbidity and dual diagnosis.* A 2002 research study concluded that 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems. It is important to continue to build on work to address the issue of “dual diagnosis”, as well as to develop effective care pathways and interventions for people experiencing less severe mental health problems linked to their drug and/or alcohol use (for example, by improving access to psychological therapies for this group). DrugScope has published a paper exploring these issues in partnership with the Centre for Mental Health and UK Drug Policy Commission.²⁵¹ We recently published a “positive practice guide for working with people who use drugs and alcohol”, in partnership with the Improving Access to Psychological Therapies programme (IAPT) and the National Treatment Agency.²⁵²

We note that alcohol problems are common amongst people experiencing multiple need, including contact with the criminal justice system, homelessness and mental health problems. DrugScope is a partner in the Making Every Adult Matter coalition with Clinks, Homeless Link and Mind. In 2011, MEAM published “Turning the tide—a vision paper for multiple needs and exclusions”, which sets out proposals to ensure that in every local area people experiencing multiple needs are supported by effective and coordinated services and empowered to tackle their problems, reach their full potential and contribute to their community.

8. *Prisons and the criminal justice system.* A 2010 report from HM Inspectorate of Prisons was entitled “Alcohol services in prisons: an unmet need”—and noted that most alcohol misusers in prison reported concurrent use of illicit drugs. The Patel Report on Prison Drug Treatment noted that around 7% of prisoners had a severe alcohol dependency, while again emphasising that poly-drug use is common among prisoners—combining alcohol, opiates, stimulants and benzodiazepines—and access to effective treatment has been limited for this group. The Bradley Report (2009) concluded that “improved services for prisoners who have a dual diagnosis of mental health and drug/alcohol problems should be urgently developed”. It is important to address these issues as new planning and commissioning structures for prison treatment are developed.

We have supported the use of community sentences (such as Drug Rehabilitation Requirements) as an alternative to prison that challenges offenders to tackle their dependency and engage in treatment. We will watch the development of alcohol abstinence requirements with interest, but our view is that community sentences for people with alcohol problems should normally have

²⁵¹ Centre for Mental Health, Drugscope and UK Drug Policy Commission (2012), “Dual diagnosis: a challenge for the reformed NHS and Public Health England” at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DSDualDiagnosisDiscussionPaper.pdf

²⁵² www.iapt.nhs.uk/silo/files/iaptdrugandalcoholpositivepracticeguide.pdf

a strong therapeutic component, providing access to appropriate interventions, treatment (where appropriate) and other support.

We recognise that these issues are comparatively marginal in the Alcohol Strategy itself, and are primarily dealt with in the 2010 Drug Strategy, which is explicitly concerned with tackling both drugs and alcohol dependency. We have welcomed the Government's commitment to bringing these two agendas closer together, and believe the Alcohol Strategy document needs to be considered in this wider context. It would be helpful for the Government to clarify the relationship between these two strategies, as there is a concern about the "read across" between the two—the Alcohol Strategy, for example, has comparatively little of substance to say on alcohol dependency, treatment and recovery.

We would welcome opportunities to provide further evidence to the Health Select Committee on the issues identified in this letter, or, more generally, on the relationship between drug and alcohol policy.

May 2012

Written evidence from Mr Christopher Snowden (GAS 49)

BACKGROUND

Alcohol consumption in the UK is currently at an unexceptional level both in historical terms and by comparison with other EU countries. After falling to an all-time low after the Second World War, per capita alcohol consumption rose gradually during the rest of the Twentieth Century before going into decline after 2002. Between 2005 and 2010, average weekly alcohol consumption fell by 20%, as the Office for National Statistics recently reported:²⁵³

"Between 2005 and 2010 average weekly alcohol consumption decreased from 14.3 units to 11.5 units per adult. Among men average alcohol consumption decreased from 19.9 units to 15.9 units a week and for women from 9.4 units to 7.6 units a week."

There have been declines in the number of people drinking more than the recommended guidelines:

"Since 2005 the GHS/GLF has shown a decline in the proportion of men drinking more than 21 units of alcohol a week and in the proportion of women drinking more than 14 units of alcohol a week. The proportion of men drinking more than 21 units a week fell from 31% in 2005 to 26% in 2010 and the proportion of women drinking more than 14 units a week fell from 21% to 17% over the same period."

This drop in consumption has been particularly acute amongst young people:

"These changes were driven by falls in the younger age groups. Among men, the percentage drinking more than 21 units of alcohol a week decreased in the 16 to 24 age group (from 32% to 21%) and in the 25 to 44 age group (from 34% to 27%). Falls were also present among women; the percentage drinking more than 14 units of alcohol a week fell in the 25 to 44 age group from 25% to 19%."

And there has also been a significant decline in the number of consumers classified as "heavy drinkers":

"When using the average weekly consumption measure, heavy drinking is defined as consuming more than 50 units a week for men and consuming more than 35 units a week for women. There have been falls in the proportions of both men and women who drink heavily since 2005. The estimates for men fell from 9% to 6% and for women fell from 5% to 3% from 2005 to 2010."

By comparison with other EU countries, alcohol consumption is almost exactly at the EU average (between Portugal and Cyprus).²⁵⁴

Campaigners for minimum pricing frequently assert that alcohol has become more affordable since 1980. Whilst true, this tells us nothing more than that Britain has enjoyed very significant economic growth in recent decades. As a consequence, almost everything has become more affordable and it is to be hoped that almost everything will be still more affordable in 30 years' time. A more normal measure of calculating prices over time is, of course, to adjust them for inflation. If we do this, we can see that alcohol has become more expensive in real terms. The Office for National Statistics reports that the real price of alcohol has risen by almost 20%.

"Between 1980 and 2008, the price of alcohol increased by 283.3%. After considering inflation (at 21.3%), alcohol prices increased by 19.3% over the period."²⁵⁵

Some campaigners have confused affordability with real terms decreases. The charity Cais, for example, has publicly stated that "in real terms, [alcohol is] cheaper than it's ever been."²⁵⁶ This is simply untrue and, contrary to popular perception, the UK has the second highest rate of duty on beer and wine, and the third highest duty on spirits. Alcohol duty makes up 45% of the price of a bottle of wine, 14% of a pint of beer and 47% of a bottle of whisky.²⁵⁷

²⁵³ ONS, General Lifestyle Survey 2010, 8 March 2012

²⁵⁴ http://www.ias.org.uk/resources/factsheets/harm_ukeu.pdf

²⁵⁵ ONS, Statistics on Alcohol, England 2009, 20 May 2009

²⁵⁶ <http://www.bbc.co.uk/news/uk-wales-14558327>

²⁵⁷ ONS, *The effects of alcohol and tobacco duties on household disposable income*, 19 December 2011; p. 6

These statistics do not obviously support the widely held perception that the UK is in the midst of a drinking epidemic caused by a flood of cheap alcohol. Extraordinary policies can only be justified in extraordinary times and there is little empirical evidence to support the narrative of a crisis of “binge-drinking”. The British have long indulged in periodic moral panics about drinking, from the “gin craze” of the eighteenth century to the “lager louts” of the 1980s. We concur with Yeomans (2009) that the current perceived crisis—which was sparked by the Licensing Act (2005)—fits much the same mould.²⁵⁸

It can be argued that overall consumption figures are a poor proxy for harmful drinking by a small minority, whose behavior has a disproportionate impact on public order offences and healthcare. Evidence for such a phenomenon in Britain today is largely anecdotal, but even if it were true, the fact that public concern has been mounting even as drinking has been waning suggests either that the crisis is much exaggerated or that overall consumption is not strongly related to public disorder and alcohol-related ill health. While we would expect attempts to manipulate price to have some effect on overall consumption, we have serious doubts about claims that this would produce significant health benefits without creating major negative unintended consequences. The Home Office has acknowledged that “price is only one factor that may affect levels of alcohol consumption, with individual, cultural, situational and social factors also influential.”²⁵⁹ We agree with this analysis and suggest that crude attempts to manipulate supply and demand will penalise the responsible majority while ignoring the fundamental causes of addiction and violence.

THE ECONOMICS OF MINIMUM PRICING

It is a fundamental principle of economics that, *ceteris paribus*, an increase in price leads to a decrease in consumption. On this principle does the case for minimum pricing rest. However, there are other factors which concern economists which tend to be overlooked by those who support this policy. Specifically, we appreciate that the elasticity of demand varies for different consumers, and that increases in the price of licit goods lead to increased consumption of illicit goods. These two factors have received inadequate attention in the debate over minimum pricing.

All predictions as to how minimum pricing might affect levels of crime, consumption and ill health are necessarily speculative and while the conjectural nature of the evidence is not sufficient reason to discard it, we believe there are sufficient flaws in these projections for them to be treated with great caution.

Perhaps the most influential research in this debate comes from a team at Sheffield University who used data from Scotland.²⁶⁰ These researchers predict that a minimum unit price of 45p would lead to overall alcohol consumption falling by 3.5% and would result in non-trivial reductions in alcohol-related crime and morbidity. According to these projections, the effect on harmful drinkers would be many times greater than the effect on so-called moderate drinkers. However, these figures are based on the assumption that harmful drinkers are as price sensitive as moderate drinkers—a claim that has no basis in the scientific literature. Very many harmful drinkers are to a greater or lesser extent addicted to alcohol. Although the price elasticity of alcohol is -0.44 , for heavy drinkers it is a more inelastic -0.28 .²⁶¹ For those who are most heavily addicted to alcohol, demand is almost entirely inelastic, which is to say they will consume alcohol at almost any price even if they have to turn to crime in order to do so.

The Sheffield University studies only briefly acknowledge the issue of price elasticity and none of their headline-making figures are adjusted to factor in this crucial variable. This is a major oversight when the whole point of minimum pricing is to address problem drinking, street-drinking and alcoholism.

Even under the mistaken assumption that alcoholics are as price sensitive as occasional drinkers, this research predicts that a 45p unit price would reduce alcohol consumption by harmful drinkers by 278.3 units a year. This sounds impressive until one considers that elsewhere in their report, the researchers show that these harmful drinkers consume between 10 and 30 units every day. We doubt whether an average decline in consumption of less than one unit per day would result in any material health benefits for the group being targeted.

In common with other researchers, the Sheffield University team ignore the likely effect of higher prices on the illicit trade. They make no attempt to predict the effect on cross-border purchases, nor is any account taken of home-brewing and home-distilling, nor of mass produced counterfeit products. Although we cannot predict the scale of the black market under a minimum pricing regime, it would almost certainly grow in proportion to the minimum price itself. Without an acknowledgement that counterfeit alcohol is already a significant problem in this country—and that illicit spirits are more hazardous to health than the regulated product—all predictions of per capita consumption and resulting health benefits must be considered highly suspect. Predictions about falling crime must be considered doubtful for the same reason. Indeed, it is likely that criminal activity in the black market would increase with no commensurate decline in alcohol-related violence to accompany it.

²⁵⁸ Yeomans, H, *Revisiting a Moral Panic: Ascetic Protestantism, Attitudes to Alcohol and the Implementation of the Licensing Act 2003*, Sociological Research Online, 14, 2009

²⁵⁹ Home Office, *The likely impacts of increasing alcohol price: a summary review of the evidence base* January 2011

²⁶⁰ Meng, Y, Hill-McManus, D & Brennan, A, *Model-based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland using the Sheffield alcohol policy model* (v 2), January 2012

²⁶¹ Wagenaar, A, *et al*, *Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1,003 estimates from 12 studies*, *Addiction*, 104; pp. 179–90

MINIMUM PRICING IS DOUBLY REGRESSIVE

The Institute for Fiscal Studies estimates that a minimum unit price of 45p would result in a transfer of wealth from drinkers to the beneficiaries (currently assumed to be the drinks industry and supermarkets) of £700 million per annum.²⁶² As large as this figure is, it would rise much further if and when the unit price rises. We fully expect the public health establishment and temperance groups to demand above inflation rises in the unit price on a regular basis once this Pandora's Box is opened. Indeed, they are already doing so. If the policy is seen to work, there will inevitably be calls for the government to "build on its success" by increasing the unit price. But if, as we expect, the policy fails to make any impact, these same groups will insist that its failure derives from the price being too low and, therefore, should be raised. In either instance, the introduction of minimum pricing will give a powerful weapon to groups who will forever believe that the price of alcohol is too low.

At whatever level the price is set, it will require the general population, and particularly the poor, to subsidise supermarkets and the drinks industry. The high cost of alcohol in this country is a major cause of secondary poverty. Nearly all indirect taxes are, of course, regressive. As the Office for National Statistics notes, indirect taxes "take a higher proportion of income from lower income households, and therefore increase income inequality."²⁶³ In the UK, direct taxes take 24% from the richest and 10% from the poorest, but the figures are almost exactly reversed when it comes to indirect taxes such as fuel duty, tobacco duty, VAT and alcohol duty.

Minimum pricing would be doubly regressive because it targets products which are disproportionately consumed by people on low incomes. But whereas the iniquitous nature of some sin taxes can be partially, though inefficiently, remedied through increased welfare payments to the poor, this would not be a solution in the case of minimum pricing because it would only serve to make alcohol "affordable" again. This implies that poverty itself would be a solution to alcoholism and drunkenness since it makes alcohol less affordable, a notion that runs counter to all the evidence which indicates that poverty is better seen as a cause of alcoholism and drunkenness. And whilst alcohol can be a cause of ill health, so can poverty—whether primary or secondary. (It is, however, true that per capita alcohol consumption is lower for those on low incomes. The very fact that these groups experience the highest rates of alcohol-related harm indicates that reducing per capita consumption is not an efficacious way of reducing harm.)

The policy only makes sense if we believe that low income drinkers will significantly reduce their alcohol consumption as a result of higher costs, but that is to allow hope to triumph over experience. As the old Russian joke goes, when a boy asks his father if he drink less when the price of vodka does up: "No," the father replies, "it means that you will eat less."

OTHER ISSUES

As regards raising the drinking age, lowering the strength of alcoholic drinks, banning advertising and mandating plain packaging, these are all policies entirely at odds with the principles of a free society. Drinking alcohol is an adult pastime and those who are 18 and over should not be prohibited from engaging in it and have a right to know which products are available. Plain packaging, like minimum pricing, would be a serious infringement of commercial freedom which would likely violate a number of free trade agreements to which the UK is a signatory. We find it troubling and scarcely believable that the government is contemplating creating a country in which bureaucrats not only set the price of products but also design their packaging.

ABOUT THE AUTHOR

Christopher Snowdon is an Institute of Economic Affairs Fellow and an independent writer and researcher. He is the author of *The Art of Suppression* (2011), *The Spirit Level Delusion* (2010) and *Velvet Glove, Iron Fist* (2009). His work focuses on pleasure, prohibition and dodgy statistics. His blog is *Velvet Glove, Iron Fist*.

May 2012

Written evidence from Cancer Research UK (GAS 50)

SUMMARY

- Cancer Research UK recognises the Government's Alcohol Strategy as a step towards reducing alcohol harm.
- Government policy should focus on the health concerns rather than the social consequences of alcohol consumption. In particular there should be more recognition of the impact of alcohol on cancer risk.
- A minimum price is an effective measure to reduce alcohol consumption.
- A new approach is needed to tackle advertising, marketing and promotion of alcohol particularly where it is accessible to children.

²⁶² Griffith, R. & Leicester, A, *The impact of introducing a minimum price on alcohol in Britain*, Institute for Fiscal Studies, 2012

²⁶³ Office for National Statistics, *The effect of taxes and benefits on household income*, 19 May 2011

- Improved awareness and increased information is also a necessary part of changing the culture towards alcohol.

OVERVIEW

1. Cancer Research UK welcomed the Government's Alcohol Strategy as an attempt to reduce alcohol consumption and harm. However the focus on binge drinking and the social consequences of alcohol consumption can lead to a misplaced emphasis. An effective strategy should prioritise the long term health implications of alcohol consumption and have at its heart a goal of reducing the number of units consumed per drinker.

2. The Government's strategy introduces a number of measures which could reduce alcohol related problems. However, we believe that it lacks a strategic approach to reduce demand for alcohol. An effective strategy should include measures to reduce affordability, reduce the promotion of alcohol and increase awareness of the harms of alcohol.

ALCOHOL AND CANCER RISK

3. Government notes that current levels of alcohol consumption are unprecedented. 28% of men and 19% of women reported drinking above recommended guidelines.²⁶⁴ Therefore Government should focus its efforts on reducing the level of consumption at the national level. A sustained reduction in alcohol consumption can provide significant benefits to individuals' health and can help reduce the incidence of cancer.

4. Awareness about the impact alcohol has on cancer risk is limited. But alcohol is one of the most important modifiable risks for cancer after smoking and obesity. Alcohol can cause seven cancers—mouth, pharyngeal, laryngeal, oesophageal, breast, bowel and liver. In 2010, 12,500 cases of cancer in the UK (4%) were attributable to alcohol.²⁶⁵ Alcohol is also estimated to account for around 6% of all cancer deaths in the UK, about 9,000 deaths per year.²⁶⁶

5. Cancer risk is associated with total alcohol consumed over time. The current balance of evidence does not demonstrate an increased cancer risk from binge drinking, versus the equivalent consumption of alcohol over the course of a week. However, the more alcohol individuals consume the greater their risk of cancer.²⁶⁷

6. Breast cancer risk is also particularly affected by alcohol intake. Alcohol is the second biggest lifestyle-related cause of UK breast cancers after excessive weight. Alcohol accounts for around 6% of breast cancer cases in the UK, over 3,000 cases each year.²⁶⁵ Having one small alcoholic drink a day is linked with a modest increase in a woman's risk of developing breast cancer.²⁶⁸ And because a lot of women in the UK drink at these levels, that could translate into many additional cases of breast cancer overall.

7. Alcohol was also associated with almost 4,600 cases of bowel cancer in 2010. In addition, 30% of oral cancers and 20% of oesophageal cancers are also attributable to alcohol.²⁶⁵ As little as three units a day can increase the risk of these cancers.²⁶⁹ This is equivalent to a large glass of wine or a pint of premium lager.

8. The Government acknowledged that lifestyle choices can affect cancer risk in their cancer strategy *Improving Outcomes: A Strategy for Cancer*.²⁷⁰ A strategy aimed at reducing alcohol consumption should be assessed within the wider context of cancer prevention.

PRICING

9. The real price of alcohol has fallen as incomes have risen. The rise in affordability has been associated with increased consumption and increased alcohol harm.²⁷¹ Therefore we support actions to reduce the affordability of alcohol. The introduction of a minimum unit price will help to reduce the harm caused by rising affordability of alcohol and in the particular limit the impact of low cost alcohol. Such products have a disproportionate impact as they tend to be drunk by harmful drinkers (those drinking above the recommended weekly guidance), binge drinkers and young drinkers.²⁶⁹

10. The research by Sheffield University demonstrates that a minimum unit price of 50p could lead to a 6.7% reduction in alcohol consumption. It also shows that at this price it could save over 3,000 lives after 10

²⁶⁴ NHS Information Centre (2010). Statistics on Alcohol: England, 2010, The Health and Social Care Information Centre

²⁶⁵ Parkin, D M (2011). Cancers attributable to consumption of alcohol in the UK in 2010. *British Journal of Cancer* 105 (S2):S14-S18; doi: 10.1038/bjc.2011.476

²⁶⁶ Doll, R & Peto, R (2003). *Epidemiology of Cancer* (eds. Warrell, D, Cox, T, Firth, J & Benz, E) (Oxford: OUP)

²⁶⁷ Thun, M, *et al*, Alcohol consumption and mortality among middle-aged and elderly U.S. adults. *N Engl J Med*, 1997. 337: p. 1705–1714

²⁶⁸ Key, J, *et al*, (2006). Meta-analysis of Studies of Alcohol and Breast Cancer with Consideration of the Methodological Issues. *Cancer Causes Control* 17(6): p. 759–770

²⁶⁹ Corrao, G, *et al*, A meta-analysis of alcohol consumption and the risk of 15 diseases. *Prev Med*, 2004. 38(5): p. 613–9.

²⁷⁰ Department of Health (2011). *Improving Outcomes: A Strategy for Cancer*. Crown publications

²⁷¹ Jackson, R Johnson, M, Campbell, F, Messina, L, Guillaume, L, Meier, P, Goyder, E, Chilcott, J and Payne, N (2010). *Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People*. School of Health and Related Research (SchHARR) University of Sheffield

years.²⁷² It is important to acknowledge that the link between a minimum price and harm reduction is non-linear. The impact of 50p minimum price is more than double that of a 40p minimum price.²⁷³ A minimum price should be set at a level where it can best reduce harm. The current evidence suggests that a minimum price would be effective if set at 50 pence per unit.

11. A minimum unit price should include an up-rating mechanism so that it remains effective over time. An automatic mechanism that adjusts the price annually taking into account growth in earnings should be included. But there should also be a regular review of the price to ensure that other factors do not require a substantial change in the minimum price.

12. We also support the ban on multi buy discounts. Evidence suggests that a well-designed ban could reduce consumption by 2.8%.²⁷³

MARKETING AND PROMOTION

13. The Government acknowledges that there is a link between the marketing of alcohol products and their consumption. However we are disappointed by their plans to limit the impact of alcohol marketing. A new approach to the regulating the promotion of alcohol is needed in order to reduce consumption and protect children and young people.

14. A focus on price alone will not be sufficient to change consumption patterns across the UK. The Government should acknowledge that the ubiquity of alcohol marketing influences the drinking culture in Britain. Alcohol marketing not only influences drinkers on which brand to choose but also influences drinkers to increase the quantity they drink.^{274,275} Alcohol promotion also normalises drinking and allows people to dismiss the long term health consequences.

15. Current controls are also ineffective at protecting young people. A number of studies have shown that alcohol marketing increases the likelihood that young people will start to use alcohol and will drink more if they are already consume alcohol.²⁷² Recent evidence shows that primary school children's exposure to alcohol brands is also high despite the current protections.²⁷⁶ Such influence could be a by-product of alcohol sponsorship of music and sporting events which have high appeal to children and young people.

16. The evidence from banning tobacco advertising does show that a comprehensive approach to marketing can reduce demand for a product.²⁷⁷ Therefore Government should restrict the content of alcohol advertisements and reduce the mediums in which they can be broadcast. Such an approach has been taken in France with the introduction of the *Loi Evin*.²⁷⁸ We recommend following this model and introducing comprehensive regulations to restrict the marketing and promotion of alcohol products.

AWARENESS AND HEALTH CAMPAIGNS

17. Raising awareness of the risk of alcohol consumption is also important for developing a culture change. Awareness of the long term health harms of regular alcohol consumption is low. 55% of people questioned in a YouGov poll believed alcohol is only harmful if a person regularly gets drunk or binge drinks.²⁷⁹ Moreover only 24% of respondents to Cancer Research UK's perception of risk survey mentioned alcohol when asked about how to reduce their risk of developing some types of cancer.²⁸⁰ Therefore we believe that cancer should be consistently identified as a potential consequence of excessive alcohol consumption.

18. We support the inclusion of alcohol within the successful Change4Life brand. In particular the recent adverts launched in February 2012 highlighted the potential long term risks of regular consumption of alcohol at home. It is important that Government continue to support health campaigns such as Change4Life in order to increase awareness of the harms of excessive drinking at home. However we must acknowledge that historically Government spending in this field is miniscule—£17.5 million in 2009–10²⁸¹ compared to the estimated £800 million spent by the alcohol industry on marketing.²⁸²

²⁷² Purhouse, R et al, (2009) *Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0*. Report to the NICE Public Health Programme Development Group

²⁷³ Department of Health (2011). *Improving Outcomes: A Strategy for Cancer*, Crown publications

²⁷⁴ Smith, L A, and Foxcroft, D R (2009). The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: Systematic review of prospective cohort studies. *BMC Public Health*, Vol. 9, pp 51

²⁷⁵ Anderson, P, de Bruijn, A, Angus, K, Gordon, R, and Hastings, G (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies. *Alcohol and Alcoholism*, 44(3), pp 229–243.

²⁷⁶ Alcohol Concern Cymru (2012). *Making an Impression*

²⁷⁷ Saffer, H and Chaloupka F (2000). The effect of tobacco advertising bans on tobacco consumption. *Journal of Health Economics*, Vol.19, pp 1117–37.

²⁷⁸ LOI no 91–32 du 10 janvier 1991 relative à la lutte contre le tabagisme et l'alcoolisme
<http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000344577&dateTexte=&categorieLien=id>

²⁷⁹ Research commissioned by the Department of Health to coincide with the launch of the 2010 NHS campaign
http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/MediaCentre/Pressreleasesarchive/DH_111622

²⁸⁰ Cancer Research UK (2009). *Perception of risk survey 2008*, BMRB

²⁸¹ Department for Health (2010)

²⁸² BMA (2009) *Under the Influence*, The damaging effect of alcohol marketing on young people

19. We are also pleased that the Government wants to ensure that the majority of alcohol products have health warnings and health guidance. However they should ensure that this is applied to all alcohol products sold in the UK.

May 2012

Written evidence from the Institute of Practitioners in Advertising (GAS 51)

INTRODUCTION

1. The IPA is the professional body for advertising, media and marketing communications agencies based in the United Kingdom. In the UK, the advertising industry directly employs over 300,000 people. In 2011, advertising expenditure was £16.1 billion.

2. As a not-for-profit membership body, the IPA's role is two-fold: to provide essential core support services to its corporate members who are key players in the industry; and to act as the industry spokesman.

3. The IPA is an active supporter of Government initiatives to promote the UK's creative industries and it works in close collaboration with other advertising-related industry trade bodies in the UK, including the Advertising Association.

4. This submission on behalf of the IPA takes directly from that provided by the Advertising Association. Whilst the IPA supports the Advertising Association's submission, we felt the issues covered by the inquiry important enough to merit our own response.

ALCOHOL ADVERTISING SUMMARY

5. Advertising is crucial to a competitive economy. It brings consumer benefits because it fuels brand competitiveness, thereby informing consumer choice. It also has an essential role in funding the media and creating a dynamic, competitive and pluralistic media marketplace. Alcohol advertising, like all advertising, is central to investment in original UK content and any disproportionate advertising restriction impacts on the level of investment available for such content.

6. It is not in the interests of the advertising industry to promote or condone irresponsible drinking. Companies advertise to promote their brand over competitors' brands, to encourage brand-switching. We are not aware of any evidence demonstrating that alcohol advertisements collectively impact on total alcohol consumption.

7. There are strict and well enforced rules that ensure alcohol marketing is not targeted at those under the legal drinking age or in a way that might appeal to them.

SUBMISSION OVERVIEW

8. Our submission falls into three parts: (i) an overview of UK advertising regulation; (ii) a response to some of the key recommendations in the Alcohol Strategy; and (iii) a response to the Committee's identified examples of international evidence of ways to reduce alcohol consumption.

OVERVIEW OF ALCOHOL ADVERTISING REGULATION

9. The UK has one of the most respected regulatory regimes for advertising in the world, overseen by the Advertising Standards Authority ("ASA"), and some of the toughest advertising regulation which enjoys a 99% compliance rate.²⁸³ We welcome the Alcohol Strategy's positive comments about advertising self-regulation.

10. Alcohol advertising in the UK is already subject to controls that seek to prevent advertisers targeting and appealing to young people. The controls cover broadcast, print and online advertising and are a mix of co-regulation (with Ofcom) and self-regulation administered by the Advertising Standards Authority and the Portman Group. The advertising of alcohol is regulated through the Advertising Codes of Practice (the CAP and BCAP Codes). These rules firmly dictate that alcohol marketing is not targeted at those under the legal drinking age, either in terms of the content of the advertisement or the content of the media that surrounds it.

11. The ASA regularly monitors alcohol advertising to ensure compliance with the rules. The ASA's adjudications against advertisers are published and result in swift action to remove or to have amended those advertisements that contravene the rules; compliance is extremely high.

CONTENT RULES

12. The CAP alcohol advertising rules were significantly tightened in 2005 in response to Government objectives set out in the 2004 Alcohol Harm Reduction Strategy. The ASA ensures that alcohol ads must never:

- Target under 18s.
- Be shown around programmes that especially appeal to under 18s.

²⁸³ <http://www.asa.org.uk/Media-Centre/2009/ASA-survey-shows-compliance-with-alcohol-rules.aspx>

- Link alcohol with irresponsible, anti-social, tough or daring behaviour.
- Show alcohol being served irresponsibly.
- Show people drinking and behaving in an adolescent or juvenile way or reflecting the culture of people under 18 years old.
- Link alcohol with seduction, sex or social success.
- Show those who are or appear to be under the age of 25 drinking alcohol or clearly having consumed alcohol.

13. Following the strengthening of the CAP rules in 2005, an Ofcom study noted a decline in the proportion of young people saying they feel that alcohol commercials are aimed at young people.²⁸⁴

EXPOSURE RULES

14. On television and radio, alcohol advertising is subject to scheduling restrictions to ensure that it does not appear around programmes of particular appeal to those under 18, and is subject to content rules to protect children and young people.

15. In cinemas, alcohol advertisements are also pre-cleared. The Cinema Advertising Association (CAA) has reviewed and tightened its pre-vetting procedures in relation to alcohol advertising in the last few years.

16. The CAP Code sets out the rules for non-broadcast advertising. It dictates that no medium should be used to advertise alcoholic drinks if more than 25% of its audience is under 18 years old. In March 2011, these rules were extended to cover companies' and organisations' marketing claims on their own websites and in other non-paid-for space online under their control, such as social network sites.

17. The advertising codes administered by the ASA supplement legislation and also ensure that advertisements are legal, decent, honest, truthful and socially responsible. The system is highly effective and considered to be gold standard in self-regulation both in the UK and internationally. As noted above, the rules on alcohol advertising are some of the strictest in the world and their effectiveness is shown by the Government's recognition of their high quality in the Alcohol Strategy itself.

RESPONSE TO SPECIFIC PROPOSALS IN THE ALCOHOL STRATEGY

Proposal to examine ways to ensure that adverts promoting alcohol are not shown during programmes of high appeal to young people

18. The Alcohol Strategy recognises that the rules referred to above prevent adverts being shown in a context which will have "a particular appeal" to people aged under 18. We believe that the combination of the exposure rules and the content rules are a proportionate way for the advertising industry to address youth alcohol consumption.

19. We do not believe that there would be any demonstrable health benefit in introducing stricter exposure rules and we are not aware of any rigorous, independent research which demonstrates such a move would result in a reduction of harmful drinking. More restrictive rules would interfere with the legitimate right of drinks advertisers to advertise their products to adult audiences and on the rights of adults to receive advertisements for legitimate products in which they might be interested.

20. The BMA say that 96% of 13 year olds are aware of alcohol advertising and we do not argue against this statistic. However, the factors behind alcohol misuse are complex and vary between population groups and regions and there are many societal causes. Peer pressure is a significant factor behind binge-drinking amongst 18–24 year olds, for example.

Proposal to consult on a ban on multi-buy promotions

21. We do not believe multi-buy alcohol promotions are inherently irresponsible; consumers are used to multi-buy promotions in respect of many different goods and services. The focus should not be on banning a particular form of marketing, but rather on ensuring that all forms of alcohol marketing are undertaken in a responsible manner. We will respond to this particular consultation when launched by the Government, but in the meantime, we urge the Government to ensure that any proposals will be proportionate and evidence-based.

Proposal to work with the ASA to ensure the full and vigorous application of ASA powers to online and social media and work with industry to develop a scheme to verify people's actual ages which will apply to alcohol company websites and associated social media

22. As noted above, social networking and digital media is a regulated space and bound by the same rules as off-line media. Marketing content cannot appeal to children and there are strict online requirements such as age gateways and parental controls for brand websites. As the proposal indicates, there is much greater

²⁸⁴ *Young People and Alcohol Advertising*, Ofcom, 16/11/07 http://stakeholders.ofcom.org.uk/market-data-research/other/tv-research/alcohol_advertising/

opportunity for drinks companies to screen out under-18s in social media enabling them to target those of legal drinking age.

23. Various measures have been put in place to ensure that children are discouraged from looking at alcohol advertising and marketing. Drinks companies provide age affirmation requirements to access their websites. In addition, and as noted above, advertising rules require the content of an alcohol ad to be targeted at those above the legal drinking age. In other words, if a young person does access the relevant brand's page, the content is unlikely to appeal to them. Alcohol Concern's recent report found that just a very small minority in a focus group had seen alcohol companies advertising on Facebook, none were aware of alcohol channels on YouTube; none of the respondents admitted to being aware of or visiting alcohol brand websites—as they “*did not anticipate that such websites would contain games and competitions, but instead expected them to be dry and informative, providing factual information...*”²⁸⁵

Proposal to continue to work through the Responsibility Deal to support the alcohol industry to market, advertise and sell their products in a responsible way and deliver the core commitment to “foster a culture of responsible drinking, which will help people to drink within guidelines”

24. The Advertising Association has participated in the Responsibility Deal process on behalf of its members (including the IPA) and signed the Pledge on advertising.

25. The Advertising Association (and the IPA) also support Government campaigns aimed at changing behaviour over the longer term. This demonstrates that advertising can be part of a wider approach to promoting behavioural change through positive messaging.

IDENTIFIED EXAMPLES OF INTERNATIONAL EVIDENCE OF WAYS TO REDUCE CONSUMPTION

An alcohol advertising ban

26. The IPA welcomes the Alcohol Strategy's recognition that there is no evidence demonstrating that an advertising ban would be a proportionate response to reducing alcohol consumption. In France, where alcohol advertising is banned on TV, cinema and more recently on the internet, an official French parliament report stated that this ban had been ineffective in reducing high-risk drinking patterns. There has been a steady decrease in annual alcohol consumption in France over the last 40 years. The decrease started long before the adoption of the *Loi Evin* rules banning such advertising in 1991 and even slowed down slightly following its adoption.²⁸⁶ Even the French anti-alcohol NGO ANPAA accepts that the effects of the law are “weak”.²⁸⁷

27. Alcohol advertising bans do not work: in Norway there is no advertising for alcoholic beverages, but consumption has been steadily increasing. In Italy, where alcohol advertising is permitted, consumption is decreasing.²⁸⁸ An advertising ban is not the solution to the complex problem of high alcohol consumption and those who press for it risk missing the real causes.

Plain packaging

28. The IPA does not recognise the relevance of the reference to plain packaging in the Health Committee's inquiry into the Alcohol Strategy: plain packaging is not referred to in the Alcohol Strategy nor has alcohol plain packaging ever been proposed by the UK Government as far as we are aware.

29. There is no hard evidence on the impact on consumption of any product arising from a plain packaging policy, but such a policy would equate to a *de facto* advertising ban. Branding provides extremely important consumer, social and economic functions and we believe that any consideration that alcohol branding might be restricted would be an extreme, disproportionate, approach.

May 2012

Written evidence from The Advertising Association (GAS 52)

INTRODUCTION

THE ADVERTISING ASSOCIATION

1. The Advertising Association (AA) is the only organisation that represents all sides of the advertising and promotion industry in the UK—advertisers, agencies and the media. In the UK, the advertising industry directly employs over 300,000 people. In 2011, advertising expenditure was £16.1 billion.

²⁸⁵ *New media, new problem? Alcohol, young people and the internet*, Alcohol Concern, June 2011, <http://www.alcoholconcern.org.uk/assets/files/Wales%20factsheets/New%20%20media,%20new%20problem.pdf>

²⁸⁶ WHO figures—<http://apps.who.int/ghodata/?vid=60580>

²⁸⁷ The *Loi Evin*: a French exception, Dr. Alain Rigaud, Président Association Nationale de Prévention en Alcoologie et Addictologie (ANPAA)

²⁸⁸ http://www.europeanspirits.org/documents/Factsheets/CPAS0772009_Fact_Sheet_advertising.pdf

2. We promote and protect advertising. We communicate its commercial and consumer benefits and we seek the optimal regulatory environment for our industry. Our goal is that advertising should enjoy responsibility from its practitioners, moderation from its regulators, and trust from its consumers.

3. We support the alcohol industry's right to market and advertise their products responsibly.

ALCOHOL ADVERTISING

4. Advertising is crucial to a competitive economy. It brings consumer benefits because it fuels brand competitiveness, thereby informing consumer choice. It also has an essential role in funding the media and creating a dynamic, competitive and pluralistic media marketplace. Alcohol advertising, like all advertising, helps fund investment in original UK content.

5. The alcoholic drinks and advertising industries are keen to play a positive and active role, in partnership with Government, in helping to find long-term solutions to alcohol misuse. The alcoholic drinks industry recognises that it has a special duty to ensure that its products are marketed responsibly, which is why alcohol companies originally set up the Portman Group, why they fund and promote the independent Drinkaware Trust, and why they support advertising self-regulation through the Advertising Standards Authority (ASA). The drinks industry regards public awareness and education initiatives as important and it funded the campaign *Why let good times go bad?* currently being rolled out by the Drinkaware Trust. The advertising industry, through the Advertising Association, ISBA (the Voice of British Advertisers), and the Outdoor Media Centre (OMC), have been involved in the Responsibility Deal process alongside the drinks industry.

6. In their commercial communications, companies seek to promote their brands responsibly but there is no value to being associated with encouraging irresponsible drinking. Alcohol misuse carries with it serious societal consequences and it is not in the interest of either the alcoholic drinks industry or the advertising industry to promote or condone it. Companies advertise to promote their brand over competitors' brands, in other words to encourage brand-switching. Various studies have shown that advertising is very effective in achieving this, but there is no evidence that alcohol advertisements collectively impact on total consumption.

7. Everybody has a role to play in making sure that under-18s do not drink and that adults drink responsibly—parents, guardians, publicans, politicians, teachers, friends *and* advertisers. While recognising that advertising has a part to play in addressing the issue of under-age drinking, there is no evidence that advertising *per se* is a root cause of alcohol abuse.

SUBMISSION OVERVIEW

8. There are strict—and well enforced—rules that ensure alcohol marketing is not targeted at those under the legal drinking age or designed to appeal to them. These rules were tightened in 2005, and the advertising codes more generally are regularly revised. We welcome the opportunity to contribute to the Health Committee's inquiry into the Government's Alcohol Strategy, as we believe it is a useful exercise in making sure that the industry is getting the balance between responsibility and proportionality correct. The Strategy itself is an important document with intentions that we support.

9. Our submission falls into three parts: firstly, an overview of UK advertising regulation, secondly, a response to some of the key recommendations in the Alcohol Strategy, and finally, a response to the Committee's identified examples of international evidence of ways to reduce consumption.

OVERVIEW OF ALCOHOL ADVERTISING REGULATION

10. The UK has one of the most respected regulatory regimes for advertising in the world and the Advertising Standards Authority has some of the toughest advertising regulation in the world, which has a 99% compliance rate.²⁸⁹ We welcome the Alcohol Strategy's positive comments about advertising self-regulation.

11. Alcohol advertising in the UK is already subject to controls that seek to prevent advertisers targeting and appealing to young people. The controls cover broadcast, print and online advertising and are a mix of co-regulation (with Ofcom) and self-regulation, administered by the ASA. The advertising of alcoholic beverages is regulated through the Advertising Codes of Practice (the CAP and BCAP Codes). These rules require that alcohol marketing is not targeted at those under the legal drinking age—either in terms of the content of the advertisement or the content of the media that surrounds it. Alcohol advertisements on television and radio are also pre-cleared before transmission.

12. The ASA regularly monitors alcohol advertising to ensure compliance with the rules. The ASA's adjudications against advertisers are published and result in swift action to remove or amend those advertisements that contravene the rules; compliance is extremely high. The Portman Group's code deals with alcohol promotions and marketing.

²⁸⁹ <http://www.asa.org.uk/Media-Centre/2009/ASA-survey-shows-compliance-with-alcohol-rules.aspx>

CONTENT RULES

13. The alcohol advertising rules were tightened significantly in 2005 in response to Government objectives set out in the 2004 Alcohol Harm Reduction Strategy. The Advertising Standards Authority ensures that alcohol ads must never:

- Target under-18s.
- Be shown around programmes that especially appeal to under-18s.
- Link alcohol with irresponsible, anti-social, tough or daring behaviour.
- Show alcohol being served irresponsibly.
- Show people drinking and behaving in an adolescent or juvenile way or reflecting the culture of people under 18 years old.
- Link alcohol with seduction, sex or social success.
- Show those who are or appear to be under the age of 25 drinking alcohol or clearly having consumed alcohol.

14. Following the strengthening of the BCAP rules in 2005, an Ofcom study has noted that there has been a decline in the proportion of young people saying they feel that alcohol commercials are aimed at them.²⁹⁰

EXPOSURE RULES

15. On television and radio, alcohol advertising is subject to scheduling restrictions which ensure that alcohol advertising does not appear around programmes of particular appeal to those under 18. For television, whether or not a programme is “of particular appeal” to under 18s is assessed using a statistical tool—the 120 index. This index identifies television programmes of particular appeal to under-18s—if the proportion of children watching a programme is more than 20% higher than the proportion of the UK television population watching the programme, it receives an index of 120 or higher, and therefore an alcohol advertisement cannot be shown around this programme.

16. The CAP Code sets out the rules for non-broadcast advertising (including cinema advertising). It dictates that no medium should be used to advertise alcoholic drinks if more than 25% of its audience is under 18 years old. In March 2011, these rules were extended to cover companies’ and other organisations’ marketing claims on their own websites and in other non-paid online space under their control, such as social network sites. Furthermore, the Portman Group’s Digital Marketing Guidelines were published in October 2009 and covered these platforms.

RESPONSE TO SPECIFIC PROPOSALS IN THE ALCOHOL STRATEGY

Proposal to examine ways to ensure that adverts promoting alcohol are not shown during programmes of high appeal to young people

17. The Alcohol Strategy recognises that the current rules prevent alcohol adverts being shown in a context which will have “a particular appeal” to people aged under 18. We believe that the combination of the exposure rules and the content are a proportionate way to regulate alcohol advertising.

18. We recognise that some television programmes that attract large audiences of all ages often include a significant number of under-18s in their audience. However, it is critical to recognize that the 120 index ensures that alcohol is not allowed to be advertised in programmes of particular appeal to under-18 *and* that the content and messaging of such advertisements target drinkers over the age of 18. Adult viewers constitute the great majority of the audience for such programmes and these are the people that the advertising is intending to target.

19. There is no demonstrable health benefit in introducing stricter exposure rules, and no rigorous, independent research which demonstrates this would result in a reduction in harmful drinking. More restrictive rules could also have disproportionate consequences on TV broadcasters and sports bodies, potentially reducing broadcaster revenues worth tens of millions of pounds, with detrimental effects on investment in original programming and on TV sports coverage.

20. The factors behind alcohol misuse are complex and vary between population groups and regions and there are many societal causes. Peer pressure is a significant factor behind binge-drinking amongst 18–24 year olds, and if the Government is seriously to tackle binge-drinking, its emphasis should be on practical measures such as information programmes at universities and colleges. In 2008, a study commissioned by the Advertising Association and undertaken by Volterra Consulting concluded that social influence operating through personal friendship networks is sufficient by itself to explain a large rise in binge drinking amongst young people.²⁹¹ This would indicate that the Government should focus on the social influences leading to high youth alcohol consumption, rather than the fact that on occasion youngsters may see alcohol advertisements that are not targeted at them.

²⁹⁰ *Young People and Alcohol Advertising*, Ofcom, 16/11/07 http://stakeholders.ofcom.org.uk/market-data-research/other/tv-research/alcohol_advertising/

²⁹¹ <http://www.adassoc.org.uk/write/Documents/Advertising%20and%20the%20misuse%20of%20alcohol.pdf>

Proposal to consult on a ban on multi-buy promotions

21. We do not believe multi-buy alcohol promotions are inherently irresponsible; consumers are used to such multi-buy promotions in respect of many different goods and services. The focus should not be on banning a form of marketing, but rather on ensuring that all forms of marketing are undertaken in a responsible manner. We will respond to this consultation when launched by the Government but in the meantime we urge the Government to ensure that any proposals are proportionate and evidence-based.

Proposal to work with the ASA to ensure the full and vigorous application of ASA powers to online and social media and work with industry to develop a scheme to verify people's actual ages which will apply to alcohol company websites and associated social media

22. Social networking and digital media are bound by the same rules as the off-line world. Marketing content cannot appeal to children and there are strict online requirements such as Age Affirmation Pages (AAPs) and parental controls for brand websites. As the proposal indicates, there is much greater opportunity for drinks companies to screen out under-18s on digital and social media, enabling them to target only those of legal drinking age.

23. As is well-recognised, the combination of the global nature of the internet and anonymous browsing experience makes fully certified age verification online extremely difficult. Nonetheless, the industry is working closely with UKCCIS to better understand the potential solutions to this issue.

24. Various measures have been put in place to ensure that children are discouraged from looking at drinks advertising and marketing. Drinks companies provide age affirmation requirements to access their websites. In addition, advertising rules require the content of an alcohol ad to be targeted at those above the legal drinking age. In other words, if a young person does access the page, the content is unlikely to appeal to them. Alcohol Concern's recent report found that only a very small minority in a focus group had seen alcohol companies advertising on Facebook, none were aware of alcohol channels on YouTube; none of the respondents admitted to being aware of or visiting alcohol brand websites—as they “*did not anticipate that such websites would contain games and competitions, but instead expected them to be dry and informative, providing factual information...*”.²⁹²

Proposal to continue to work through the Responsibility Deal to support the alcohol industry to market, advertise and sell their products in a responsible way and deliver the core commitment to “foster a culture of responsible drinking, which will help people to drink within guidelines”

25. The Advertising Association has participated in the Responsibility Deal process and signed the Pledge on advertising. This included working with ISBA and the Outdoor Media Centre in respect of the new voluntary restriction put in place by OMC on outdoor alcohol advertising within 100m of schools.

26. We also support the various Government campaigns aimed at changing behaviour over the longer term. We believe advertising can be part of the wider holistic approach to promoting behavioural change through positive messaging.

IDENTIFIED EXAMPLES OF INTERNATIONAL EVIDENCE OF WAYS TO REDUCE CONSUMPTION

An alcohol advertising ban

27. The Advertising Association is a firm proponent of evidence-based policy making so we welcome the Strategy's recognition that there is no evidence demonstrating that an advertising ban is a proportionate response to reducing alcohol consumption. In France, where alcohol advertising is banned on TV, cinema and the internet, an official French parliament report stated that this ban had been ineffective in reducing high-risk drinking patterns. There has been a steady decrease in annual alcohol consumption in France over the last 40 years. The decrease started long before the adoption of the *Loi Evin* rules banning such advertising in 1991 and even slowed down slightly following its adoption.²⁹³ Even the French anti-alcohol NGO ANPAA accepts that the effects of the law are “weak”.²⁹⁴

28. Alcohol advertising bans do not work: in Norway there is no advertising for alcoholic beverages, but consumption has been steadily increasing. In Italy, where alcohol advertising is permitted, consumption is decreasing.²⁹⁵ An advertising ban is not the solution to the complex problem of harmful alcohol consumption and those who press for it risk missing the real causes.

²⁹² *New media, new problem? Alcohol, young people and the internet*, Alcohol Concern, June 2011, <http://www.alcoholconcern.org.uk/assets/files/Wales%20factsheets/New%20%20media,%20new%20problem.pdf>

²⁹³ WHO figures—<http://apps.who.int/ghodata/?vid=60580>

²⁹⁴ *The Loi Evin: a French exception*, Dr. Alain Rigaud, Président Association Nationale de Prévention en Alcoologie et Addictologie (ANPAA)

²⁹⁵ http://www.europeanspirits.org/documents/Factsheets/CPAS0772009_Fact_Sheet_advertising.pdf

Plain packaging

29. We do not recognise the provenance of the reference to plain packaging in the Health Committee's inquiry into the Alcohol Strategy: it is not in the Alcohol Strategy nor has alcohol plain packaging ever been proposed by the UK Government.

30. There is no hard evidence on the impact on consumption of any product arising from a plain packaging policy, but such a policy would equate to a de facto advertising ban. Branding provides extremely important consumer, social and economic functions and we believe that any consideration that alcohol branding might be restricted would be an extreme, disproportionate regulatory approach.

May 2012

Supplementary note by the Advertising Association (GAS 52A)

I wanted to provide clarification on a point raised in a recent witness session by Dr Wollaston. The point related to alcohol advertising in cinemas being shown around Harry Potter movies. I can categorically state that alcohol advertising has never been shown alongside any of the Harry Potter films, and I provide you information below as an addendum to our submission as to why that is the case.

1. The Committee of Advertising Practice (CAP) Code sets out the rules for non-broadcast advertising including cinema. It dictates that no medium should be used to advertise alcoholic drinks if more than 25% of its audience is under 18 years old.
2. As is outlined above, if over 25% of a cinema audience is under 18 years-old, then a film will not carry alcohol advertising. These rules are administered by the Cinema Advertising Association who, as the content and nature of films changes every year, use independent modelling to project the likely audience profile for a film. This is based on a sample of similar films whose actual profile post release is used as the base for the modelling of future releases.
3. Further to these exposure rules based on percentages, the CAA also takes other steps to reduce the incidence of youth exposure to alcohol advertising. For example, unless the film is "18" certificate, the CAA takes the view that all releases featuring comic book characters in a central role are not permitted to carry alcohol advertising, given the potential appeal of those characters to younger audiences. This has meant that a number of highly successful films—including *Marvel Avengers Assemble*, which is currently making box office records, cannot carry alcohol. Similar data analysis has meant that "gross out" comedies receiving "15" certificates rarely carry alcohol advertising.
4. It is also essential to also note that many films that are popular with adults are lower certificate films, for example *The Best Exotic Marigold Hotel*. This film received a 12a certificate but, as the majority of its viewership was middle-aged or older, it would be wholly disproportionate to have banned alcohol advertising around this film.
5. Even when alcohol advertising is permitted with a film, its proportion does not exceed 40% of total advertising reel time, and CAA members endeavour to ensure that alcohol ads are always interspersed with non-alcohol ads.
6. The rules and self-regulatory behaviour set out above are a proportionate way to protect children from seeing alcohol advertising while at the same time ensuring that cinemas can benefit from advertising alcohol products in their cinemas in a responsible way. Cinemas, and particularly local cinemas, rely on advertising revenue. Any impact to the amount of advertising revenue that they receive could threaten their viability.

Additionally, the Committee Chairman made reference to his interest in the *Loi Evin* rules which heavily restrict alcohol advertising in France in the final evidence session. Our original submission makes clear that there is much independent evidence showing that this ban had been ineffective in reducing high-risk drinking patterns. We are happy to provide further evidence backing up our view that an advertising ban along the lines of *Loi Evin* is not an effective public policy measure to address the serious problem of irresponsible drinking.

William Blomefield
Regulatory Affairs Manager

June 2012

Written evidence from the All Party Parliamentary Group on Alcohol Misuse (GAS 53)

1. THE APPG

1. The Group comprises members from across both Houses, from all parties and none. Due to the timing of this enquiry, this submission has been approved by the Officers of the Group²⁹⁶ rather than the full membership, although it has been circulated to them to seek comments. It draws on the evidence of Alcohol Concern, the national agency on alcohol misuse, which provides the secretariat for the All Party Parliamentary Group. It also builds on previous discussions within the Group and can fairly be seen as a reflection of the approach of the parliamentarians who share a concern about Alcohol Misuse.

2. It has been acknowledged by members, and by expert advisors addressing our meetings, that pricing is one of the most effective measures to reduce excessive consumption with its associated health and other harms.

3. We therefore strongly welcome the commitment to a minimum unit price which would lower consumption and reduce alcohol-related harms.

4. We also welcome the government's acknowledgement that price is only one part of an overall prevention strategy and that other action is needed, particularly to reduce the availability and promotion of alcohol.

5. Children and young people are especially vulnerable to the effects of alcohol marketing. Consequently, such marketing should be restricted to adult audiences.

6. Furthermore, in order to help those already either in difficulty with their drinking or at risk of harm, the availability of early interventions is essential, both to help people assess their drinking levels and identify the potential harm, and to receive information and assistance to cut back. For those already moving towards alcohol dependence and harm (either to themselves or others), the availability of appropriate treatment is an essential element of any strategy.

7. The NHS reorganisation offers the potential for a real impact on the provision of services (both brief interventions and more intensive treatment) especially given the role of GPs in commissioning and the new role of local government. However, such potential will only be realised if current health spending priorities are refocused, with much greater expenditure on cost-effective alcohol treatment and advice services.

8. The strategy will only be effective if there is an adequately resourced, expert and committed body to help drive, plan and implement the many recommendations and to assist GP commissioners, service providers, local government and all the other players to build the capacity and programmes to play their part. It is therefore vital that the one national agency set up with exactly this remit, Alcohol Concern, is provided with the wherewithal to fulfil this vital task.

2. PUBLIC HEALTH

9. The enhanced role of public health provides the opportunity for effective interventions. We know (as set out by Alcohol Concern to the Committee) of the overwhelming scientific evidence that excessive consumption significantly increases risk to long-term health. Furthermore, alcohol-related illnesses are some of the major preventable causes of death.

10. Sadly, liver disease is the only major cause of death still increasing year-on-year²⁹⁷ with deaths from liver cirrhosis having increased more than five-fold between 1970 and 2006.²⁹⁸

11. Over 10 million adults drink more than recommended guidelines, with 2.6 million drinking more than twice their "safe" limits.²⁹⁹

12. Alcohol misuse places a huge burden on the NHS—as much as £2.7 billion a year. Hospital admissions due to alcohol misuse amounted to 1.1 million in 2009–10, a 100% increase from 2002–03.³⁰⁰

13. This is a public health burden which neither the country, nor the individuals concerned (and their families), can afford.

14. It is increasingly the case that the public has recognised, firstly, that excessive drinking has got out of hand and that, secondly, something should and can be done about this. People know that price and availability are key determinants of consumption and, in particular in relation to disturbances and low level violence, the number and size of outlets should be controlled. Hence the often vocal objections to the granting of licences. It is therefore important for local authorities to have greater freedom to set licensing fees to discourage the growth of off-licence sales, and to resist the continuous pressure for ever more outlets, including from post offices, near schools and in other inappropriate places.

²⁹⁶ Baroness Hayter; Lord Brooke of Alverthorpe; Tracey Crouch MP; Baroness Finlay; Russell Brown MP

²⁹⁷ Office for National Statistics, *Health statistics quarterly*, Winter 2008.

²⁹⁸ House of Commons Health Select Committee, *Alcohol: First report of session 2009–10*, Volume 1.

²⁹⁹ House of Commons Public Accounts Committee, *Reducing Alcohol Harm: health services in England for alcohol misuse*, 2010.

³⁰⁰ North West Public Health Observatory, *Alcohol-Related Hospital Admissions*, 2009.

3. MINIMUM UNIT PRICE

15. The All Party Parliamentary Group welcomes the Government's commitment to Minimum Unit Pricing as a step towards more appropriate alcohol pricing.

16. Any such increase will reduce consumption. But equally important is the message it sends out to all drinkers and to society in general. Over the past quarter century, a culture of alcohol overuse has developed, with heavy drinking frequently regarded by drinkers as an essential part of "a good night out" and drunkenness seen by some as acceptable (even desirably) despite its contribution to regrettable incidents.³⁰¹ Changes to our drinking culture and behaviour are needed, with the affordability of alcohol being a key driver in achieving this.³⁰²

17. Wagenaar's meta-analysis concluded that: "price affects drinking of all types of beverages, and across the population of drinkers from light drinkers to heavy drinkers. We know of no other preventative intervention to reduce drinking that has the consistency of effects".³⁰³

18. A locally imposed minimum pricing restriction in Australia resulted in a 19.4% reduction in alcohol consumption, fewer hospital admissions for alcohol-related illnesses and fewer arrests.³⁰⁴

19. In British Columbia, with Minimum Unit Pricing in place for 20 years, a 10% increase in minimum prices reduced consumption of spirits and liqueurs by 6.8%, wine by 8.9%, alcoholic sodas and ciders by 13.9%, beer by 1.5%, and all alcoholic drinks by 3.4%.³⁰⁵

20. A 2009 study found that the more intensive the pricing policy, the greater the harm reduction.³⁰⁶ Low minimum prices had little impact, but the effectiveness accelerated rapidly from a Minimum Unit Price of 40p up to 70p. Whilst 40p would result in a reduction in consumption of 2.7% (with 3,600 fewer hospital admissions and 1,100 fewer crimes pa), 50p would see a 7.2% reduction in consumption (8,900 fewer hospital admissions and 4,200 fewer crimes).

21. A Minimum Unit Price might encourage producers to reduce the alcoholic content of their products.³⁰⁷ Wine usually has an alcohol content of 12% (nine units per bottle). At the cheapest end of the market, where three bottles sell for £10, a MUP of 50p would increase the price of one bottle from £3.33 to £4.50. However, if the producers reduced the alcohol content to 9%, the price could remain at £3.38.

22. Producing and promoting such lower strength drinks can be an effective way to reduce consumption, with its associated intoxication and impairment.³⁰⁸

4. THE EFFECTIVENESS OF OTHER INTERVENTIONS

23. The most effective interventions in reducing alcohol-related harm have been ranked as: price, restrictions on the availability of alcohol, drink-driving measures, brief interventions with at-risk drinkers, and treatment of drinkers with alcohol dependence.³⁰⁹

24. In particular, we emphasise that this list does NOT include educational approaches—the normal "tool" recommended or adopted by the industry, and often supported by government. It can make people feel they are doing something and, in particular, it provides resources or events to showcase to emphasise one's concerns. But these have little lasting effect compared with price, availability and treatment interventions.

25. Regulatory approaches (such as price, availability, marketing) reduce the incidence of alcohol-related harm, whereas educational approaches (including school-based education and public education programs) do not.³¹⁰

26. Educational programmes, typically favoured by the drinks industry, are expensive yet have little long-term effect on consumption or alcohol-related problems. Although they can increase knowledge and change attitudes, actual alcohol use remain largely unaffected.³¹¹ Indeed, "education alone is too weak a strategy to counteract other forces that pervade the environment".³¹²

³⁰¹ Alcohol Concern, *A drinking nation? Wales and alcohol*, 2010

³⁰² Bailey, J, *et al*, *Achieving Positive Change in the Drinking Culture of Wales*, Glyndŵr University Wrexham and Bangor University, 2011.

³⁰³ Wagenaar, A C, Salois, M J and Komro, K A, *Effects of beverage alcohol price and tax levels on drinking: A meta-analysis of 1,003 estimates from 112 studies*, 34th Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society for Social & Epidemiological Research on Alcohol, Vicotir, British Columbia, June 2008.

³⁰⁴ Gray, D, *et al*, "Beating the grog: An evaluation of the Tennant Creek liquor licensing restrictions", *Australian and New Zealand Journal of Public Health*, 24(1), 2000.

³⁰⁵ Stockwell, T, *et al*, "Does minimum pricing reduce alcohol consumption? The experience of a Canadian province", *Addiction*, 2012

³⁰⁶ School of Health and Related Research, *Model-Based Appraisal of Alcohol Minimum Pricing and Off-Licensed Trade Discount Bans in Scotland: An Scottish Adaptation of the Sheffield Alcohol Policy Model*, 2009.

³⁰⁷ *ibid*.

³⁰⁸ Babor, T, *et al*, *Alcohol: No Ordinary Commodity*, 2010, OUP.

³⁰⁹ *ibid*.

³¹⁰ Anderson, P, "Global alcohol policy and the alcohol industry", *Current Opinion in Psychiatry*, 22(3), 2009.

³¹¹ Babor, T, *et al*, *op. cit*, 2010.

³¹² Bailey, J, *et al*, *op. cit*, 2011

Alcohol Labelling

27. The recent implementation of the EU Food Information for Consumers Regulation (FIR) contains a provision allowing energy-only labelling for alcoholic drinks. This facilitates the disclosure of calorific content. Such calorific content of alcohol will assist consumers in deciding what and how much to drink. It would therefore benefit public health if consumers can easily understand the calorific content of the alcohol and therefore limit energy intake accordingly. This might be of particular assistance to diabetics, the obese and regular drinkers wishing to limit their calorie intake to recommended levels. Similarly, those with weight problems would be more easily able to manage their condition if the calorific content of drinks were on the labels. It should be noted that whilst alcohol can be highly calorific and linked to obesity, there is low awareness of this. Thus some drinkers might reduce their intake if they realised the high calorific content of the alcohol. There should be a level playing field for manufacturers of soft drinks and alcoholic drinks. At present there is a risk that someone comparing a soft drink product displaying calorific content with alcoholic with no calorific disclosure might think the latter contains fewer calories.

28. We therefore recommend that all alcoholic drinks should carry standardised calorie content information on the label.

29. This should be acceptable to producers, especially as the one intervention generally accepted by the industry is about Unit labelling on drinks products. However, we should also note in regard to the latter, that evaluations of the effects of alcohol warning labels in the US, shown improved awareness of safe drinking, but only slight evidence of any effects in changing actual drinking behaviour.³¹³ So whilst any such information is to be warmly welcomed, like education it cannot be relied on to impact harmful behaviour.

Availability and drink/driving

30. Restrictions on availability, by contrast, does reduce harm, including violence.

31. Similarly, law enforcement alongside sustained publicity campaigns has reduced the number of drink-drive accidents. Despite this, 17% of all road fatalities in 2009 resulted from drink-driving.³¹⁴ It is therefore extremely regrettable that there are no measures to reduce drinking and driving in the strategy.

32. The All Party Parliamentary Group therefore calls on the Committee to endorse the recommendations of Sir Peter North to lower the legal blood-alcohol limit to 50mg of alcohol in 100ml of blood,³¹⁵ and bring the country in line with virtually every other European country.

5. INVESTING IN TREATMENT

33. Around half of the £2 billion spent on public health and treatment goes on drugs interventions, whilst PCTs spend an average only £600,000 a year on alcohol treatment and counselling, just 0.1% of a typical PCT's expenditure.³¹⁶

34. The lack of high-level support for alcohol services has resulted in a piecemeal approach to provision. The 1.6 million people in England experiencing alcohol dependency³¹⁷ are entitled to far greater priority than is indicated in the strategy. Only one in every 18 dependent drinkers currently receives treatment³¹⁸ despite the fact that support for such people drinkers makes good economic sense: for every £1 spent on treating dependent drinkers, £5 is saved on health, welfare and crime.³¹⁹

35. We know that hospital A&E departments can be overwhelmed by problem drinkers (or their victims) though there are other, less visible, impacts on the NHS with chronic health and trauma injuries in GP surgeries and on medical wards. Without serious investment in interventions to help those misusing alcohol with their drinking, such impacts on the health service will continue to grow.

36. The Government outlined a number of important high-impact interventions in the Alcohol Strategy, including Brief Intervention and Advice, and alcohol liaison nurses in the A&E. As the new arrangements for commissioning alcohol services are embedded, it is vital that these services are funded by local authorities and the NHS.

37. The APPG welcomes the Government's commitment to look at how GPs can be supported to screen for alcohol misuse, through the Quality and Outcomes Framework. In the reformed NHS, GPs will continue to be at the frontline of diagnosing and treating people with alcohol problems and they will have a crucial role to play in identifying, assessing and referring people with alcohol use disorders. However, GPs have tended to under-identify alcohol misuse, with GPs identifying only one in 67 males and one in 82 female hazardous and

³¹³ Wilkinson, C & Room, R. *Warnings on alcohol containers and advertisements: International experience and evidence of effects*, Drug & Alcohol Review, 28(4), 2009

³¹⁴ Department for Transport

³¹⁵ Sir Peter North, *Report of the Review of the Drink and Drug Driving Law*, 2010

³¹⁶ National Audit Office, *Reducing Alcohol Harm: Health services in England for alcohol misuse*, 2008.

³¹⁷ McManus, S, *et al* (eds), *Adult psychiatric morbidity in England, 2007, 2009*

³¹⁸ Alcohol Needs Assessment Research, *The 2004 national needs assessment for England*, Department of Health, 2005.

³¹⁹ Godfrey, C, *et al*, "Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT)", *British Medical Journal*, 2005, 331

harmful drinkers. Furthermore, less than a third of GPs used an alcohol screening questionnaire; and of those third, they only used them for an average of 33 patients a year.

38. The lack of incentives for GPs actively to seek to minimise alcohol harm were specifically raised by Group Members in the Lords during the Health and Social Care Bill debates; we hope that QOF points can be developed to address this.³²⁰

6. ALCOHOL MARKETING AND THE DRINKS INDUSTRY

39. Not only are children and young people particularly vulnerable to alcohol marketing, but it establishes early on in their minds: (a) that this is a desirable/glamorous commodity; and (b) that it is socially acceptable to see it infuse normal life. By shaping their attitudes, perceptions and expectancies about alcohol, this is bound to influence later drinking habits.³²¹

40. Given the association between marketing and youth drinking, many have concluded that the alcohol industry should not be involved in alcohol policy, a position endorsed by the World Health Organisation, which does not collaborate with the alcohol industry.³²²

41. Alcohol Concern has highlighted the frequency and volume of exposure by young people to advertising. Over one million children were exposed to alcohol advertising during the televised England games of the World Cup in 2010.³²³ 10 and 11 year olds were as able to identify branding and advertising for alcohol as for products aimed at them (such as ice cream and cake).³²⁴

42. The Group therefore regrets that the Government's strategy does not strengthen regulations on alcohol marketing. Perhaps as alarming is the desire to encourage "advertising which builds more positive associations (for example, between alcohol and positive socialising) instead of negative ones (for example, between alcohol and wild, disinhibited behaviour)". This runs contrary to the current ASA rules which rightly prohibit advertising that implies that alcohol can enhance the social success of an individual or event.

7. A NATIONAL AGENCY

43. Without a specialised, non-governmental agency able to provide the expertise, guidance, support and know-how to GP commissioners, local government, service providers and the range of professionals involved in alcohol misuse, it is difficult to see how the government's strategy can be delivered on the ground. The Department itself cannot act with the speed, flexibility and range of resources and advice needed; it does not link naturally with the network of alcohol agencies and specialists (across the whole of local government as well as police, probation, transport and education) and does not reflect local community and other interests. Alcohol Concern, with its long record in these areas, its broad based executive and range of expertise and with a single focus on alcohol misuse, is a necessary part of a successful strategy. As an independent body, and as part of the voluntary sector, it is also far more effective, and better value for money, than any statutory equivalent. It can work alongside the whole field of service providers, AA as well as the health service, and develop best practice across the range of interventions.

44. We therefore also call on the Committee to ensure that this body is now properly funded to help drive and deliver the commendable objectives set out in the government's strategy.

May 2012

Written evidence from Ofcom (GAS 55)

INTRODUCTION

1.1 Ofcom welcomes this opportunity to submit evidence to the House of Commons Health Committee's inquiry into the Government's Alcohol Strategy, published in March 2012.

1.2 Ofcom is the UK regulator of the communications industries, with responsibilities across television, radio, telecommunications and wireless communications services. Ofcom was established on 29 December 2003 and replaced the Independent Television Commission (ITC), the Radio Authority, the Broadcasting Standards Commission, Oftel and the Radio Communications Agency.

³²⁰ House of Commons Health Committee, *Alcohol: First Report Session of 2009–10*.

³²¹ Anderson, P, *The impact of alcohol advertising: ELSA project on the evidence to strengthen regulation to protect young people*, Utrecht, National Foundation for Alcohol Prevention, 2007.

³²² Jones, S C, *et al.*, "How effective is the revised regulatory code for alcohol advertising in Australia?", *Drug and Alcohol Review*, 27(1), 2008. Anderson, P, *op cit*, 2009. Hastings, G, *et al.*, "Failure of self-regulation of UK alcohol advertising", *BMJ*, 2010, 340. Gordon, R, *et al.*, "Assessing the cumulative impact of alcohol marketing on young people's drinking: Cross-sectional data findings", *Addiction Research & Theory*, 2011, 19(1). WHO Expert Committee on problems related to alcohol consumption, WHO Technical Report Series, 2007.

³²³ Alcohol Concern, *Overexposed: Alcohol marketing during the World Cup 2010*, 2010.

³²⁴ Alcohol Concern, *Making an impression: Recognition of alcohol brands by primary school children*, 2012.

1.3 This submission sets out the background to the regulation of broadcast advertising, Ofcom's powers and duties in this area, the scheduling and content rules governing the advertising, programme sponsorship and product placement of alcohol on TV.

POWERS AND DUTIES

2.1 Ofcom has a number of duties and powers under the Communications Act 2003 that are relevant when considering alcohol advertising. Ofcom's principal duty when carrying out its functions is to further the interests of citizens and consumers in communications matters (section 3 (1) of the Act).

2.2 Ofcom is required to secure a number of objectives when carrying out its functions which include *the application in the case of all television and radio services, of standards that provide adequate protection to members of the public from the inclusion of offensive and harmful material in such services* (section 3 (2) of the Act).

2.3 In performing its duties, Ofcom is required in all cases to have regard to a number of statutory considerations including:

The vulnerability of children and of others whose circumstances appear to OFCOM to put them in need of special protection (section 3 (4)): (h).

2.4 Under Section 319 of the Act, Ofcom also has a duty to set, and from time to time review and revise, standards for the content of programmes to be included in television and radio services as appear to it best calculated to secure certain standards objectives. Those objectives include:

That persons under the age of eighteen are protected (section 319 (2) (a)).

2.5 The additional statutory objectives under section 319 of the Act which are relevant to alcohol advertising are:

(2 (f)): that generally accepted standards are applied to the contents of television and radio services so as to provide adequate protection for members of the public from the inclusion in such services of offensive and harmful material;

(2 (h)): that the inclusion of advertising which may be misleading, harmful or offensive in television and radio services is prevented;

(2 (j)): that the unsuitable sponsorship of programmes included in television and radio services is prevented;

2.6 Section 319 (4) also requires Ofcom to have regard—in particular, and to such extent as appears to them to be relevant to the securing of the standards objectives, to a number of matters including:

(a) the degree of harm or offence likely to be caused by the inclusion of any particular sort of material in programmes generally, or in programmes of a particular description;

(b) the likely size and composition of the potential audience for programmes included in television and radio services generally, or in television and radio services of a particular description;

2.7 This requirement seeks to ensure that the implementation of the duties in section 319 is proportionate, following section 3 (3) of the Act which requires Ofcom, in performing its duties, to have regard in all cases, to:

(a) the principles under which regulatory activities should be transparent, accountable, proportionate, consistent and targeted only at cases in which action is needed; and

(b) any other principles appearing to Ofcom to represent the best regulatory practice.

2.8 Accordingly, Ofcom is required to act proportionately when performing its duties. This includes the setting or revising of content standards for alcohol advertising in such a way as to secure the protection of persons under 18 and the protection of any others whose circumstances appear to Ofcom to put them in need of special protection.

In addition Ofcom's regulatory principles also require our interventions to be evidence-based in both deliberation and outcome. Ofcom's regulatory principles³²⁵ seek to ensure that policy decisions are evidence based, drawing on market data as well as qualitative and quantitative research.

2.9 Ofcom does have powers under the Act to prohibit *advertisements and forms and methods of advertising or sponsorship (whether generally or in particular circumstances)* (section 321 (1) (b)).

2.10 Finally, under section 321 (6) of the Act, the Secretary of State retains the power to direct Ofcom to prohibit descriptions of advertisements that should not be included in programme services and also, forms and methods of advertising and sponsorship. Ofcom has a duty to comply with any such direction (section 321 (6)).

³²⁵ <http://www.ofcom.org.uk/about/sdrp/>

BACKGROUND TO BROADCAST ADVERTISING CO-REGULATION

3.1 In October 2003 Ofcom consulted on proposals to transfer broadcast advertising content regulation to a new system to be established under the auspices of the Advertising Standards Authority (ASA). In July 2004, the Deregulation and Contracting Out Act 1994 gave effect to such an approach.

3.2 The Communications Act 2003 encourages Ofcom to consider effective forms of self-regulation for its various functions where appropriate. In 2004 Ofcom decided that the most efficient means of regulating broadcast advertising was through a co-regulatory relationship with the ASA and the Broadcast Committee for Advertising Practice, as this would:

- provide a one-stop shop for advertising complaints, making it easier for the public to complain about advertising (indeed, even before the change, more people mistakenly complained to the ASA about TV advertising than to Ofcom’s predecessor, the ITC);
- allow all broadcast and non-broadcast advertising (including on the internet and on phone services) to be subject to a common self-regulatory approach, under a single established body, thus providing greater clarity for consumers and scope for a more consistent policy across different forms of advertising;
- encourage the advertising industry to take responsibility for its own behaviour; and
- minimise duplication of resources within Ofcom and the ASA, and further the statutory objective in the Communications Act of promoting self and co-regulation where appropriate.

3.3 From November 2004, Ofcom delegated day-to-day responsibility for applying the broadcast advertising codes to the ASA. At the same time, responsibility for the TV and Radio Advertising Standards Codes was delegated to the Broadcast Committee of Advertising Practice (BCAP), the industry rule-making body, comprising advertisers, agencies and broadcast media.

3.4 Ofcom stands behind the co-regulator, and retains its statutory responsibility for the regulation of broadcast advertising under the Communications Act. BCAP can only make changes to the Codes with Ofcom’s agreement and following public consultation, having also consulted the independent Advertising Advisory Committee (AAC). Ofcom also retains responsibility for taking licence compliance action against broadcasters if advertisers fail to respond to adjudications by the ASA.

REGULATION OF ALCOHOL ADVERTISING

Overview

4.1 One long-standing public policy objective for the regulation of TV advertising is to reduce any negative impact of alcohol advertising on children and young teenagers.

4.2 Ofcom conducts its own periodic research into the exposure of children and young people to alcohol advertising. As the Alcohol Strategy states the Government’s desire to ensure that adverts promoting alcohol are not shown during programmes of “high appeal” to young people, Ofcom has commissioned new research to assess the level of children’s exposure to alcohol advertising during programmes where large numbers of children may constitute a small proportion of viewers and are therefore not caught by the existing scheduling rules (see below). We shall share this research with Government and publish our findings in due course. In addition, we are aware of, and have in the past considered academic research presented to us on the relationship between alcohol advertising and consumption, Ofcom remains open to any new evidence that may emerge.

4.3 There are two forms of regulation for TV alcohol advertising (which also apply to programme sponsorship):

- scheduling rules: where and when adverts appear on television; and
- content rules: the imagery, wording and tone of the adverts.

Rules on the scheduling of alcohol advertising

4.4 Scheduling rules already limit where alcohol advertisements may appear in the schedules. Alcohol may not be advertised in or adjacent to children’s programmes or programmes commissioned for, principally directed at or likely to appeal particularly to audiences below the age of 18.

4.5 Since 1999 a system of “indexing” has helped to prevent adverts being directed at children. A programme of “particular appeal” to children is deemed to be one that attracts an audience index of 120 for this age group. If a programme attracts an under-16 audience in a proportion similar to that group’s presence in the viewing audience as a whole, it is said to index at 100. So an index of 120 is an over-representation of that group by 20%. For example, the proportion of 10–15 year olds in the viewing population is 8.24%, so any programme where more than 9.84% (8.24 x 1.2) of the audience is made up of 10–15 year olds would not be allowed to carry alcohol advertising in or around it.

4.6 In other words, if the audience for a programme is expected to contain a disproportionately large number of young people, the broadcaster cannot place alcohol adverts in or around it. This is a more targeted approach than a pre-watershed ban as it hones in on specific programmes appealing to young people regardless of what

time they appear in the schedule. For example *Glee* is broadcast after 9pm on Sky One, but alcohol advertisements cannot be placed in or around it because of the disproportionately high number of young people watching the show.

4.7 Indexing is the standard approach used to limit children's exposure to a variety of advertising categories. These include HFSS food and beverages, sanitary protection, gambling, condoms, certain religious matter, slimming products, medicines, vitamins and dietary supplements, matches, trailers for 18/15 certificate films, advertising for all of which is excluded in and around programmes whose audiences contain a disproportionate number of children or young people.

Rules on the content of alcohol advertising

4.8 The current rules reflect a review carried out in July 2004, when Ofcom consulted on proposals to revise Section 11.8 of the Advertising Standards Code for television advertising relating to alcoholic drinks. The decision to review the content rules was prompted by findings from research commissioned by the ITC, the ASA and the British Board of Film Classification (BBFC) into young people and alcohol. This indicated that alcohol advertising had some influence on young viewer's attitudes towards alcohol, albeit at a relatively low level compared to other factors. The review took place against a backdrop of widespread concern (including Government concerns expressed in its Alcohol Harm Reduction Strategy) about the drinking behaviour amongst teenagers and young adults, including excessive or binge drinking or anti-social behaviour associated with drinking.

4.9 Following the consultation, new rules for television advertising came into force on 1 January 2005 with a "grace period" until 30 September 2005 for advertisers who might have already committed themselves to campaigns which might not comply with the revised rules. In tandem with this process, the Committee of Advertising Practice (CAP) amended the alcohol rules in the non-broadcast advertising Code.

4.10 In particular, the changes to the Codes sought to prevent alcohol advertising having a strong appeal to "under 18s" and, in particular, being associated with youth culture. For example a new rule in the TV Code requires that alcohol advertising "must not be likely to appeal strongly to people under 18, in particular by reflecting or being associated with youth culture". The rules are also designed to protect vulnerable groups by preventing suggestions that alcohol can increase popularity or confidence etc. As a result of the rule changes, at least one alcohol advertising campaign that ran in Europe and the United States was banned in the UK. Details of the 2004 rules changes are given in Annex 1;³²⁶ a clean version of the current rules is shown in Annex 2.³²⁷

4.11 Ofcom did not propose to add a time based ban to the scheduling rules at the time, for two reasons. Firstly, research indicated that advertising could have a relatively small influence on young people's attitudes to alcohol compared to other social, family and market factors and secondly because teenagers and most older children watched (and watch) a significant amount of post-watershed TV and would continue to see alcohol advertisements at these times. The existing rules, last assessed during the 2009 BCAP Advertising Code Review, seek to target those programmes of particular appeal to child audiences both before and after the watershed. This is clearly something that can and should be revisited periodically.

Assessing the impact of the updated rules

4.12 In 2007 Ofcom/ASA conducted research into the impact of the rule changes.³²⁸ The research was designed to provide general information on young people's drinking habits and the alcohol advertising market and to assess the effect of the changes to the content rules. The report found that although TV's share of total alcohol media expenditure fell from 61% in 2002 to 49.1% in 2006 (as outdoor, press and radio spend grew), the number of alcohol advertising spots on TV rose over the same period. This was due in part to the growth in channel numbers. However despite the increase in the number of advertisements shown on TV, the amount of advertising seen by 10–15 year olds and 24 year olds between 2002 and 2006 fell by 31.1% and 39.0% respectively.

4.13 The research also set out to measure the extent to which the 2005 changes to the alcohol advertising rules may have impacted on the appeal of alcohol for people under 18. The considerable market and cultural changes during that period (including changes in licensing laws and changes in the types of drinks consumed) meant that it was difficult to separate from other factors the impact of the advertising rule changes on young people's attitudes and behaviour towards both alcohol and alcohol advertising. As a result the finding should be viewed with a degree of caution.

4.14 Against that background, there were some positive indications of changes in behaviour. The research found that 11–13 year olds were less likely to have drunk alcohol at all, but there was very little change in the proportion of 11–17 year olds saying they regularly drink to get drunk between the two waves of research. There was a significant fall in the proportion of 18–19 year olds regularly drinking to get drunk. The age at which it was most common for young people to report regularly drinking to get drunk was 20 to 21 years old.

³²⁶ <http://stakeholders.ofcom.org.uk/binaries/consultations/AlcAds/statement/decision.pdf>

³²⁷ http://www.bcap.org.uk/The-Codes/BCAP-Code/~/_media/Files/CAP/Codes%20BCAP%20pdf/BCAP%20Section%2019.ashx

³²⁸ *Young People and Alcohol Advertising 2007 Ofcom/ASA*

4.15 In terms of perceptions, young people's ability to recall alcohol advertising had declined (potentially linked to the reduction in their exposure to TV advertising) since the introduction of the new rules. There was no change in how much young people said they liked the adverts and there was an increase in those saying that advertisements made the drink look appealing and would encourage people to drink it. However the proportion of young people saying they felt the alcohol commercials were aimed at them had declined.

*Product Placement*³²⁹

4.16 In 2010, the UK Government took advantage of European legislation,³³⁰ which provides EU Member States with scope to allow product placement in specific programme genres subject to certain restrictions. However, the Government decided not to allow the product placement of alcohol, which along with a number of other product categories, remains prohibited in programmes made under UK jurisdiction.
May 2012

Written evidence from 2020health.org (GAS 56)

SUMMARY

- Alcohol policy should be led by the Home Office.
- Self-regulation is no regulation. We have the most lax alcohol regulation in Europe and the fastest rising rates of alcohol related liver disease.
- The local pub has an important role to play in promoting responsible drinking and community health and cohesion.
- Statutory regulation on advertising is far too lax and should be brought in line with other European countries, following WHO recommendations.
- A universal alcohol assessment should be offered at age 30.
- Public health should use the JSNA to commission alcohol services according to need.
- Brief Interventions have been shown to reduce risky drinking and would lead to a saving to the NHS, with an average reduction of 5 units per week remaining one year after the intervention took place.
- Public Health should take responsibility for education of the local population on alcohol, to ensure that all understand the harms of risky drinking.
- The clear display of units on bottles or cans of all alcoholic drinks should be made compulsory. Units should be displayed on the front of the bottle and a minimum font size should be specified.
- A minimum price of 40p per unit should be introduced for all alcohol sales.
- Alcohol education should be an annual component of PHSE through secondary school education. This should include information on the long-term risks of drinking at different levels.
- A national public health education campaign is needed.

INTRODUCTION

The lifestyle choices that we make will affect our health, our relationships, our work and our future. Alcohol consumption is one of the key areas where choices are being overly influenced by a powerful industry and the public is being exposed to coercion on a daily basis. Considering the costs to the public purse are estimated at up to £55 billion a year, we need a much more radical alcohol strategy to reverse the drain on the taxpayer and the prevent the huge number of damaged lives through alcohol misuse. We have to transform our thinking in society so that alcohol is not a prerequisite for enjoyment.

1. *Government Leadership*: The Alcohol Strategy should be a joint policy across Whitehall led by HO and including the DCMS, DH, DCLG and HM Treasury. The HO should lead because the largest costs of alcohol misuse come in the domain of the HO (crime, anti-social behaviour, domestic violence and family breakdown) and it is vital for people to understand that many determinants of health lie outside of healthcare.

2. *Alcohol policy* should be consistent between England and the devolved administrations to avoid public misunderstanding and cross-border problems and enable a consistent message for the public.

3. *Regulation*. The Portman group has been shown to be entirely ineffective. Self-regulation is no regulation. Whilst including the industry in discussions about legislation is fine, they cannot do anything effective to reduce the consumption of alcohol as this would be commercially unacceptable for their shareholders. "Responsibility Deal" agreements such as unit labelling on the back of bottles and cans in tiny font that cannot be read either by anyone over the age of 45 without glasses or in low lighting is hardly going to make an

³²⁹ Product placement is the inclusion in a programme of a product, service or trade mark, or a reference to it, for a commercial purpose and in return for payment or other valuable consideration This is a summary of the definition of product placement set out in the Act, by means of the Regulations. The definition can be found at Schedule 11A, paragraph 1(1) of the Act (see Annex 10).

³³⁰ the Audiovisual Media Services (AVMS) Directive

impression. Likewise, midwife training paid for by the alcohol industry could be a waste of time. Alcohol consumed before and during the first trimester of pregnancy before a midwife is seen has a huge impact on foetal health.

- 3.1 Drinkaware, like Gamcare, is a convenient way for industry to claim that they are being responsible. However the impact of such charities pales into insignificance compared with the amount of money spent by the industry on advertising and promotion.
- 3.2 The local pub is in a different situation. The British Beer and Pub Association have promoted clear, large print information about drink units through beer mats and posters but the local pub can take an active role in helping to moderate consumption, offer non-alcohol and low alcohol alternatives and promote the European model of having a drink with a meal. There is also anecdotal evidence that the local pub has a role to play in mental and public health and can play a significant role in community cohesion and informal policing. Enabling pubs to diversify and extent their community involvement would make a positive contribution to society.

4. *Minimum pricing* would send an important signal to consumers about drinking in moderation. Despite increasing taxation, the affordability of alcohol in the UK has been steadily increasing and in 2010, alcohol was found to be 45% more affordable on average than in 1980.³³¹ An association between taxation and alcohol consumption has been shown. Barber et al in 2003³³² identified that where the price of alcohol was raised the incidence of road deaths, violent crime associated with alcohol and incidence of cirrhosis fell. When Finland reduced taxation in 2004 to stem the flood of cheap imports, the country experienced a 17% rise in alcohol associated mortality.³³³ However in countries such as France and Italy there is less taxation and alcohol can be purchased cheaply. In France, the quality of the product has been given a higher focus and improving quality of wine and setting these products at a higher price has resulted in a reduction in the purchase of cheaper wines. Such a culture change would be difficult in England.

- 4.1 A minimum price per unit of alcohol and an end to “bogof” promotions could stop supermarkets selling alcohol as a loss leader. NICE public health guidance has suggested a minimum price of 40p per unit. The WHO reported that a price increase and minimum pricing per unit were more likely to reduce drinking in those who drank at harmful levels than those who consumed less and even a small shift in price can reduce consumption. Modelling suggests that a minimum price of 40p per unit would lead to a 2.4% reduction in consumption,³³⁴ and a saving of £80.3 million to the NHS together with savings of £6.8 million in crime and £13.2 million in employee absenteeism.³³⁵

5. *Advertising* has a detrimental impact on children and adults. ELSA³³⁶ concluded that:

“Alcohol advertisements are related to positive attitudes and beliefs about alcohol amongst young people, and increase the likelihood of young people starting to drink, the amount they drink, and the amount they drink on any one occasion.” This view is strongly supported by the World Health Organisation.

- 5.1 While the UK has many regulations relating to the taxation and production of alcohol, it is one of only two countries in Europe where there is no statutory regulation with regard to the advertising and marketing of alcohol, a system of co-regulation and non-statutory guidance being in place, the other country with limited regulation being the Netherlands, which incidentally has also seen a rise in the incidence of cirrhosis.
- 5.2 In general the UK is perceived as lax as with regard to advertising when compared to other European countries and has been criticised for ignoring other national media rules when transmitting abroad. England should be brought in line with other European countries, following WHO recommendations.

³³¹ The NHS Information Centre (2011): Statistics on Alcohol, England 2011. The NHS Information Centre. Leeds.

³³² Barber et al (2003): WHO Alcohol and Policy Group report.

³³³ Koski A, Sirén R, Vuori E, Poikolainen K (2007): Alcohol tax cut and the increase in alcohol- positive sudden deaths: a time series analysis. *Addiction*. 2007 Mar;102(3):362–8.

³³⁴ NICE (2010): Alcohol-use disorders: preventing the development of hazardous and harmful drinking (PH24). NICE. London.

³³⁵ NICE (2010): Implementing NICE guidance: Costing Report, Alcohol-use disorders: preventing harmful drinking. NICE. London.

³³⁶ STAP (2007): Alcohol marketing in Europe: strengthening regulation to protect young people. Utrecht: National Foundation for Alcohol Prevention.

³³⁷ STAP (2007): Regulation of Alcohol Marketing in Europe Utrecht: National Foundation for Alcohol Prevention.

Table 1

A COMPARISON OF EUROPEAN REGULATIONS ON ADVERTISING. DATA TAKEN FROM STAP (2007)³³⁸

COMPARISON OF EUROPEAN REGULATIONS ON ADVERTISING

	<i>Advertising to Children</i>	<i>Location/ Time</i>	<i>Media Channel</i>	<i>Sanctions</i>
France	S	S	S	S
Italy	S	S	S	S
Norway	S	S	S	S
Finland	S	S	S	S
Germany	S	S	S	S
Spain	S	S	S	S
UK	NS	NS	NS	NS

Key:

S: statutory

NS: non statutory

6. *Health Impact:* The long-term health harm resulting from drinking is well known among the medical and scientific professions and alcohol has been implicated in over 60 types of disease and injury.³³⁹ The risks associated with high alcohol intake include increased risks of high blood pressure, stroke, coronary heart disease, liver disease and several forms of cancer as well as mental health disorders. Contrary to popular belief there is no safe level of alcohol consumption. The annual risk of death from alcohol consumption increases from only 10 grams alcohol/day (1.25 units), as can be seen from the graph below, which takes into account both the risks due to alcohol consumption and alcohol's small protective effect against heart disease.

- 6.1 The death rate from liver disease has been rapidly increasing in recent years and has doubled in the past two decades. Eleven of every 100,000 deaths were due to chronic liver disease and cirrhosis in 2008. For alcoholic liver disease alone there were 14,700 admissions in 2009–10, with the cost per person-specific hospitalisation calculated at £4,626.³⁴⁰
- 6.2 Alcohol, as a toxic substance, increases the risk of diseases in many different parts of the body. Whilst there will of course be individual variation in how alcohol affects different people, we have good data about the increased risk of different diseases due to increasing levels of alcohol consumption. For most conditions related to alcohol the message is simple; the more alcohol consumed, the greater the risk of harm. Table 2 shows the increased risk of different conditions associated with drinking 3 or 6 units of alcohol per day, compared to no alcohol consumption. These are just two snapshots of the gradual increase in risk which occurs as alcohol consumption increases.

³³⁸ STAP (2007): Regulation of Alcohol Marketing in Europe Utrecht: National Foundation for Alcohol Prevention.

³³⁹ World Health Organisation (2004): WHO Global Status Report on Alcohol 2004. WHO. Geneva.

³⁴⁰ Purshouse R, Brennan A, Latimer N, Meng Y, Rafia R, Jackson R, Meier P (2009): Appendices from Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0 Report to the NICE Public Health Programme Development Group. University of Sheffield. Sheffield.

Figure 1: Absolute annual risk of death from drinking different average amounts of alcohol per day, from 10 g (1.25 units) alcohol/day to 100 g (12.5 units)/day. Taken from Rehm *et al*, 2011³⁴¹

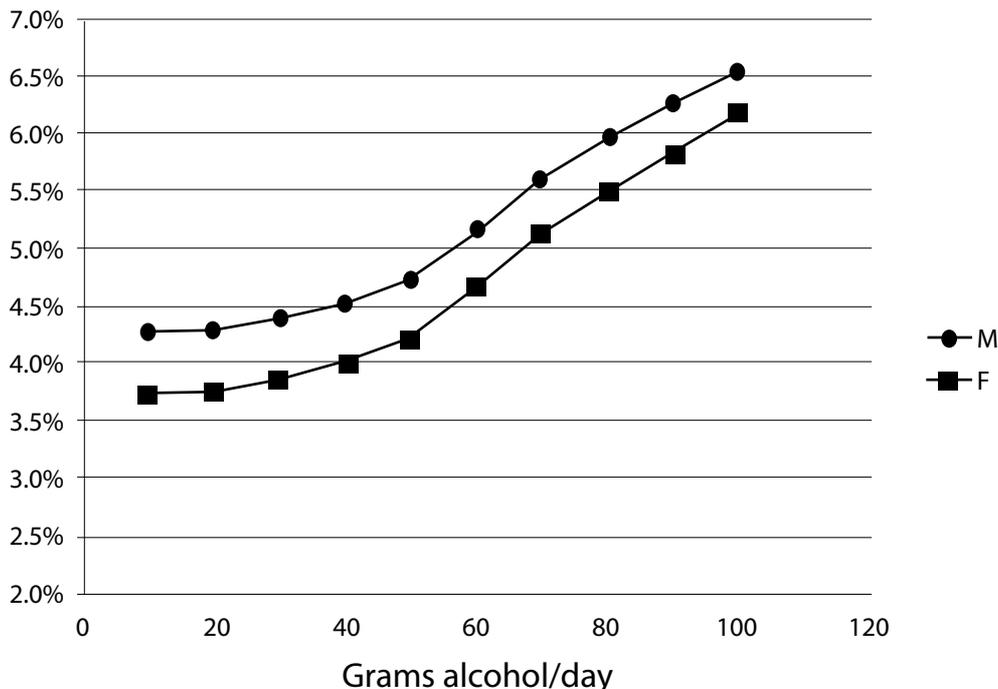


Table 2: The increased risk associated with drinking three or six units of alcohol per day. Data taken from the Australian Guidelines to Reduce Health Risks from Drinking Alcohol³⁴² and Corrao *et al* (2004)³⁴³

Condition	Increased risk associated with drinking:	
	3 units of alcohol per day (1.5 pints of beer, 250ml of wine)	6 units of alcohol per day (3 pints of beer, 500ml of wine)
Liver disease	3 times	7 times
Mouth cancer	2.5 times	5 times
Throat cancer	1.8 times	3 times
Breast cancer	1.3 times	2 times
Hypertension (high blood pressure)	1.7 times	3 times
Ischaemic stroke	No change	2 times
Haemorrhagic stroke	1.8 times	3 times
Pancreatitis	1.3 times	2 times

- 6.3 GPs do not routinely ask about alcohol as they do with smoking. This should be the case, and if there seems to be an issue, people should be offered a “Brief Intervention” which is a 15 minute discussion about alcohol consumption (see 6.3). A universal alcohol assessment should be offered at age 30. This could be cheaply and easily done as an online or email-based assessment. Screening of alcohol consumption should be included in all NHS Health Checks.
- 6.4 Public health should use the Joint Strategic Needs Assessment to commission alcohol services according to need. This would include a service for the delivery of Brief Interventions, with measurable outcomes.
- 6.5 Brief Interventions have been shown to reduce risky drinking, with an average reduction of 5 units per week remaining one year after the intervention took place. Brief interventions cost as little as £15 per patient, and the reduction in alcohol-associated health costs resulting from a policy of screening and brief interventions on GP registration would lead to a saving of £124 million across the NHS over 10 years.

7. *Education:* The government’s Alcohol Strategy mixed up binge drinking, dependency and excessive alcohol consumption. 2020health’s report “From one to many” clearly set out that a quarter of adults are drinking to excess but are NOT binge drinkers or alcoholics.³⁴⁴

³⁴¹ Rehm J, Zatonksi W, Taylor B, Anderson P (2011): Epidemiology and alcohol policy in Europe. *Addiction*, 106 (Suppl. 1), 11–19

³⁴² National Health and Medical Research Council (2009): Australian Guidelines to reduce health risks from Drinking Alcohol. NHMRC. Canberra.

³⁴³ Corrao G, Bagnardi V, Zamboni A, La Vecchia C. (2004): A meta-analysis of alcohol consumption and the risk of 15 diseases. *Prev Med.* 38(5):613–9.

³⁴⁴ <http://www.2020health.org/2020health/Publication/Wellbeing-and-Public-Health/From-one-to-many.html>

- 7.1 Public Health should take responsibility for education of the local population on alcohol, to ensure that all understand the harms of risky drinking. A national public health education campaign is needed. to ensure that the population is made aware of the harms related to risky drinking. The campaign needs to advise people of the risks of different conditions associated with drinking, and the harms of drinking every day. In particular the campaign should highlight risks such as the risk of specific cancers, of which many are not aware.
- 7.2 The UK has through PHSE a formal mechanism for education in schools; however it is left to individual head teachers to determine time spent on the subject and the content. Ofsted's assessment of the education in schools on the dangers of alcohol recognises this as a gap within the UK's educational system. The danger is that there is a focus on binge drinking rather than an informed approach towards drinking generally. Given the UK's propensity to drink there would appear to be the need for improved education, coupled with a more hard hitting national campaign to deliver the messages on the harmful effects of alcohol.

8. *Labelling*: Progress on public information and awareness could be achieved by the clear display of units on bottles or cans of all alcoholic drinks being made compulsory. Units should be displayed on the front of the bottle and a minimum font size should be specified.

May 2012

Written evidence from Greene King (GAS 57)

SUMMARY

Greene King, one of the UK's largest pub retailers and largest brewer of cask ale, is generally supportive of the Government's Alcohol Strategy. In particular, we support the intention to implement a Minimum Unit Price (MUP) for alcohol as we believe it is the most effective form of direct intervention for reducing the rising incidence of alcohol related problems in the UK.

However, we are concerned that a number of important stakeholders, including Government and the media, fail to recognise that there are different types of alcohol and alcohol drinking behaviour.

It is important to understand exactly what type of alcohol is being drunk, where it is being drunk, how it is being drunk and by whom. Alcohol is not a single product, different types of alcohol have different effects on society and this should be reflected in policy. We have seen significant changes in the nation's drinking behaviour in the last 30 years and we believe that this should be reflected in government policy going forward.

INTRODUCTION

1. Greene King is one of the UK's largest pub retailers and brewers. It operates c. 2,400 pubs, restaurants and hotels across England, Wales and Scotland, which include Hungry Horse, Old English Inns, Loch Fyne Restaurants and Eating Inn. Greene King also brews Greene King IPA, the no.1 cask ale in the UK, Old Speckled Hen, the no.1 premium ale in the UK, Abbot Ale, the no.1 premium cask ale in the UK and Belhaven Best, the no.1 ale brand in Scotland. The brewer has operated from its Bury St Edmunds base since 1799.

2. Greene King welcomes the Health Committee's Inquiry into the Government's Alcohol Strategy. We also welcome the Coalition Government's plans to introduce minimum unit pricing (MUP), with a commitment to consult on the most effective price level for MUP.

3. As a brewer and pub operator, we have long called for MUP as one of the most effective and targeted measures in the fight to tackle the growing health and societal problems of binge drinking and related anti-social behaviour. Alcohol pricing and availability are key to this abuse, which is carried out by a minority of people, fuelled by the easy availability of alcohol from retail outlets, often at very cheap prices.

4. We are committed to supporting the Government's policy unit team in its work to define the appropriate level per unit and the mechanism for determining any future level. It is our view that 40 pence per unit is too low a level to have enough of an impact on public health. We favour the 45–50 pence per unit as favoured by the Scottish Government.

5. Greene King believes that MUP alone cannot deliver the desired societal and health improvements and that MUP should be introduced alongside other supportive measures including restrictions on the availability of alcohol in unsupervised environments and specific restrictions on promotions, alcohol displays, time of sale and better health education. We believe that the Government should work with the industry, health groups and other stakeholders to develop an effective code on these measures to tackle the problem.

Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role

6. With the growing impact of alcohol misuse being felt across society, it is logical that all Government departments should be involved in shaping and implementing alcohol policy. We believe that the initiative should be co-ordinated and led by a single Department and that that Department should be the Home Office.

The issue about alcohol is misuse and not use, and as a responsible brewer of beer and retailer of alcohol, we have concerns that this key distinction could get blurred under a different Government Department lead.

Given the Coalition's commitment to a more joined-up Government, we believe that a working party of senior officials should be convened from across Government departments, led and co-ordinated by the Home Office. This is not just an issue for the Department of Health; we see areas of compatibility with HM Treasury, and the Departments for Education, Communities, Business, Culture and other areas of Government.

Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol

7. We welcome a standard MUP across the UK so that brewers, retailers and consumers have a clear understanding of pricing and the purpose underpinning the policy.

Different levels would be potentially divisive, confusing to consumers and would potentially cause domestic "booze cruises" across UK national borders. This problem already exists in the USA, where excise duty varies across state lines.

Government would also have to police illegal cross-border activity. If HMRC is concerned that above 40 pence per unit it would lose duty revenue, it should consider the wider costs to government of not having an effective MUP for alcohol and net those off.

The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group

8. Greene King actively supports the Public Health Responsibility Deal and is pleased to report good progress on a number of pledges since it was launched last year. We also support the role of the Portman Group. Overall, we believe industry does have an important role to play in addressing alcohol-related illness and disorder.

9. As part of our own efforts to affect behaviour, Greene King has created Enjoy Responsibly, a website that provides practical information and advice on responsible drinking. The site looks at issues around alcohol, including how alcohol affects your health and alcohol and the law, as well as resources such as a unit calculator and links to local support services. <http://enjoyresponsibly.co.uk/>

10. Responsible drinking must become more than "just a slogan" and ideally, as in parts of continental Europe, be repositioned as part of an overall social and dining experience.

11. The shift in consumption to stronger wines, spirits and ciders, increasingly consumed at home, continues to compound the UK's alcohol-related problems. Though any solution must be effective in curbing irresponsible consumers and retailers, we believe it should be structured and targeted so that it does not penalise the vast majority who drink responsibly and who view alcohol as a welcome part of their socialising with friends and family.

12. We believe that MUP, rather than further penal duty increases, would go a long way to addressing this problem. We believe the price should be set at a meaningful level and should be introduced alongside other measures to restrict the availability and limit the promotion of alcohol in certain channels. We would also like to see extra funding to improve the culture of alcohol consumption in the UK, with the intention of reducing alcohol-related crime and illness.

The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing

13. Like both the Scottish and UK Governments, we refer to the limited evidence from countries such as Canada and theoretical studies from bodies such as the University of Sheffield and the IFS. The Government has to set an MUP that positively impacts on the public health without meaningfully distorting the market in order not to fall foul of competition law. We believe this is achievable at 45–50p.

The effects of marketing on alcohol consumption, in particular in relation to children and young people

14. The Government has already banned the advertising of alcohol on sites close to schools. We endorse and support this policy. However, as a commercial business, Greene King would be opposed to banning of alcohol marketing outside our pubs or restaurants, as that would be anti-competitive.

15. Where bans have occurred in other countries, it is the incumbent producers who benefit most as it creates a barrier to entry into the market. We don't believe the marketing of alcohol affects how much is drunk, rather which brands are drunk.

The impact that current levels of alcohol consumption will have on the public's health in the longer term

16. Whilst overall alcohol consumption has fallen recently, it is still at a very high level by historical standards. Combined with this is the fact that alcohol misuse is having an increasingly detrimental effect on

public health. There appears to be a strong correlation between the increase in alcohol related harm and the shift in consumption away from beer to higher abv drinks such as cider, wine and spirits.

More needs to be done to combat the increasing prevalence of consumption of higher abv drinks, primarily purchased from the off-trade, in order to curb the growing public health problem related to alcohol.

17. The problems affecting the public's health in the longer term, given the current levels of alcohol consumption, are significantly about the *type* of alcohol consumed; where it is consumed, and by whom it is consumed. Each year, the statistics around public health worsen in relation to alcohol misuse, despite the fact that consumption of beer is decreasing. In fact the entire decline in alcohol consumption in the last ten years consisted of beer.

18. Beer is already heavily taxed. However, Government income from beer duty has risen by just 1% per annum since 2006, with volume sales declining almost in parallel to duty increases. By further pushing up the minimum price per unit of alcohol through a statutory minimum price and by switching duty from beer to cider, wine and spirits, the higher ABV alcohol products, the government would be financially better off whilst also tackling irresponsible consumption of alcohol.

19. The combination of a MUP and duty transfer would encourage a switch in purchasing and consumption from the unregulated off-trade to the highly regulated on-trade, and from higher abv cider, wines and spirits to lower abv beer.

Both trends would help to address the impact of binge drinking and would materially lower the cost to government particularly in relation to the current excessive NHS and Policing costs, from alcohol related harm and disorder. These trends would also increase overall VAT receipts for government.

*International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking, such as:
Public health interventions such as education and information*

20. As in other walks of life, we believe that "prevention" is better than cure. Greene King would like to see the introduction of Alcohol education in all UK schools as a fundamental part of the curriculum alongside other forms of personal, social and health education. We understand that there is a large burden on the various curricula of the UK; however, the statistics around under-age drinking show that action is required and that alcohol education should be a fundamental national concern.

21. We would draw the Committee's attention to the WHO report *Global Status Report on Alcohol and Health 2011* http://www.who.int/substance_abuse/publications/global_alcohol_report/en/index.html

22. The Global status report on alcohol and health (2011) is a comprehensive perspective on the global, regional and country consumption of alcohol, patterns of drinking, health consequences and policy responses in Member States. It represents a continuing effort by the World Health Organisation (WHO) to support Member States in collecting information in order to assist them in their efforts to reduce the harmful use of alcohol, and its health and social consequences.

23. Greene King has created an alcohol-support education website, Enjoy Responsibly: <http://enjoyresponsibly.co.uk/>

Reducing the strength of alcoholic beverages

24. Greene King was keen to see the Government reduce duty on below 2.8% ABV products and in response to that move, we launched, in September 2011, Tolly English Ale as our brand in this new category. We have been pleased with the performance of the brand so far.

Raising the legal drinking age

25. The current legal drinking age in the UK is appropriate. However, young people need better advice from Government and industry sources on the effects of alcohol on young people which can be more detrimental than on adults.

Written evidence from Scottish Health Action on Alcohol Problems (GAS 58)

SHAAP RESPONSE TO UK GOVERNMENT'S ALCOHOL STRATEGY

- SHAAP, which was set up in 2006 by the Scottish Medical Royal Colleges and Faculties, is pleased to respond to the Health Committee's enquiry into the UK Government's Alcohol Strategy.
- Our members have had the opportunity to contribute to the responses submitted by the Alcohol Health Alliance and the Royal College of Psychiatrists and we endorse their views, in particular we welcome the commitment to introduce a minimum unit price for alcohol.
- Our experience in Scotland is that an effective Alcohol strategy requires a clear vision, informed by evidence and learning from other countries and strong public advocacy. SHAAP has taken a leading role in this. The medical profession has been prominent in the debate within Scotland and, we believe, has had a key role in raising awareness of the extent of alcohol problems and developing and promoting effective policy and practice solutions.
- Effective alcohol strategy requires effective co-ordination and mutual support by Government at all levels, local, devolved, UK and Europe and jurisdictions must work together in order to establish and maintain progress.

1. *Minimum Unit Price (page 7)*

We believe that a minimum unit price is one of the most effective measures in reducing the harm which comes from the consumption of the cheapest forms of alcohol. SHAAP is convinced by the considerable international evidence on the relationship between price and harm (Wagenaar *et al*, 2009; Babor *et al*, 2010) and the studies which have shown that the price of the cheapest type of alcohol, the floor price, is of particular importance (Grunevald *et al*, 2006).

The initial minimum unit price should be high enough to be effective in reducing harm and should have a noticeable impact for all income groups. An effective monitoring system and a simple implementation system are essential. The impact of minimum unit price should be monitored closely with prompt and good quality data enabling adjustment as required.

We see several advantages to a minimum price set at the effective level across the UK.

2. *Multi-buy Discount Ban (page 7)*

Scotland has already implemented restrictions on irresponsible promotions in both the on trade and off trade sectors with some evidence of benefit already recorded. SHAAP welcomes the proposal to launch a consultation on multi-buy discount ban but we believe that this should include irresponsible on trade multi-buy promotions.

3. *Alcohol Advertising (page 8)*

SHAAP welcomes the recognition in the strategy of the negative impact of marketing and advertising but we believe a more vigorous approach is required. The current system of co-regulation with the ASA and the Portman Group is ineffective and the Commons Health Committee has concluded it is failing young people (House of Commons Health Committee 2010). Regulation should be independent of both the alcohol and advertising industries.

4. *Changing behaviour at local level—Licensing (page 10)*

SHAAP welcomes the recognition that there should be an obligation on licensing boards to assist in protecting and improving public health and that a public health objective should inform licensing decisions. To make a difference this needs to be informed by needs good local data. Local health information, such as alcohol-related hospital admissions, should be informing decisions made by licensing boards. In addition to this we believe that there should be a clear statutory role for health bodies in licensing decisions at local level. Implementing the public health principle in Scotland has required significant advocacy work by SHAAP and others and the effort required should not be underestimated.

5. *Treatment and Support—A Stepped Care Approach (page 15 and 22)*

We agree with the observations of our colleagues in AHA that the UK strategy is not strong on support and treatment. We endorse a whole population approach along with interventions targeted at those experiencing and at greatest risk of serious problems. A stepped care approach to intervention is consistent with this approach. There has been considerable development of screening and brief intervention in Scotland and our experience can be useful to other parts of the UK. The Scottish SBI programme required central planning, monitoring and support for effective delivery. This was particularly important in securing the involvement of Primary Health Care, the setting with the strongest evidence base and best opportunity to access a broad population. In addition to SBI, ring fenced investment allowed the development of a range of specialist services for those with more entrenched alcohol problems. These developments were in line with the evidence base reviewed by the Scottish Intercollegiate Guidelines Network and the Health Technology Board for Scotland in the early 2000s and since further developed by NICE.

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Wagenaar A C *et al* (2009). Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction*, 104(2) 179–90.

May 2012

Written evidence from the Local Government Association (GAS 59)

ABOUT THE LOCAL GOVERNMENT ASSOCIATION

1. The Local Government Association's (LGA) mission is to support, promote and improve local government. We work with councils to achieve our shared vision for local government by focusing our efforts where we can have real impact, being bold and ambitious, and supporting councils to make a difference, deliver and be trusted.

2. The LGA is an organisation that is run by its members. We are a political organisation because it is our elected representatives from all different political parties that direct the organisation through our boards and panels. However, we always strive to agree a common cross-party position on issues and to speak with one voice on behalf of local government.

3. The LGA covers every part of England and Wales, and includes county and district councils, metropolitan and unitary councils, London boroughs, Welsh unitary councils, fire, police, national park, and passenger transport authorities.

SUMMARY

4. We welcome the cross-government approach to the alcohol strategy and the continued development of tools that councils can use to tackle problems being experienced in their area. We believe that the Alcohol Strategy is a positive step in the right direction.

5. With responsibility for alcohol services moving from the NHS to local government next year, councils will be charged with commissioning not just public health prevention programmes for alcohol misuse but the full range of alcohol services out of the ring-fenced public health budget. We believe successful reform will encourage and enable innovation in healthcare and lead to more positive outcomes for local people.

6. Councils are already working on a daily basis to limit the anti social behaviour resulting from excessive alcohol consumption and remedy the impact it can have on communities. It is critical that councils can benefit from increased flexibility to carry out this role and truly target local problems. We support the recognition within the Strategy of working towards targeted interventions based on local knowledge.

7. We cannot begin to tackle the problems posed by alcohol in our society unless we consider what is happening across a broad spectrum. We have to understand the underlying social and cultural pressures behind inappropriate or excessive consumption.

MINIMUM PRICING

8. Minimum pricing is seen by some as a panacea or magic bullet. We know there is no simple solution to alcohol misuse, but tackling cheap drinks is only one part of the problem. While making alcohol less affordable should be seen as an important tool, it is not the entire toolkit available to tackling binge drinking. Focusing solely on making alcohol less affordable will fail to address the root causes of excessive drinking as well as the anti social behaviour and risks to health it causes.

9. National policies like minimum pricing and banning multi-buy discounts will only go so far in deterring excessive drinking and do not take into account the varying issues in town and city centres across the country. We need to see councils given the powers and flexibility to tackle problems locally.

10. There is some detailed analysis to be done around minimum prices to ensure that it raises the price of alcohol to levels that discourage pre-loading drinking, and excessive consumption of cheap, high-strength drinks, yet does not unfairly penalise families who enjoy a responsible drink or inadvertently generate illicit trade.

PUBLIC HEALTH REFORM

11. However much we might like to think it, the problems of alcohol misuse are not those of a small minority. We should not just be concerned solely with the binge drinking clubbers, pre-loading on a Friday and Saturday night or the street drinker whose life has been destroyed by drink or those with acute cirrhosis caused by years of abuse. There are those young and old alike, who too often drink to excess and a hard core of problem drinkers of all ages, of all social classes throughout our society as a whole. Local authorities have long called for a wide-ranging approach to tackle the root causes of problem drinking.

12. The public health challenges we face have changed considerably since the nineteenth century but local government's role remains pivotal. Over recent years, public health policy and practice have become increasingly medicalised, narrowly targeted and fragmented. Local government is today reasserting its role in improving the health of the public.

13. In the light of new challenges and with the growing recognition of the importance of addressing the social determinants of health, government at all levels has recognised that improving the health and wellbeing of the public is beyond the remit of the NHS alone and firmly within the territory of local government.

14. We support proposals to give accredited hospital staff the power to issue Penalty Notices for Disorder (PNDs) to drunks causing alarm, distress or harassment in hospitals.

15. We support efforts that allow hospitals to share anonymised information on alcohol related assaults and injuries with local partners for use in targeting problem premises.

LICENSING

16. The LGA strongly supports the inclusion of a health objective in the Licensing Act. This approach will provide councils with the ability to consider the health related impacts of alcohol in their area when fulfilling their licensing responsibilities.

17. The Government proposal for a council to declare themselves to be at "saturation" point and refuse all further licence applications will provide an important tool for councils to target local issues. The wording on saturation points will be important because councils and communities will want flexibility to tailor it to local circumstances, rather than having to take an authority wide approach as councils will have to do with the late night levy.

18. The principle behind the introduction of a saturation point is to give councils flexible tools that can be used to target the unique issues in their area. We believe that there is the opportunity to build a wider array of flexible tools for councils to really tackle irresponsible drinking at a local level, such as the ability to restrict advertising and promotional offers in areas with high alcohol consumption.

19. We believe that as the licensing authority, councils should be able to take health related harms into consideration in decisions on Culminative Impact Assessments. This is considered a current gap and could make a significant difference to local wellbeing.

20. The LGA continues to advocate that the bureaucracy of the current licensing system can be reduced to allow councils to support responsible businesses and act more quickly on residents' concerns. This would include being able to refuse permission for a new nightclub or bar on a street that already has a proliferation of them.

21. The LGA supports a Late Night Levy for late night pubs and nightclubs that contributes to reducing the negative impact that late night drinking can have on an area. It is vital that each council decide how their portion of the Levy can be spent to effectively target local issues and work innovatively with partners as problems associated with late night drinking emerge.

RETAILERS AND MANUFACTURERS

22. We support efforts by the retailers and manufacturers to tackle problem drinking through the Responsibility Deal; in particular efforts to improve the labelling of alcohol products such as unit and health information by the end of 2013. We also support efforts by the Government in working with industry and non-governmental organisations to remove a significant number of units (one billion units) of alcohol from the UK market (currently 50 billion) through changes in how alcohol is produced and sold.

Written evidence from Lundbeck (GAS 60)

SUMMARY

- Alcohol is a major health problem; it contributes to 60 types of disease and injury, including 80% of deaths from liver disease and it is the second biggest risk factor for cancer after smoking. Lundbeck therefore proposes that the Department of Health takes central responsibility for Alcohol Strategy and co-ordinates policy across Whitehall.
- There are estimated to be 1.6 million dependent drinkers in England and 2.6 million people drinking twice the recommended limit. Over 10 million adults drink more than the recommended limit.
- Current levels of alcohol consumption will in the longer term contribute to poorer health and greater health inequalities.
- As the number of people being screened for alcohol misuse increases, through measures such as the NHS Health Check, local commissioners will need to ensure that appropriate treatment and support services for alcohol problems are made available. Currently, access to alcohol services is limited, only 1 in 18 (less than 6%) of dependent drinkers receives treatment.
- Tackling alcohol harm will require investment in alcohol services. Alcohol Concern has recommended at least 15% of dependent drinkers should be able to access treatment.
- The Health and Social Care Act reforms to the NHS and public health systems will create a number of challenges and opportunities for producing an integrated approach to the future planning of alcohol services.

1.0 Introduction

1.1 Lundbeck are specialists in psychiatry and pioneers in neurology. Lundbeck is an ethical research-based pharmaceutical company specialising in central nervous system (CNS) disorders, such as depression and anxiety, schizophrenia, Alzheimer's and Parkinson's disease. We also have an interest in alcohol policy.

2.0 *Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role*

2.1 The Government's Alcohol Strategy is a cross-governmental approach to reducing alcohol harm and tackling crime and disorder related to alcohol. The Strategy was launched by the Home Office in April 2012.

2.2 A significant proportion of the policies in the Strategy are Home Office led, such as licensing, irresponsible promotions in pubs and clubs and alcohol minimum pricing. The Strategy also addresses health policy and initiatives for reducing alcohol harm, such as the inclusion of alcohol screening in the NHS Health Check assessments and the new public health responsibilities of local authorities in tackling alcohol misuse. It is clear that alcohol misuse has a significant impact on various public policies, such as policing and advertising—and the Alcohol Strategy reflects this.

2.3 We would propose that the Department of Health, not the Home Office, takes central responsibility for the Alcohol Strategy and co-ordinates policy across Whitehall. The reason for this is that alcohol is a major health problem; it contributes to 60 types of disease and injury, including 80% of deaths from liver disease and it is the second biggest risk factor for cancer after smoking.^{345,346} If the Department of Health led on the Alcohol Strategy it would send a clear signal to the public that alcohol is a significant health problem.

2.4 Furthermore, health interventions, such as alcohol screening and brief advice, have been proven to be effective tools in helping people to reduce their alcohol consumption or abstain from alcohol, preventing the progression and development of alcohol-related health problems, eg liver disease and hypertension. Brief advice on alcohol misuse in primary care leads to one in eight people reducing their drinking to sensible levels, compared to smoking cessation where only one in 12 change their behaviour.³⁴⁵

3.0 *Coordination of policy across the UK with the devolved administrations and the impact of pursuing different approaches to alcohol*

3.1 Lundbeck welcomes a co-ordinated approach to alcohol harm across the devolved administrations.

4.0 *The impact that current levels of alcohol consumption will have on the public's health in the longer term*

4.1 There are estimated to be 1.6 million dependent drinkers in England and 2.6 million people drinking twice the recommended limit. Over 10 million adults drink more than the recommended limit.¹

4.2 Evidence indicates that current levels of alcohol consumption will have a detrimental impact on the long term health of the public. It is predicted that liver disease could overtake stroke and coronary heart disease as

³⁴⁵ Alcohol Concern, *Making alcohol a health priority—Opportunities to reduce alcohol harm and rising costs*, February 2011, available here: <http://www.alcoholconcern.org.uk/assets/files/Publications/2011/Making%20alcohol%20a%20health%20priority-opportunities%20to%20curb%20alcohol%20harm%20and%20reduce%20rising%20costs.pdf>

³⁴⁶ British Liver Trust, *Reducing alcohol harm: recovery and informed choice for those with alcohol-related health problems*, February 2012, available here: <http://www.britishlivertrust.org.uk/home/get-involved/campaigns/tackling-alcohol-misuse.aspx>

a cause of death within the next 10–20 years.³⁴⁷ It has also been predicted that there could be an additional 8,900 deaths from alcohol by 2019 based on current levels of drinking.³⁴⁸

4.3 A substantial range of medical conditions are affected by alcohol use, as the Table 1 in the appendix demonstrates. Evidence also shows the risk of liver disease increases three times if a person drinks three units a day and seven times if a person drinks six units a day.³⁴⁹ The risk of developing hypertension is increased by 26%³⁵⁰ by consuming one drink a day, whilst two drinks a day can increase the risk of developing diabetes by 82%.³⁵¹

4.4 It is also important to note that alcohol misuse is a major contributor to health inequality. In the most deprived areas of the UK, men are five times more likely and women three times more likely to die an alcohol-related death than those in the least deprived areas.³⁵² Alcohol consumption has an inverse social gradient; people with lower socioeconomic status are more likely to have problematic drinking patterns and dependence.³⁵³

4.5 Furthermore, hospital admissions for alcohol-specific conditions are associated with increased levels of deprivation across all regions in England.³⁵³ Thus, current levels of alcohol consumption will in the longer term contribute to poorer health and greater health inequalities.

5.0 *Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services*

5.1 The Alcohol Strategy recognises that there are a significant number of adults drinking over and above the recommended guidelines. It sets out measures to support individuals to change their alcohol consumption through the provision of screening and subsequent brief advice within the NHS Health Check for adults aged 40 to 75 and a review the alcohol guidelines for adults. The Department of Health will also consider the recently published Screening and Intervention Programme for Sensible Drinking (SIPS) research to see if it can support further action by GPs on alcohol misuse via the Quality and Outcomes Framework.

5.2 Lundbeck welcomes the inclusion of these measures in the Alcohol Strategy. Screening and early intervention are vital tools in helping individuals change their behavior, along with identifying those with alcohol dependence.

5.3 Lundbeck's view is that as the number of people being screened for alcohol misuse increases, through measures such as the NHS Health Check, local commissioners will need to ensure that appropriate treatment and support for alcohol problems are made available. Currently, access to alcohol services is limited, only one in 18 (less than 6%) of dependent drinkers receives treatment.³⁴⁷ Over 70% of GPs said there was a shortage of detoxification and rehabilitation services.³⁴⁷ Tackling alcohol harm will require investment in alcohol services. Alcohol Concern has recommended at least 15% of dependent drinkers should be able to access treatment.³⁴⁷ Furthermore, alcohol interventions have been proven to be cost-effective; screening and brief interventions in general practice will save £58,000 for every 1,000 patients screened.³⁴⁷

6.0 *Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm*

6.1 The Health and Social Care Act reforms to the NHS and public health systems will create a number of challenges and opportunities for producing an integrated approach to the future planning of alcohol services.

6.2 Firstly, the coordinated approach in the NHS and Public Health Outcomes Framework and the Commissioning Outcomes Framework on alcohol misuse provides an incentive to integrate the commissioning of alcohol services. The frameworks include indicators on alcohol-related hospital admissions and the under 75 mortality rate from liver disease, and will therefore require local authorities, clinical commissioning groups (CCGs) and the NHS Commissioning Board to focus on reducing alcohol harm. However, a coordinated approach also raises the question of who is ultimately responsible for reducing alcohol harm—is it local authorities, the NHS Commissioning Board or CCGs?

6.3 Secondly, the Health and Social Care Act will entail the fragmentation of commissioning and funding arrangements for alcohol services. Directors of Public Health in local authorities will become responsible for commissioning of alcohol services from their public health budgets. CCGs will provide treatment for the physical complications of alcohol misuse, such as liver or kidney disease. As well as potentially being

³⁴⁷ Alcohol Concern, *Making alcohol a health priority—Opportunities to reduce alcohol harm and rising costs*, February 2011, available here: <http://www.alcoholconcern.org.uk/assets/files/Publications/2011/Making%20alcohol%20a%20health%20priority-opportunities%20to%20curb%20alcohol%20harms%20and%20reduce%20rising%20costs.pdf>

³⁴⁸ Sheron N, Gilmore I & Hawkey C (2011), *Projections of alcohol deaths—a wake up call*, *The Lancet*, Vol 377: 1297–99

³⁴⁹ 2020Health, *From one too many*, October 2011, available here: <http://www.2020health.org/2020health/Publication/Wellbeing-and-Public-Health/From-one-to-many.html>

³⁵⁰ Sesso H D, Cook N R, Buring J E *et al* (2008). *Alcohol consumption and the risk of hypertension in men and women: Hypertension* 51: 1080–1087

³⁵¹ Kao W H, Puddey I B, Bland L L, Watson R L, Bracanti F L (2001). *Alcohol consumption and the risk of type 2 diabetes mellitus: atherosclerosis risk in communities study: AM J Epidemiol* 154: 748–57

³⁵² House of Commons Health Select Committee, *Alcohol: First Report of Session 2009–10*, 2009

³⁵³ The Marmot Review, *Fair Society, Health Lives: Strategic Review of Health Inequalities in England*, 2010

commissioned by Directors of Public Health to under additional activities on alcohol misuse. At the same time, Public Health England will take responsibility for national awareness campaigns and building up an evidence base on public health interventions. There is a real risk that the involvement of these different bodies in alcohol services could result in an uncoordinated approach, with some services or patients with alcohol misuse or dependence falling through the gaps.

6.4 Furthermore, multiple commissioners and bodies in the area of alcohol misuse may lead to uncertainty as to who is responsible for commissioning a service. For example, with Directors of Public Health responsible for public health budgets, clinical commissioning groups may take the view that Directors of Public Health are responsible for alcohol services, and that they do not require to take action on alcohol misuse. However, it is vital that GPs also invest resources and time in identifying and treating alcohol problems.

6.5 Thirdly, it will be the role of Health and Wellbeing Boards to ensure to integration across public health services and the local NHS services, based on local health needs established in the Joint Strategic Needs Assessment. However, a number of challenges have been identified with Health and Wellbeing Boards. The Kings Fund has found that board members will need time and resources to develop their skills to effectively fulfill their function.³⁵⁴ Additionally, there will be considerable variations in the remit of the Boards, as local authorities will have discretion over setting up the Boards.³⁵⁵

6.6 Finally, an estimated 85% of people with alcohol dependence also have a mental health problem, known as a dual diagnosis.³⁵⁶ Heavy drinkers may also misuse illegal drugs.³⁵⁵ Therefore it is vital that the Government's alcohol and drug strategies are coordinated to ensure a coherent approach to all people with alcohol misuse and dependence problems. Local commissioners also need to work with alcohol, drug and mental health services to ensure services provide an appropriate and coherent care pathway to meet the needs of local people.

May 2012

APPENDIX

Table 1

ALCOHOL USE AND PHYSICAL COMPLICATIONS

Gastrointestinal	Liver disease, including alcohol-related fatty liver, alcoholic hepatitis, alcohol-related cirrhosis and multiple complications of cirrhosis and portal hypertension Liver cell cancer—hepatocellular carcinoma Parotid enlargement Gastro-oesophageal reflux Peptic ulcer, gastritis, duodenitis Oesophageal rupture from violent vomiting bouts Small bowel damage leading to malabsorption Altered bowel habit with diarrhoea predominating
Cardiovascular	Hypertension High output cardiac failure Acute rhythm disturbances in alcohol intoxication Coronary artery disease
Neurological	Cortical atrophy Cerebellar damage (midline structures maximally affected) Peripheral neuropathy Autonomic neuropathy Wernicke's encephalopathy Wernicke-Korsakoff syndrome Central pontine myelinolysis Marchiafava-Bignami syndrome Myopathy Cerebrovascular accidents Withdrawal delirium and neuronal damage
Musculoskeletal	Rhabdomyolysis Compartment syndromes Gout Osteopaenia Osteonecrosis

³⁵⁴ Kings Fund, *Health and Wellbeing Boards: Systems leaders or talking shops?*, April 2012, available here: <http://www.kingsfund.org.uk/publications/hwbs.html>

³⁵⁵ Institute of Alcohol Studies, *Alcohol and Mental Health: IAS Factsheet*, available here: <http://www.ias.org.uk/resources/factsheets/mentalhealth.pdf>

³⁵⁶ Farrell M & Marshall E J, *Organisation and delivery of treatment services for dual diagnosis*, *Psychiatry*, 2006 6:1:34–36

Hematological	Thrombocytopenia from bone marrow suppression Pancytopenia from hypersplenism Haemolytic anaemia with advanced liver disease—spur cell anaemia Macrocytic anaemia Folate and B12 deficiency anaemias Coagulopathies from liver disease
Immunological	Impaired B and T cell function mediated by alcohol toxicity Autoimmune phenomena triggered by acetaldehyde adducts acting as immunogenic targets IgA nephropathy
Respiratory	Increased predisposition to respiratory infection TB as a common infection Aspiration pneumonia Sleep apnoea
Endocrine	Syndrome of inappropriate antidiuretic hormone secretion (SIADH) Altered thyroid function Altered oestrogen metabolism associated with liver damage Masculinisation in women Pseudo Cushing's disease Altered calcium and bone metabolism Hypoglycaemia Aggravation of diabetes mellitus Ketoacidosis Hypertriglyceridaemia Testicular atrophy Hypoparathyroidism
Renal	IgA nephropathy
Infectious diseases	Hepatitis C virus Pneumonia Tuberculosis Sexually transmitted diseases
Nutritional disorders	Vitamin and mineral deficiencies; B1, B6, riboflavin, niacin, calcium, phosphate, zinc, magnesium Protein calorie malnutrition
Alcohol and malignancy	The risk of developing certain malignancies increases from base risk levels with any alcohol consumption. These include breast, oropharyngeal and oesophageal cancers. Other malignancies such as colon, pancreatic, hepatic and ovarian are more prevalent in those drinking more than 40 gm per day.

Source: Australian Government Department of Health and Ageing (2009): Guidelines for the Treatment of Alcohol Problems, p146–147

Written evidence from The Alcohol Harm Reduction Group in County Durham and the Alcohol Strategy Implementation Group in Darlington (GAS 61)

1. *Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role*

1.1 The strategy published by the Home Office, whilst encompassing the broad range of issues, is light on detail. In particular there is no indication of financial commitment, targets and outcomes to tackle alcohol related harm.

1.2 The strategy does not achieve an even balance between prevention, treatment and disorder. Instead the emphasis is on the last of these.

1.3 The document perpetuates the tabloid beliefs that any alcohol problems we have are firmly the result of young people binge drinking and those who make unacceptable choices either by being ignorant or irresponsible. It does not reflect that we have significant numbers in the population who are drinking at increasing and higher risk levels which impacts on wide range of health and social problems.

1.4 The ownership by the DH appears to be small. Whilst we welcome support for Identification and Brief Advice (IBA) and Alcohol Liaison Nurses in hospitals, this does not go far enough. We welcome the need for IBA to be included in the QOF for GPs, though this needs to be actioned imminently in order to prevent further harm. Investment is required across all four tiers of the treatment pathway for both offenders and non-offenders, recovery/aftercare and support for families. Our concern continues to be the lack of identifiable funding available to address the range of problems beyond anti-social behaviour.

2. Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol

2.1 We agree that alcohol policy ought to be coordinated across the UK. Work across the north east through our Balance office already ensures that our neighbours share sound evidence based practice. We believe however that the level at which minimum unit price (MUP) is set should be coordinated across the jurisdictions.

3. The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group

3.1 The Alcohol Harm Reduction Group (in the case of County Durham) and the Alcohol Strategy Implementation Group (in the case of Darlington) welcomes the strategy's indication that the alcohol industry needs to do more. However we think that there is a significant conflict of interest when businesses which have an obligation to increase profits for shareholders are involved in shaping public health policy.

3.2 Current responsibility deals have indicated to us that the alcohol industry will not deliver the changes needed unless those changes are supported by legislation. The conflict arises when the alcohol industry's outcome to maximise sales is put against the need to reduce the amount of alcohol consumed at a population level.

3.3 We are concerned that the strategy reinforces this conflict and seems to rely on organisations which are totally funded by the alcohol industry eg the Portman Group.

4. The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing

4.1 The Alcohol Harm Reduction Group (Co Durham) and the Alcohol Implementation Strategy Group (Darlington) supports a minimum price per unit to address the problem of the affordability of alcohol. Evidence from the Sheffield study indicates that the introduction of minimum price would reduce consumption amongst harmful drinkers and young drinkers and at the same time have a minimal effect on those drinking within the recommended guidelines.

4.2 We welcome the commitment to the introduction of a minimum unit price for alcohol. However, we accept the view of many independent experts including the view of the BMA and believe that the proposed 40p per unit level would be ineffective. Our view would be the minimum unit price should be set at 50p and reviewed regularly.

4.3 Our worst case scenario would be if MUP created additional profit for the alcohol industry that was then ploughed back into increasing the sophistication of alcohol marketing. We would like to see how the government would address this issue, including increasing taxation.

4.4 The introduction of a MUP at 50p would have the advantage of better management of alcohol pricing between on and off licence premises, protect small businesses, including the community pub, as well as tackle the issue of pre-loading.

5. The effects of marketing on alcohol consumption, particularly in relation to children and young people

5.1 The Alcohol Harm Reduction Group (Co Durham) and the Alcohol Strategy Implementation Group (Darlington) welcomes the strategy's recognition of the role played by alcohol advertising and marketing which impacts on young people. It is widely known that market research data on 15–16 year olds is used to guide campaign development and many marketing documents make reference to the need to recruit new drinkers. Additionally girls and boys are bombarded by messages that build and reinforce positive associations between drinking and sex. Because most adverts are aimed at young men, women are generally portrayed within limiting gender stereotypes. Researchers have raised concerns about the way in which sexist concepts are being heavily promoted through advertising to young consumers. The danger is twofold—promoting young people to drink more and demeaning women or implying the promise of sex.

5.2 Music and sport sponsorship by the alcohol industry is not specifically included in any advertising code, though clearly has enormous impact—again this needs to be reviewed.

5.3 We also welcome work to develop an effective online age verification system to prevent alcohol advertising and marketing activity being presented to young people on line.

5.4 We continue to be concerned that alcohol advertising is not fully addressed in the strategy and continues to rely on the industry's self regulation. We would prefer to see a more rigorous approach taken as, for example, in France, where alcohol promotion is restricted to media only accessed by adults.

6. The impact that current levels of alcohol consumption will have on the public's health in the longer term

6.1 Evidence which indicates the impact on public health of the current levels of alcohol consumption paint a concerning picture, especially when the impact is matched against the need for service provision. Over the

period 2002–03 to 2009–10 there have been admission rate increases of 121% in Darlington and 135% in County Durham.

6.2 The Office of National Statistics estimated that in the UK there were 8,664 alcohol-related deaths in 2009, which is more than double the 4,023 recorded during 1992.

6.3 In its publication *Reducing Alcohol Harm*, the British Liver Trust states that “the challenge of alcohol misuse is reaching epidemic proportions in the United Kingdom; with the average intake of alcohol rising steadily, NHS admissions from alcohol increasing” and cites research that suggests the current death toll from alcohol is equivalent to “a jumbo jet crashing every 17 days”.

6.4 It is estimated that 80% of liver disease is directly related to alcohol and possibly around a quarter of the total attributable mortality. Liver disease is the fifth most common cause of death in England. However, the British Liver Trust warns that this prevalence is growing and “mortality from liver disease could overtake stroke and coronary heart disease as a cause of death within 10 to 20 years”.

6.5 The British Liver Trust states that “there is unequivocal evidence of a relationship between alcohol consumption and liver disease” and goes on to suggest that “liver death rates offer a good measure for the success of any alcohol policy”.

7. Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services

7.1 County Durham PCT secured nearly £3 million for alcohol prevention and treatment services over the past four years and Darlington secured nearly £600k. With the move of Public Health to Local Authorities there is a concern that the commissioning of alcohol services is not a mandated, but a discretionary, service. We believe this needs to change. Additionally, the current investment levels need to be maintained and increased over time as the demand also increases.

7.2 There has been an indication that substance misuse services should be jointly provided in future. Whilst this may create efficiencies and provide some resilience for small areas where resources are limited, we believe there needs to be further work to understand the different population group accessing treatment. For example, in County Durham the dedicated alcohol treatment service has 83% of clients with alcohol-only issues.

7.3 As CCGs will be commissioning hospital-based services, there needs to be a clear directive that they should work with Local Authorities to commission across the full treatment pathway rather than expect Local Authorities to fund all activity.

8. Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm

8.1 The proposed health reforms include the responsibility for alcohol services moving from NHS to local government. Our current configuration to address alcohol harm already works across the services division. We expect that this opportunity will continue to allow us to develop robust alcohol harm reduction programmes across all sectors.

9. International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking, such as:

9.1 Public health interventions such as education and information:

- (a) The cross-cutting approaches in the strategy are welcomed to address alcohol harm. However, whilst we value the provision of education and information, we believe that alcohol campaigns can only be effective when they are a part of wider programmes, as they have been in our social norms work.
- (b) In County Durham and Darlington our local approach to alcohol misuse prevention appears to be working. We have worked closely with local secondary schools over the past four years to develop a “social norms” based approach, which uses information from our Healthy Behaviours Survey (last year 77% of pupils from secondary schools involved in the scheme took part).
- (c) Results from this work show year-on-year reductions in reported levels of alcohol use, as well as evidence of helping young people to understand that drinking is not as common as they thought. High profile local communications campaigns based on the positive social norm messages have been an important component of this work, as well as clear links to PSHE education delivery.
- (d) This strategy emphasises the responsibility of the NHS to address alcohol use during patient contacts. Positive social norm messages can be used to support this as part of a multi-agency approach to early intervention. We are looking to expand our social norms work to include primary schools, further education settings and major employers as part of a partnership approach to addressing alcohol misuse.

- (e) The work also provides considerable intelligence to complement local needs assessment work. Undoing the perceived normalisation of young people's alcohol misuse is one of our biggest challenges. Greater emphasis could be placed on this in the proposed strategy.

9.2 Reducing the strength of alcoholic beverages:

Steps to reducing the strength of alcoholic drinks, and labelling alcoholic beverages to warn of the harm of excess drinking are welcomed, but we question whether they should be left in the hands of the alcohol industry.

9.3 Raising the legal drinking age:

While we recognise the emerging evidence that alcohol can damage the developing brain until the early twenties, we believe that further work is required to educate the public about the dangers of alcohol to young people before such measures are considered.

9.4 Plain packaging and marketing bans:

We would welcome any additional research that shows young people are drawn to brands with eye-catching packaging. Studies show that the younger people start drinking, the more likely they are to develop alcohol problems later in life. However, we believe that this, whilst important, is only one dimension in advertising, and future measures ought to include advertising restrictions including no advertising before the 9pm watershed. We also believe that any advertising should not be associated with glamorous life style choices.

We would stress the importance of acknowledging and implementing what we already know to work. The World Health Organisation (WHO) recommend: "Increasing the price of alcoholic beverages is one of the *most effective interventions to reduce harmful use of alcohol.*" The policy recommends raising taxes on alcohol, prohibiting promotional pricing and establishing minimum prices for alcoholic beverages.

May 2012

Written evidence from the London Health Improvement Board (GAS 63)

- This submission provides the Commons Health Committee with information about the London Health Improvement Board's (LHIB) work on alcohol.
- While it does not seek to address specifically all the issues raised with the terms of reference and call for evidence, we do believe that the work of the LHIB around alcohol will be of interest, in particular the evidence base it has identified as well as its ongoing work.

THE LONDON HEALTH IMPROVEMENT BOARD—AN INTRODUCTION

1. The LHIB has been initially established in shadow form pending legislation required to put it on a statutory footing. The proposal to establish the LHIB in shadow form was agreed by the Secretary of State in March 2011 following approaches from the Mayor of London and London Councils. Shadow status does not mean that the board is inactive: agreed methods of operating are already underway and the programme has been allocated a budget from April 2012–13 of up to £2 million from the NHS.

2. The LHIB has identified four initial objectives representing major health problems in the capital; cancer, childhood obesity, data transparency and *alcohol abuse*. These will be addressed by adopting a strategic pan-London view.

3. The Board is chaired by the Mayor of London. Membership is listed in the appendix.

4. While awaiting statutory footing, the membership of the LHIB brings together the Greater London Authority (GLA), London Councils and the NHS. The LHIB and its partners will work closely with colleagues in allied areas such as criminal justice to ensure the most effective responses to the multi-faceted problems associated with alcohol use. All LHIB papers (including references for all data quoted) are available at <http://www.lhib.org.uk/>

THE IMPACT OF ALCOHOL IN LONDON

5. The harmful use of alcohol by a large number of Londoners has a significant adverse impact on a range of health, social, and business outcomes. It is recognised however that many Londoners do not use alcohol, and many who do, use it in ways that pose few risks. Alcohol also provides social and economic benefits for Londoners.

6. The Department of Health estimates that 2.4 million Londoners drink alcohol at harmful and hazardous levels. A further 280,000 are dependent on alcohol. In terms of those for whom alcohol is the most harmful, it is estimated that 400,000 people in London drink 50 units of alcohol or more per week and have an even greater chance of developing serious health problems. (Health guidelines suggest a maximum of three to four units of alcohol a day for men and two to three units a day for women, with one alcohol free day per week,

so 50 units represents over twice the recommended levels). Using national data it is estimated that approximately 280,000 Londoners are dependent on alcohol in order to function in their daily life.

7. Trends relating to alcohol harm have been increasing. In the UK consumption was recorded as 9.4 litres in 2004 pure alcohol per capita per year, in 2011 the recorded adult per capita consumption is around 11.7 litres per capita per year. This correlates to additional demands on health and other resources and in some areas, such as alcohol related A&E attendances and crime; the level is so high that a continuing upward trend would be difficult to sustain.

HEALTH IMPACTS

8. On average, 1,800 people die in London as a direct result of alcohol use per year, with many more suffering ill-health where alcohol is a contributory factor. This rate is increasing.

9. In 2007–08, 1.4% of Londoners were admitted to hospital due to alcohol, with research suggesting this represents under-reporting. In 2009–10, 127,509 individuals or 1.65% of Londoners were admitted into London hospitals as a result of alcohol related harm. Of these admissions one in four were admitted for a wholly attributable (alcohol) condition such as alcoholic liver disease, or severe intoxication. Of major concern is the fact this is a 124% increase from the number of admissions in 2003.

10. Furthermore, rises in death rates from chronic liver disease and cirrhosis have occurred in most age groups in England. In 45–54 year olds, there has been a greater than four-fold increase amongst men since the early 1970s and a three-fold increase in women. In 35–44 year olds, the rise has been even larger: an eight-fold increase in men and approaching a seven-fold increase in women. Analysis of Government data by the British Liver Trust noted a 35% increase in under 35s dying from alcoholic liver disease between 2004 and 2008, and that liver disease was the only major disease in Britain to show a year on year increase since 1970.

11. In Britain, alcohol causes about 6,000 cancers of the mouth, food pipe, voice-box and pharynx—the area at the back of the mouth and top of the throat—3,000 bowel cancers and 2,500 breast cancers. Most of these cases were caused by people drinking more than the recommended daily limits for alcohol, although even drinking small amounts added to the risk of some cancers developing.

12. In London, it is estimated that alcohol related harm accounts for 35% of all A&E attendances, and up to 70% of all attendances at the peak times of midnight to 5am on the weekend. In 2009–10, the London Ambulance service received 60,686 emergency calls because somebody had too much to drink—the equivalent to one call every eight and a half minutes.

13. The impact of alcohol on mental health is significant. It is estimated that in 65% of suicides in the UK, alcohol intoxication plays a part. Alcohol consumption is also strongly linked to self-harm, Scottish research showed it was a factor in 62% of males and 50% of females attending hospital with self-harm injuries.

SOCIAL ISSUES AND CRIMINAL JUSTICE

14. Alcohol is strongly linked with a wide range of criminal offences including drink driving, being drunk and disorderly, criminal damage, assaults, domestic violence, and other public disorder offences. According to data produced by the North West Health Observatory, in London the rates of alcohol attributable recorded crimes, violent crimes and sexual violence are all significantly higher than the English average. According to the 2009–10 British Crime Survey, 50% of victims in violent incidents believed that perpetrators were under the influence of alcohol. The same survey also indicates that each year approximately 54,000 Londoner's are victims of alcohol related domestic violence (where physical injury occurred).

PUBLIC EXPERIENCE, AND ATTITUDES AND WILLINGNESS TO CHANGE

15. More Londoners felt that “people being rowdy or drunk in public places” was a problem in their area than the national average (38% compared to 31% across England and Wales).

16. In March 2011, a survey of 7,500 Londoners conducted by the Greater London Authority and Regional Public Health Group, gathered information about Londoners' relationship with alcohol. The topline results of the survey were:

- 72% of Londoners are concerned by alcohol related crime and violence.
- 51% of Londoners think that if they were given more community power to make decisions over licensing the problems associated with alcohol would improve.
- 48% of Londoners are concerned about their long term alcohol related health issues.
- 31% of Londoners feel that there are too many places in their local area where alcohol can be purchased.
- 52% of Londoners think that employers should have a role in advising employees on alcohol consumption.

CHILDREN AND YOUNG PEOPLE

17. In England, between 780,000 and 1.3 million children are affected by parental alcohol problems. A joint Alcohol Concern and The Children's Society report in 2010 estimated that 2.6 million children live with a parent whose drinking puts them at risk of neglect, and 705,000 live with a dependent drinker. The two charities argued for a national inquiry into the scale of harm and impact on society and for improved resources to protect children.

18. The report highlighted the following:

- In a study of four London boroughs, almost two thirds (62%) of all children subject to care proceedings had parents who misused substances.
- More than 100 children, including children as young as five, contact ChildLine every week with worries about their parent's drinking or drug use.
- There is evidence of parental substance misuse in 57% of serious case reviews (of serious or fatal child abuse). Since there is currently no routine screening by children and families services for parental alcohol misuse, this is likely to be an underestimate.
- Alcohol plays a part in 25–33% of known cases of child abuse.
- In a study of young offending cases where the young person was also misusing alcohol, 78% had a history of parental alcohol abuse or domestic abuse within the family.

19. Heavy binge drinking by adolescents and young adults is associated with increased long-term risk for heart disease, high blood pressure, type 2 diabetes, and other metabolic disorders. A UK study found that binge drinking in adolescence was associated with increased risk of health, social, educational and economic adversity continuing into later adult life. The problems included increased risk of alcohol dependence and harmful drinking in adulthood, illicit drug use, poorer educational outcomes, criminal convictions and lower socioeconomic status. In particular:

- Young binge drinkers are almost three times more likely to self-report committing an offence than those who drink but do not normally get drunk, and five times more likely than non-drinkers of the same age.
- The differences are particularly marked for violent offences. Forty per cent of 13 and 14 year olds reported being "drunk or stoned" when they experienced first sexual intercourse. After binge drinking, one in seven 16–24 year olds have had unprotected sex, one in five have had sex they later regretted and one in ten have been unable to remember if they had sex the night before.

IMPACT ON INEQUALITIES

20. Although alcohol related harm is felt across the socio-economic spectrum in London, it is also linked to significant health and social inequalities. While lower socio-economic groups consume lower levels of alcohol, if they do consume, they are more likely to be exposed to the harmful impacts of alcohol due to having limited protective factors. Alcohol related hospital admissions tend to be higher in areas of deprivation in London. Certain socially and economically deprived groups also suffer disproportionate harm from alcohol. In particular rough sleepers suffer significant harm from alcohol use and are overrepresented in repeat attendances at A&E, repeat admissions and ambulance call outs.

THE ECONOMIC IMPACT

21. As a consequence of its health and social impacts, however, alcohol misuse costs approximately £2.46 billion to deal with in London:

- £405 million to the NHS.
- £825 million as a result of crime and disorder to the police and local government.
- £960 million in lost productivity to employers.
- £270 million to the wider community.

22. There is an economic benefit from the sale and service of alcohol in London. For example, 1.5% of employees in London work in licensed premises; with many other employees working in associated and ancillary areas. Town centre activity at night provides economic benefits for many boroughs.

23. However, there is evidence (eg London Drink Debate) that many people do not use town centres at night due to the fear of crime and anti-social behaviour. Apart from the impact this has on the general well-being of local communities, it is likely that greater economic benefits for particular areas may come from more people visiting restaurants, theatres and other amenities if alcohol related problems were tackled.

24. Alcohol use also has a major impact on the workplace and therefore creates costs for business. Direct effects include impaired on-the-job performance due to intoxication or withdrawal symptoms, while the indirect consequences include increased absenteeism and impaired performance due to the psychological effects of alcohol abuse. In London, approximately £20 million is spent on supporting individuals who are claiming

incapacity benefits because of alcoholism. The FreshStart alcohol clinic in Wandsworth recorded a rate of absenteeism from employment for their patients of 19.2 days a year (approximately double the national average).

25. It is important to keep in mind that the costs outlined above are likely to be higher in the future as a result of the increasing trend in alcohol misuse.

IMPACT ON LOCAL AUTHORITIES

26. In 2010–11, almost all London boroughs identified alcohol as an issue that needed to be addressed in their Joint Strategic Needs Assessments. The need to address alcohol related harm was mirrored by Primary Care Trusts in their 2010–11 Commissioning Strategy Plans.

27. Misuse of alcohol puts pressure on social care through the effects of drinking on individuals and families. Costs of child social work associated with parental alcohol misuse were estimated in Leeds in 2008–09 to be between £15.7 million and £38 million. There is no detailed research on the costs to adult social care applicable to London.

28. The cost and burden of alcohol related harm to local authorities cuts across most areas of their responsibility, and with the transfer of public health this will add another responsibility where alcohol harm will require action. The costs are often linked across areas of responsibility; for example an individual requiring housing, adult social care and child safeguarding as a result of their problematic alcohol use.

GLOBAL, NATIONAL AND LONDON COMPARISONS

29. Compared to other English speaking countries Britain has high annual consumption of alcohol, the equivalent of 13.4 litres of pure alcohol per person per annum (Australia 10 litres), New Zealand (9.6 litres), and the US (9.4 litres). The UK also has higher rates of consumption than that of the European average (9.24 litres per person of pure alcohol). Historically, the UK was a relatively moderate consumer compared with other Western European countries. In recent years this has changed and the UK is now one of the heaviest alcohol consuming countries in the world. Liver cirrhosis is often regarded as a proxy for the health damage caused by long-term excessive drinking. In England, liver cirrhosis mortality approximately trebled between 1970 and 1998 and currently rates in the UK are the highest in Western Europe. Compared to the rest of England, London has lower rates of alcohol related health harms, but tends to have a higher level of alcohol related violence, particularly sexual violence.

EFFECTIVE ACTIONS

30. This section outlines the evidence base for effective action.

31. The World Health Organisation has published a meta-analysis of the evidence relating to effectiveness of policies that reduce alcohol related harm. The study showed that a convincing amount of evidence existed in support of the following policy interventions:

- *Increasing the cost of alcohol*: international evidence shows that increasing the cost of alcohol has a population level impact reducing alcohol related harm.
- *Restrictions on outlet density*: evidence from Australia and New Zealand demonstrates that reducing alcohol outlet density can have an impact on reducing violence and problem drinking.
- *Restrictions on days and hours of sale*: has been shown to reduce population level harm.
- *Lower legal blood alcohol levels for driving*: reductions in alcohol related traffic deaths have been recorded across most western nations as a result of reduced blood alcohol levels and effective enforcement of these.
- *Identification and Brief Advice programmes (IBA, providing an audit of a person's drinking and providing a brief intervention if required)*: UK research has demonstrated that one in eight people who drink hazardously reduce their drinking as a result of undergoing IBA. It is also an effective screening tool for more intensive interventions for dependent and high-risk drinkers.
- *Treatment for alcohol use disorders*: addressing dependence and problematic drinking through specialist treatment increases the likelihood that these drinkers will abstain or reduce their drinking, and therefore reduce the harm they suffer.

32. Media campaigns were not supported as an effective policy intervention due to low evaluation of successful outcomes for these programmes. This evidence has been tested for consistency against a number of studies, efficacy of research and cross-cultural applicability.

LHIB ALCOHOL RELATED ACTIVITIES FOR 2012

33. Taking account of the evidence base available and the resources it has the London Health Improvement Board is focussing on the enforcement of licensing laws, application of IBA and continued provision of treatment services as the most effective ways of reducing alcohol related harm in the capital. The work is

underpinned by a team which brings together expertise and support from regional public health, boroughs, the GLA and other key agencies. The following are the key actions being undertaken in 2012:

- *Developing a London vision*: working with stakeholders to ensure support and aligning actions with key partners
- *Responsible supply*: supporting London Councils and licensing to develop a compendium of licensing best practice and support best practice implementation. Work to develop a best practice scheme for off-licence sales. Develop a cost benefit analysis tool on the night time economy. Engage with businesses to improve responsibility training. Look to expand and build upon existing schemes (Best Bar None, Purple Flag).
- *Early interventions*: maintain and develop the delivery of Identification and Brief Advice programmes. Support the development of early interventions in the criminal justice sector and work with the Mayor's Office for Policing and Crime on delivering sobriety schemes.

May 2012

APPENDIX

MEMBERSHIP OF THE LONDON HEALTH IMPROVEMENT BOARD

The Mayor of London, Boris Johnson—Chair

Cllr Teresa O'Neill, Leader—London Borough of Bexley

Cllr Julian Bell, Leader—London Borough of Ealing

Cllr Derek Osbourne, Leader—Royal Borough of Kingston Upon Thames

Cllr Liam Smith, Leader—London Borough of Barking and Dagenham

Dame Ruth Carnall, Chief Executive—NHS London

Alwen Williams, Inner North East London Cluster Chief Executive

Dr Howard Freeman, GP and chair of London GP Council

Prof David Fish, Managing Director of UCL Partners

Dr Simon Tanner, Regional Director for Public Health in London and statutory health advisor to the Mayor

Written evidence from the NHS Confederation (GAS 64)

EXECUTIVE SUMMARY

- The NHS Confederation represents all organisations that commission and provide NHS services. It is the only membership body to bring together and speak on behalf of the whole of the NHS. While we recognise the range of actions proposed across government in the alcohol strategy, our submission focuses on the area where we have expertise, the health service.
- Alcohol abuse is putting a growing strain on our health services. Alcohol related admissions to hospitals more than doubled between 2002–03 and 2009–10. The burden on the NHS will be unsustainable if demand continues to grow.
- Improvements to public health and NHS services must be made in conjunction with cross government action if we are to effectively tackle the impact on our health of the way in which we consume alcohol. We therefore welcome the Government's efforts in the alcohol strategy to provide additional powers to health trusts and local authorities to work together to reduce alcohol harm.
- Our submission outlines examples of successful NHS led initiatives, on both a local and regional level. However, the fact that only one in 18 people who are dependent on alcohol receives treatment shows there is scope for further improvement. This will require further action from central and local government as well as the NHS. The NHS Confederation makes the following recommendations to help address this issue:
 - GPs, community providers, mental health services and ambulance trusts can all play a greater role in tackling alcohol abuse.
 - Mechanisms for offering financial incentives to NHS providers for their prevention and health promotion activities should be considered. The current tariff system of paying for many services effectively penalises rather than rewards preventative, demand-reducing work. Furthermore, the pressure to meet rapidly increasing demand from drinkers who urgently need services in a crisis makes it difficult for preventative work to keep pace.
 - The NHS needs to maximise the opportunities healthcare professionals have with individuals and communities to improve their health and well-being (the so-called "every contact counts" approach). We recommend that:

- National bodies' contracts should be reviewed to ensure they support the delivery of the every contact counts approach.
- Commissioners should similarly consider how their service specifications in providers' contracts support this approach.
- The NHS should also develop services which help individuals with an alcohol related disease to understand the root causes of their condition in order to tackle it more effectively.
- Local authorities must have enough money to commission and deliver public health services, including alcohol services.
- Health and wellbeing boards should coordinate work to tackle alcohol abuse at a local level, to make the most of the resources and expertise across the whole range of organisations, funding, commissioning and delivering this. In doing so, they should engage with Police and Crime Commissioners and academy schools, as neither are represented on health and wellbeing boards.
- Local coordination and clear accountabilities for both commissioning services and achieving outcomes are important in preventing fragmentation of support for young people and children, given arrangements for commissioning their services will be even more complex in the new system.
- Public Health England and the NHS Commissioning Board should lead on providing the support and advice that local areas will need to develop cost effective and best practice based plans for tackling alcohol abuse.
- To assist health and wellbeing boards in their role coordinating joint work on alcohol harm reduction, we would like the Government to articulate how taken together outcome framework indicators could be used to encourage more preventative work.

1. *The impact of alcohol abuse on the NHS*

1.1 The increase in alcohol abuse in the UK has resulted in an increased demand for NHS services. It was already costing the NHS £2.7 billion a year in 2006/07 (the most recent year for which figures are available)³⁵⁷ and demand has increased significantly since then. For example, alcohol related admissions to hospital more than doubled between 2002–03 and 2009–10, from 510,200 to 1,057,000.³⁵⁸ Difficulties in recording alcohol-related harm mean that the impact is likely to be even higher. The burden on the NHS will be unsustainable if demand continues to grow.

1.2 With the pressure to react to a growing number of urgent needs, preventative and specialist services have struggled to keep pace with alcohol driven demand and hospitals have been bearing the brunt of the burden. In 2008 over 70% of the cost of alcohol to the NHS was spent on hospital treatment.³⁵⁹ Inpatient costs were almost 45% of the total NHS expenditure in alcohol related services that year compared to around 12% in 2001.³⁶⁰

1.3 Other NHS services are also experiencing rising demand as a result of alcohol abuse. For example, a third of mental health service users have alcohol problems.³⁶¹ Furthermore, over six% of calls to London ambulance services are alcohol related incidents. This is approximately 68,792 calls a year.³⁶² Since the ambulance crews only record the illness and not the cause of the illness, the actual figure is likely to be much higher. This adds to growing pressures; the overall number of calls handled by the ambulance service nearly doubled between 2000–1 to 2010–11, from 4.41 million to 8.05 million.³⁶³

2. *How the NHS is tackling alcohol abuse*

2.1 Our report *Too much of the hard stuff: what alcohol costs the NHS*³⁶⁴ sets out a number of initiatives our members have implemented to tackle alcohol abuse and decrease the impact this problem has on NHS services. This includes the Royal Bolton Hospital which established a specific alcohol team overseeing both inpatient and outpatient care, with patients being seen in a specialist clinic. The team saved the trust over 1,000 bed days a year by ensuring that patients who previously would have received inpatient treatment were given rapid outpatient appointments with the community alcohol team. This meant a saving to the trust of approximately £250, 000³⁶⁵ over one year.

³⁵⁷ NHS Information Centre (2011). *Alcohol statistics*

³⁵⁸ Ibid

³⁵⁹ Public Accounts Committee (2009). *Reducing alcohol harm: health services in England for alcohol misuse*

³⁶⁰ Royal College of Physicians (2001). *Alcohol, can the NHS afford it? A report of a working part of the Royal College of Physicians*

³⁶¹ Organisation for Economic Cooperation and Development (2009). *Health Data*

³⁶² London Ambulance Service figures (2011), http://www.londonambulance.nhs.uk/news/alcohol-related_calls.aspx

³⁶³ NHS Information Centre, *Ambulance service England statistics 2010–11*

³⁶⁴ <http://www.nhsconfed.org/Publications/briefings/Pages/What-alcohol-costs-the-NHS.aspx> (NHS Confederation, 2010)

³⁶⁵ The NHS Institute estimates the cost of £250 per bed day. 1,000 bed days saved x £250 per bed day = £250,000. [http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/Return_on_Investment_\(ROI\)_calculator.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/Return_on_Investment_(ROI)_calculator.html)

2.2 NHS North West has established a large scale project to target alcohol abuse and reduce alcohol related hospital admissions. The project has resulted in greater partnership working between agencies and more consistency in the way the problem is dealt with across the region. A range of practical measures have been implemented including better training for staff and placing alcohol specialist nurses in acute services. This is a long term project, which hopes to save £36 million over the next two years and there are already signs of progress. For example, Blackpool Acute Trust reported a 7% decrease in hospital admissions, a net saving of £130,000, in 2010, the first year of implementing the project. This was in comparison to a 14% increase in admissions during 2009.

2.3 Our Mental Health Network's report *Seeing double: meeting the challenge of dual diagnosis*³⁶⁶ argued that NHS organisations need to improve training, promote greater awareness in staff and encourage greater partnership working between agencies if the NHS is to effectively tackle alcohol abuse. The report looked specifically at the challenges posed by people who have concurrent mental health and substance abuse or alcohol problems, so called "dual diagnosis". It highlighted that the complex interrelation between alcohol and mental health problems in these cases means that the stakeholders involved in effective interventions are numerous. An integrated and coordinated service with cross agency working is therefore key. The report found excellent examples of good practice but argued that national level provision is patchy and remains an area of concern.

2.4 While a number of our members have implemented successful alcohol initiatives, overall the increase in demand for NHS services as a result of alcohol abuse has not been matched with an increase in the availability of appropriate alcohol services. Only one in 18 people who are dependent on alcohol receive treatment and the availability of specialist services differs widely across England.³⁶⁷ The pressure to meet rapidly increasing demand from drinkers who urgently need services in a crisis makes it difficult for preventative work to keep pace. Furthermore, current financial pressures could make it harder still to fund preventative work.

2.5 There is clearly scope for further improvement to NHS services to tackle alcohol abuse. However, this will require further action from central and local government as well as the NHS.

2.6 The current system of paying for the amount of work done in many services (tariff) means efforts to reduce demand through preventative work not only lack positive incentives, but also could effectively be penalised rather than rewarded. We recommend that mechanisms for offering financial reward to providers for their prevention and health promotion activities should be considered by the Department for Health. For example, the Commissioning for Quality and Innovation payment framework could include public health incentives.

2.7 Hospitals cannot tackle this problem alone. Effective interventions for patients need to be mirrored in the community and in primary care. As we argued in *Too much of the hard stuff: what alcohol costs the NHS*, out-of-hospital services can provide high quality and cost effective solutions and ease the pressure on hospital services. GPs, for example, are well placed to identify and address alcohol related harm given their close community links. A series of controlled trials demonstrated that brief advice from a GP or community nurse leads to one in eight people reducing their drinking to within sensible limits.³⁶⁸ The study found the figure was one in 20 for smoking cessation services.³⁶⁹ Mental health services and ambulance trusts can also play an increased role.

3. Making every contact count

3.1 The NHS must maximise the opportunities healthcare professionals have to improve the health and well-being of individuals, families and communities (the so-called "every contact counts" approach). There are many instances where individuals who are unaware that their regular overconsumption of alcohol is harming their health come into contact with the NHS. The NHS needs to work with others, including the police and local authorities, to ensure all age groups, particularly young people, are aware of these risks.

3.2 While we welcome the Government and the Future Forum's support for making every contact count, we believe that the NHS needs to make a cultural shift in thinking and behaviour to ensure this policy becomes the norm throughout the health service. Financial incentives must be looked at (see paragraph 2.6). The following steps would also help achieve this:

- National bodies' contracts should be reviewed to ensure they support the delivery of the every contact counts approach. If the Department of Health, for example, plans to redesign community pharmacy to support this objective then the national pharmacy contract will need to be revisited.
- Commissioners should similarly consider how their service specifications in providers' contracts support this approach.

³⁶⁶ <http://www.nhsconfed.org/Publications/briefings/2009-Briefings/Pages/Seeing-double-meeting-challenge.aspx> (NHS Confederation, 2009)

³⁶⁷ Public Accounts Committee (2009) *Reducing alcohol harm: health services in England for alcohol abuse*

³⁶⁸ Moyer, A, Finney, J, Swearingen, C and Vergun, P (2002). Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment seeking populations, *Addiction*, 97, 279-292

³⁶⁹ Silagy, C and Stead, L F (2003). Physician advice for smoking cessation (Cochrane Review), in: *The Cochrane Library*, Issue 4 (Chichester, Wiley)

3.3 In addition to making every contact count, the NHS should build on what individuals identify as supporting their own well-being, rather than focusing on the separate lifestyle behaviours identified by the health service, such as alcohol consumption. In practice, this would mean services which help individuals with an alcohol related disease to understand the root causes of this condition in order to tackle it more effectively. Such an approach would also help change the existing power dynamic between patients and the NHS; turning patients from passive recipients of services to potential partners, who actively take responsibility for their own health.

4. *Integration and making the funding work*

4.1 In the new system, NHS funding for alcohol services will be transferred to local authorities as part of the public health ring-fenced budget. Additional funding for alcohol services will come from a number of other sources. The Police and Crime Commissioners (PCCs) will have funding to tackle alcohol related harm within their areas. Schools will have funding for personal, health, social and economic education (although they will not have a statutory place on health and well-being boards). Local authorities are also in receipt of funds for the troubled families programme.

4.2 We are concerned that this arrangement risks fragmenting efforts to tackle alcohol abuse. To address this we recommend:

- Health and wellbeing boards play a leadership role, coordinating joint work on tackling alcohol abuse at a local level. The boards should ensure various commissioning bodies work together to make the most of resources and expertise across the system.
- It will be essential that the boards engage with PCCs and academy schools, as neither are represented on health and wellbeing boards.
- Public Health England and the NHS Commissioning Board should lead on providing the support and advice that local areas will need to develop cost effective and best practice based plans for tackling alcohol abuse.
- There are a number of indicators in the different outcomes frameworks which are relevant to alcohol. To assist health and wellbeing boards in their role coordinating joint work on alcohol harm reduction, we would like the Government to articulate how taken together the indicators could be used to encourage more preventative work.

4.3 The risk of fragmentation in alcohol services is even greater in relation to children and young people. In addition to the situation described above, there are eight levels in the new system at which health and wellbeing commissioning for children and young people will take place. To address this we recommend:

- The Government is explicit about where accountability lies for alcohol services for children and young people and how shared outcomes between the NHS and public health outcomes frameworks will be monitored, measured and incentivised across organisational boundaries.
- The outcomes strategy for children incorporates all health-related (NHS, social care, public health) and non-health (education, youth justice, policy, children's services) services to make it clear how different sectors contribute to reducing alcohol related harm and improving health and wellbeing outcomes.

4.4 Our members are concerned that local authorities may not have enough money to commission and deliver all the public health services that they will be responsible for, including alcohol services. While the public health budget will be ring fenced, we emphasise that it is not easy to define "public health" and therefore to identify public health activity and spend accordingly. This could mean the budget set by the Government for public health funding will not adequately meet local needs.

May 2012

Written evidence from the Association of Licensed Multiple Retailers (GAS 65)

1. The Association of Licensed Multiple Retailers (*ALMR*) welcomes the opportunity to submit written evidence to the Health Select Committee inquiry on the Government's alcohol strategy.

2. By way of background, between them our 103 member companies operate nearly 12,000 outlets, employing 350,000 staff (out of a total of half a million in the industry). These outlets are primarily pubs and bars but also include casual dining outlets, licensed accommodation providers and nightclubs. Our annual benchmarking survey shows that food led pubs (classified as where food represents 30% or higher as a percentage of turnover) now represent the largest sector in the industry, accounting for one-in-three of the total. On average, food sales now make up a quarter of the turnover of all pubs, rising to above 50% for food-led outlets. Indeed in 2011, food sales outstripped beer revenues in the retained estate of Birmingham-based pub operator Mitchells and Butlers for the first time.

3. We represent all of the major multiple licensed retailers with hundreds of premises down to the small independent companies operating 50 outlets or fewer under their own branding, predominantly suburban community outlets. These are valuable social and economic assets—community centres, social spaces, tourist

attractions and significant revenue generators—as well as providing a well regulated and controlled environment for people to enjoy alcohol responsibly and socially.

4. The ALMR is in the process of absorbing the 250-strong Bar Entertainment and Dance Association into membership, creating one retail voice for licensed hospitality. It is important to note that we do not represent brewers or other alcohol producers. Our members' retail alcohol products responsibly and ensure they are enjoyed in a supervised environment. They are not responsible for the products themselves and cannot control how they are packaged or what volume of alcohol they contain. This in contrast to the supermarkets who can influence such matters through their supplier relationships, purchasing rights and own brand products.

5. We would make a few opening remarks that we hope the Committee will find useful when considering our specific responses to the terms of reference it has set out below.

6. Launching the Alcohol Strategy, the Prime Minister described pubs as the “*safest and friendliest place to drink... an important part of the social fabric of our communities*”. The fundamental premise of the strategy is to make supermarkets more expensive in order to benefit and support the pub. Ministers are clear that preloading is the real problem and drives a lot of late night disorder and causes health problems. The Prime Ministers says this is behind more controls—“*it is too easy to get drunk on cheap alcohol before they even set food in the pub*”.

7. Unlike his cabinet colleagues in the Home Office and Number 10 the Health Secretary was mute on the role the pub might play in helping improve our relationship with alcohol. Instead he highlighted that “*last year there were 1.2 million admissions to hospital associated with alcohol*”. Obviously alcohol is a factor and any death from misuse is one death too many, but we consider that we have to put these figures in context. For example, the majority of deaths from liver disease are not directly attributable to alcohol—indeed the proportion that is alcohol related is actually falling. We are in danger of failing to tackle this significant health problem by focusing on alcohol to the exclusion of all other lifestyle risk factors.

8. The health lobby argues that a 10% increase in price reduces consumption by 5%, but we and the rest of the industry focus on the more sophisticated arguments of using policy levers to switch consumption patterns. Encouraging people to drink in pubs means that they consume measured quantities served by supervised by trained staff.

9. Recognition of this by Government in the alcohol strategy is a start, but a VAT cut for eating and drinking out would help make that a reality, and that continues to be a priority.

10. Our response to the Committee's specific terms of reference is as follows:

Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role

11. The ALMR welcomes the Committee's interest in this area as it notes that the Prime Minister himself launched the Government's Alcohol Strategy and there are a number of Government Departments pursuing policy and regulatory initiatives which specifically reference the positive contribution pubs and bars can make to local economies and communities across the UK. These include the recently published National Planning Policy Framework and the Government's response to the Portas Review of the High Street.

12. Primary Care Trusts and Local Health Boards are now responsible authorities with a direct say in local licensing matters, so it is important that the Department of Health at a national level recognises firstly, the basis on which alcohol related admissions are calculated and secondly, why people end up in our hospitals in the first place.

13. The Department of Health has recently released guidelines that will see the number of hospital admissions counted as alcohol-related fall dramatically.

14. The previous guidelines called for all diagnoses to be counted towards admissions statistics, so if someone admitted for a particular health problem also had a problem categorised as alcohol-related (like hypertension or cardiac arrhythmia) then the admission would count as alcohol-related. The new guidance will mean only the primary diagnosis will be counted in the admissions statistics.

15. Previously, diagnoses “partially attributable” to alcohol made up the bulk of all alcohol-related admissions. There were 194,800 admissions in 2009–10 where the primary diagnosis was either partially or wholly attributable to alcohol, less than 20% of the widely reported figure of one million which the Secretary of State identified. Only 68,500 admissions were wholly attributable to alcohol—representing an increase of 52.2% from 2002–03—and this increase can be at least partially explained by a general rise in admissions (of 27%) and the four hour A&E target resulting in the creation of alcohol wards for those not in danger but too drunk to be released.

16. On the second matter, we are very concerned that at present all too often the blame for alcohol related admissions to hospital is laid at the door of the nearest pub, bar or nightclub. This is despite the well-documented habit, particularly among young people, of “preloading” and the continued availability of alcohol in the off trade and “fast food” establishments late at night—after many of our members' premises have closed.

17. Figures from the Centre for Public Health, Liverpool John Moores University, suggest that those who drink at home are two and half times more likely to have been in a fight in the last 12 months, and pre-loading is more strongly associated with being involved in nightlife violence than the total amount of alcohol drunk. Police Guidance (first issued in 2006) instructs that anyone “found to be drunk and incapable should be treated as being in need of medical assistance and an ambulance called” with custody used only as a “last resort”.

18. People pre-load on alcohol because it’s much cheaper to buy it in the supermarket than in a pub or bar. Alcoholic drinks can be as much as 10 times more expensive to purchase in a pub or bar than they are in the supermarket or off licence. A glass of wine that costs £4.86 on average in the on trade would be the equivalent of £0.64 purchased from the off trade. This is eight times more expensive. Six years ago it would “only” have been three times more expensive.

19. Increasing excise duty faster than the rate of inflation via the “escalator” and allowing supermarkets to use their tax free status on food to subsidise loss leading alcohol promotions have had the combined effect of driving consumers to purchase their alcohol from the off trade. The outcome is that over 70% of all alcohol in this country is now purchased through the off trade. This is set only to increase. The latest Beer Barometer published by the British Beer and Pub Association in April 2012 shows pub beer sales down 6% in the first quarter of 2012, compared to a 5% increase in off-licence sales. The overall consequence is to bring down the average price paid for alcohol and this will not help promote responsible consumption.

20. In terms of the extent to which the Department of Health should take a leading role—we consider that assessing our industry through a one dimensional regulatory framework—whether it be alcohol harm or alcohol crime and disorder, simply does not do justice to today’s modern pubs and bars and what they have to offer.

21. With food led pubs in the ascendancy our larger members are playing an active role in the Department of Health’s Responsibility Deal not just through delivering the pledges agreed on alcohol but on food as well. We would like to see more of an explicit recognition of our members’ ability to drive change through their establishments and the benefits that consumers up and down the country have experienced.

Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol

22. We are following closely the Scottish Executive’s progress in legislating for a minimum unit price of alcohol. Like Scotland, the UK Government’s alcohol strategy recognises that minimum unit pricing is only one component of a number of measures that could be introduced to prevent the selling of alcohol at “pocket money prices”. While there are differences of opinion among members regarding the efficacy of minimum pricing alone we support a multi-layered approach to tackling the problem.

23. In this context, the Alcohol Strategy also raises the prospect of revisiting the existing Code of Practice on promotions, price and advertising. The licensed trade is already governed by five measures under the Code. There is the opportunity to level up the playing field between the on-trade and the off-trade by using the remaining slots available to address shortcomings in the off trade.

24. In addition we consider that local authorities need to be encouraged to use their existing powers under the 2005 Act better to control supermarket sales and promotions. They already have the power to impose restrictions on siting, hours of opening and bulk purchasing (such as existed under the previous licensing regime), but current Government Guidance indicates suggests that off-licences should be subject to light touch regulation and should be granted in the terms they are requested. We believe that this should be amended so that applications are to be scrutinised in the same way as those for pubs and bars.

The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group

25. The licensed trade takes its responsibility in addressing alcohol related health problems very seriously. Our larger members are active participants in both the food and alcohol components of the Department of Health’s Responsibility Deal. We are also working with our smaller member companies to explore how best they can implement similar initiatives learning from best practice from within the trade.

26. Drinkaware is a producer-funded initiative with messaging on responsible drinking delivered by our members at point of sale. Overall the alcohol industry contributes £5.2 million in funding to Drinkaware initiatives with retail members providing £1 million of that. Furthermore, that sum is more than matched by “in kind” support resulting from the in-house costs involved in advertising and promoting Drinkaware messages and campaigns to those that visit our premises, and in social media communications.

The impact that current levels of alcohol consumption will have on the public’s health in the longer term

27. We would like to draw the Committee’s attention to the latest General Lifestyle Survey published by the Office for National Statistics in February 2012 which states that between 2005 and 2010 average weekly consumption of alcohol fell steadily from 14.3 units to 11.5 per adult. The proportion exceeding the recommended weekly limit fell from 31% to 26% (men) and 21 to 17 (women). Those admitting to heavy

drinking fell by about a third and 87% of people say that they are giving themselves three alcohol-free days a week—in line with the latest recommendation from the British Medical Association.

28. While we recognise that we have to tread carefully with statistics around self-reported behavior these figures are supported by alcohol sales data. This has fallen, in both value and volume, from about 11.6 litres of pure alcohol per adult per year in 2004, to about 10 litres in 2011.

29. This will have a knock on effect on alcohol related admissions. Those who present with chronic liver disease represent the consequences of excessive alcohol consumption over a number of years. There is every reason to suppose that figures will fall over the long term as the consequence of falling alcohol consumption.

CONCLUSION

30. The Alcohol Strategy emphasises tackling the problem of excessive drinking from “every angle” and we need a government that wants to work in genuine partnership with our industry.

31. This will be a partnership that helps us exercise our supervisory duties by helping pubs invest and modernise to attract a more diverse community through their doors; one that levels up the playing field between pubs, bars and supermarkets by narrowing the price differential and limiting the unconditional availability of alcohol in shops; one that provides us with certainty that politicians really do appreciate just how much we can be both a force for good on local high streets and in local communities as well as an engine of growth and job creation in our local economies.

32. If this country wants a grown up relationship with alcohol then politicians and regulators should explore ways of using policy and fiscal levers to encourage more people to drink in supervised pubs rather than in the unsupervised environment of the home.

May 2012

Written evidence from the Royal College of General Practitioners (GAS 66)

ABOUT THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care.

The RCGP endorses the points made in the Alcohol Health Alliance UK submission, but has made comments of its own following review by the College’s policy team, led by Honorary Secretary Professor Amanda Howe, and drawing on the expertise of Dr Linda Harris, the College’s Clinical Director for Substance Misuse and Associated Health. RCGP comments are placed in bold in underneath the relevant sections of the AHA text below.³⁷⁰

5. THE ROLE OF THE ALCOHOL INDUSTRY

5.3 In line with WHO recommendations, while we believe business must play a part and have the opportunity to engage with health issues, health experts must lead on setting policy priorities.³⁷¹ Although businesses have a role to play in protecting and promoting the health and wellbeing of their employees and the wider community, and implementing and supporting public health initiatives it is not the place or responsibility of business to define public health policy or to be responsible for public health information, as in many cases this is in direct conflict with their interests and responsibilities to their shareholders and employees.

The College supports the statement made in the above paragraph, and would add that there is a need to gather more evidence on what positive role local businesses can play. The College would like to see an interim report on the local implementation of the Responsibility Deal and outcomes achieved so far, with a view to identifying whether it has been successful and what if any pockets of good practice can be identified.

5.4 To address this conflict of interest the AHA recommends that industry contributes to funding for public health initiatives via a truly independent charity or blind trust, constituted as a grant-giving foundation to support bodies operating for the public good with a track record of reducing alcohol harm, without involvement from industry representatives. All programmes and policies should be subject to proactive monitoring and independent evaluation, including those with private investment.

The College supports the above statement, with the addition that Alcohol Concern could be a vehicle for independent public health campaigning, R&D initiatives and targeted specialist campaigning—this would avoid the need to set up a separate charity diluting already very sparse resources for established groups with similar aims and objectives.

³⁷⁰ For full text of Alcohol Health Alliance UK submission see HC 132 Ev ???

³⁷¹ World Health Organization. *The World Health Report 2002: reducing risks, promoting healthy life*. Geneva: WHO, 2002.

6. GREATER INVESTMENT IN EFFECTIVE INTERVENTIONS

6.3 The strategy raises a number of health risks such as foetal alcohol spectrum disorders and mental illness, along with highlighting the value of early identification and treatment of alcohol disorders. A comprehensive system of care is required to successfully address the wide spectrum of health harms, however the strategy fails to provide any specific actions or funding in these areas.

The College strongly endorses this point. In the absence of additional or targeted funding, professional and voluntary sector groups working with the consequences of alcohol abuse will find it more difficult to promote their healthy behaviour change messages. Whilst they are less common in general practice than other alcohol-related disorders, foetal spectrum disorders are a concern and investment in prevention is very important.

Early diagnosis and treatment of alcohol use disorders

6.6 The NICE Guidance on alcohol use disorders states that primary prevention of alcohol-related harm at primary care level is both effective and cost effective.³⁷² This should be incentivised through including a measure in the Quality and Outcomes Framework for GPs to record the alcohol intake of their patients and to give brief advice where indicated. For patients who do not respond to simple advice there should be a stepped programme of further intervention.

The College strongly supports the above call for inclusion of a new measure in the Quality Outcomes Framework. In the meantime, there needs to be a focus on promoting the NICE guidance and using the findings of the SIPS project³⁷³ as pointers for local commissioners who could strongly influence the development of local service specifications for commissioned alcohol treatment.

6.7 Cost effective treatment interventions for alcohol dependence have been described in NICE guidelines³⁷⁴ but are currently available only to a small proportion of those who could benefit from it. This will require sustained investment in specialist alcohol services to achieve parity for services for drug misusers.

Findings from the National Alcohol Payment by Results Pilots, which concluded in April 2012, will be relevant here. The pilots could potentially provide the basis for a locally-led approach to encouraging providers to benchmark their existing service provision with NICE's recommendations, and may also encourage service providers to work together to redesign services and promote a more balanced, evidence-based and outcomes-oriented offer. Dissemination and careful consideration of the findings of the pilots is needed. The findings of this pilot should be compared with those of the current (separate) Drugs and Alcohol Recovery Pilot which is not based on NICE based pathways and packages of care. As stated above, the College believes there should be a focus on promoting the NICE guidance.

Secondary care services

6.8 Healthcare modelling methodology suggests that if each district general hospital established a seven day Alcohol Specialist Nurse Service to care for patients admitted for less than one day and an Assertive Outreach Alcohol Service to care for frequent hospital attendees and long-stay patients, it could result in a 5% reduction in alcohol-related hospital admissions, with potential cost savings to its locality of £1.6 million per annum. This would equate to savings of £393 million per annum if rolled out nationally.³⁷⁵

6.9 The AHA recommends that there should be a multidisciplinary 'Alcohol Care Team', a seven day Alcohol Specialist Nurse Service and an 'Assertive Outreach Alcohol Service' in every District Hospital. Transitions between teams and services should be quick and seamless in order to increase the efficiency and cost effectiveness of the service.³⁷³

GPs and Primary Care teams play a crucial role in liaison with acute and community services and we would stress that these teams should be involved in step up/step down interventions and packages of care as part of integrated care pathways. They could also involve already funded out of hours providers as part of a local collaborative.

7. THE CHANGING PUBLIC HEALTH SYSTEM

7.1 The AHA believes there is potential to work more closely with local authorities to drive change and innovation, and deliver services targeted to the needs of local communities. However, with the changes to the public health system come risks that must be mitigated. These include: unjustifiable variation, piecemeal and fragmented service provision, an absence of quality evaluation metrics, and a lack of information sharing and best practice. The AHA are keen to work with central and local government to identify mechanisms that deliver on the localism agenda, whilst protecting the need for coordinated, integrated and evidence-based policy-making and service delivery.

³⁷² National Institute for Health and Clinical Excellence. *Alcohol-use Disorders: Preventing the Development of Hazardous and Harmful Drinking: PH24*. London: NICE, 2010.

³⁷³ The Alcohol Screening and Brief Intervention Pilots: <http://www.sips.iop.kcl.ac.uk/faqs.php>

³⁷⁴ National Institute for Health and Clinical Excellence. *Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence. Clinical Guideline 115*. London: NICE, 2011.

³⁷⁵ The British Society of Gastroenterology and the Royal Bolton Hospital NHS Foundation Trust. *Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care*. London: NHS Evidence, 2011.

The College would agree that the need to embrace localism is key. Health and Wellbeing Boards have a vital role through Joint Strategic Needs Assessments in influencing the commissioning decisions made by CCGs. The Boards will need to effectively campaign to ensure alcohol treatment and service provision is balanced and adequately resourced at a local level.

7.2 A national service framework on alcohol, which could be adapted to local needs, would be an effective way of keeping costs down, sharing best practice and getting the best value for money. A framework could be led by a dedicated alcohol team within Public Health England, with established experts leading the research work at the highest level, setting out principles for action, rather than prescriptive plans. This allows for local areas to develop plans to meet local needs with the backing of expertise and knowledge provided by PHE.

In the College's view national service frameworks (NSFs) have the potential to be very effective when introduced and implemented rigorously through a nationally applied performance management structure. However, alongside the Alcohol Health Alliance's call for an NSF, the College argues that there is a need to focus on the development and use of the current NICE guidance and the associated commissioning guidance which would then be adopted by Health and Wellbeing Board. We would also reiterate (as stated in 6.7 above) that there is a need to carefully analyse the forthcoming findings of the national alcohol payment by results pilot, which is based on NICE packages of care.

9. COORDINATION OF ALCOHOL POLICY

9.1 Policies relating to alcohol fall under a broad range of governmental departments, including the Home Office, the Department of Health, the Treasury, the departments of Culture, Media and Sport and Transport and Communities and Local Government and the Ministry of Justice. There is therefore a particularly strong case for a cross-departmental unit on alcohol, and the AHA suggests that such a unit could be led by the Chief Medical Officer—reporting to the Home Affairs (Public Health) Cabinet Sub-committee. A cross governmental alcohol unit could maximise the impact of the different strands of the government's strategy and ensure there is rigorous evaluation applied to all aspects of the strategy.

9.2 A cross governmental alcohol unit would also be well placed to coordinate policy with the devolved administrations. Greater consistency around policies relating to the price, availability and promotion of alcohol will be important in ensuring success across the UK. In particular, efforts to introduce a minimum unit price on alcohol are already well underway in Scotland and under discussion in Northern Ireland—therefore it is important that the timeframes for introducing a minimum unit price in England and Wales aligns as closely as possible with the devolved administrations.

The College strongly endorses the call for a cross-governmental alcohol unit. The current Department of Health alcohol policy unit is small and has little or no budget of its own. The inter-ministerial group on drugs is an example of a cross-departmental group that is driving forward key changes in policy.
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Written evidence from the Joseph Rowntree Foundation (GAS 67)

The Joseph Rowntree Foundation (JRF) is one of the largest social policy research and development charities in the UK. For over a century we have been engaged with searching out the causes of social problems, investigating solutions and seeking to influence those who can make changes. JRF's purpose is to understand the root causes of social problems, to identify ways of overcoming them, and to show how social needs can be met in practice. The Joseph Rowntree Housing Trust (JRHT) shares the aims of JRF and engages in practical housing and care work.

In 2007, JRF began a major programme of research on young people and alcohol, focusing on developing our understanding of the way in which young people's drinking cultures are formed and influenced, with the aim of supporting a reduction in problematic drinking amongst young people. We are delighted to have the opportunity to respond to the Health Select Committee's Inquiry on the government's Alcohol Strategy, drawing on the findings from this body of work.

HEALTH MESSAGES AND PARENTING

Our research shows that parents have a very significant influence on their children's approach to alcohol and drinking, and that this influence continues into their teenage years. This said, parents' own drinking behaviour and parenting style appears to be more important than their role in imparting health messages.

A major evidence review commissioned at the beginning of our programme (Velleman, 2009) makes it clear that children begin to learn about alcohol and drunkenness at a very young age (aged 3 onwards). As they get older, children assume that they will grow up to drink in the same way as their parents (Valentine, 2010).

For this reason, approaches aimed at minimising young people's drinking must take account of these early influences, and parents in particular need to be made aware of the impact that drinking in front of even very young children may have. For instance, evidence suggests that drinking to excess in front of young children on holiday or at family celebrations, can have a negative effect on their drinking outcomes (Valentine, 2010).

Engaged parenting, where parents and children spend plenty of time together, with parents aware of their children's friends and whereabouts, has a positive influence on the nature and level of young people's drinking (Sondhi *et al.*, 2011). Similarly, while peers also have a significant influence, parents have a role in choosing the friends their children have and in supervising those friendships (Velleman, 2009). It is therefore important that parents are made aware of the potential for this kind of engaged and active parenting to have a range of positive outcomes, including delaying their child's first drink and moderating their drinking.

Finally, our research indicates that the guidance parents give children about alcohol and drinking is drawn more from their own experiences and beliefs than from official health messages. Many parents adopt a "continental" approach, introducing their children to drinking with family meals, while others focus their guidance on the importance of avoiding hangovers or risky situations, glossing over the long term health consequences of drinking. This suggests that the health messages parents currently receive may not be helpful to them in offering guidance to their children, largely because they do not reflect parents' own choices around alcohol (Sohndi, 2011).

Taken together, these findings suggest the need for an approach to informing, supporting and educating parents that emphasises the influence of their own drinking choices as well as of active parenting, alongside support for talking to children about alcohol in a way that reflects some of the long term consequences of drinking as well as short term risks.

ADVERTISING AND MARKETING

As Velleman notes, "*young people who see, hear and read more alcohol advertisements are more likely to drink and drink heavily than their peers*" (Velleman, 2009). Clearly, the level of exposure young people have to marketing materials or to wider media featuring alcohol does have an impact on the choices they make about drinking and drunkenness.

This said, findings from other research projects in our programme indicate that the relationship between young people and media influences is becoming increasingly complex in ways that have significant implications both for our approach to advertising and marketing and to health promotion activities.

Our research exploring media influences on children and young people aged 11–18 made it clear that young people were watching alcohol advertisements both pre and post watershed, as well as looking at alcohol advertisements in magazines and on both formal and informal social networking sites (Sumnall *et al.*, 2011). These advertisements "*not only directly advertised alcoholic beverages, but also depicted alcohol in the promotion of non-alcoholic consumer items and the sponsorship of leisure activities such as football and music festivals*".

This exposure to advertising in online and social media indicates that the extension of the Advertising Standards Authority remit to cover these platforms is an important step, as is the government's commitment in the Alcohol Strategy to working with the ASA on enforcement in this field. However, these findings also point to the weakness of the existing co-regulation by Ofcom and self-regulation via the ASA and the Portman Group as "*60% of respondents were exposed to alcohol advertisements on a daily basis; 11–12-year-olds (our youngest participants) were exposed at this level of frequency just as much as older age groups*" (Sumnall, 2011).

While this research makes it clear that young people are very active consumers of alcohol related advertising and marketing, it also indicates that they are relatively critical consumers. Young people in this study were aware of the financial and editorial incentives that might influence the media's presentation of alcohol. They were critical of the way in which drinking alcohol was gendered in the media, where drinking was presented as a mandatory part of being a man, whereas women drinking was presented in a contradictory way: either glamorous, or unfeminine. They felt that the overall picture was exaggerated: drinking was portrayed as a pervasive norm (everyone drinks) and negative consequences of drinking were limited to portrayals of alcoholism and violence.

Finally, it is important to note that alcohol consumers, including young people, are also active *producers* of alcohol marketing materials. Our research found that only 0.5% of social media site pages devoted to specific brands of alcohol were official. The remaining 99.5% were unofficial, customer generated content which presented positive images and stories about alcohol brands and drunkenness without any of the responsible drinking messaging that is often included on official sites. Social networking and online applications have become part of the leisure experience of drinking for many young people, with fan groups for drunkenness and customer generated online drinking games.

This suggests that the approach to regulation of advertising alcohol should be strengthened, but that the emergence of online marketing and social networking mean that the impact of regulation may be limited. The young people's critical consumption of media points to the possibility of a successful counter marketing approach, along the lines of the Florida "Truth" campaign (see below).

PUBLIC HEALTH EDUCATION AND MARKETING

At the outset of our alcohol programme, we commissioned a review that explored the critical success factors for initiatives that have successfully changed public knowledge, attitudes and behaviours in other fields (Stead et al, 2009), with the aim of transferring this learning to influencing drinking cultures. This review, which included HIV awareness campaigns, drink driving campaigns and anti-smoking campaigns, identified a number of factors that are particularly relevant to changing social norms relating to alcohol.

The first key factor identified by the review was that initiatives aimed at changing cultural and social norms require a long term commitment to a single approach. By way of example, the shift in social norms relating to smoking has taken place over 50 years, changing norms around use of condoms has taken more than 20 years. This has both funding and political implications.

The second key factor involved a re-framing of the problem, where *“moving away from traditional ‘victim blaming’ gave the campaign an unassailable moral superiority in face of counter-arguments about ‘freedom’ and profits”* (Stead et al, 2009).

Finally, it was clear that successful campaigns identified and spoke directly to their audience, often using humour and empathy. This is especially relevant to attempts to influence young people’s drinking, where traditional health messages may fall on stony ground. An excellent example of this is the Florida “Truth” campaign, now implemented and evaluated in a range of locations in the USA. Rather than focusing on the young smoker, the Truth campaign used counter marketing techniques to focus on tobacco industry tactics, presenting the young smoker as having been manipulated by big business.

MINIMUM UNIT PRICING

None of our research focused on alcohol pricing, so we have limited evidence to offer on this topic. However, our research into peer group influences on drinking makes it clear that young people are actively trying to moderate their own drinking as well as that of their friends, and that taking out a limited amount of money is their primary tactic. This suggests that low price alcohol, as well as discounted offerings in the night time economy may be undermining young people’s attempts to drink more responsibly (Sondhi, 2011).

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