

Institute of Alcohol Studies Response to Public Consultation on Healthy Lives, Healthy People White Paper: Our Strategy for Public Health in England

Supplementary response to the submission from the Alcohol Health Alliance

The Institute of Alcohol Studies (IAS) is an independent organization that aims to serve the public interest on public policy issues linked to alcohol, by advocating for the use of scientific evidence in policy-making to reduce alcohol-related harm.

We welcome the opportunity to respond to *Healthy lives, healthy people White Paper: Our strategy for public health in England* and *Healthy lives, healthy people: transparency in outcomes – proposals for a public outcomes framework*. The bulk of our response to the consultation can be found in the submission from the Alcohol Health Alliance (AHA), of which IAS has been a member since its establishment in 2007.

In this submission we would like to supplement the AHA response with some additional points and recommendations that the IAS sees relevant to answering some of the specific questions outlined in the consultation.

Developing a national alcohol strategy: The need for strong leadership and a clear message

As mentioned in the AHA response to this consultation, we welcome the inclusion of civil society and local communities in developing public health solutions. However, we recognize the importance of leadership and coordination from Central Government required to make initiatives at a local level effective, both in terms of their health outputs but also in terms of cost.

There is currently a lack of clarity about the development of a cross-departmental national alcohol strategy that focuses on price, promotion and availability, and is based on evidence of what works. In order to be effective this strategy requires a cross-departmental committee to coordinate, which will in turn need to connect effectively with research bodies and public health experts. Once a comprehensive national strategy is formulated, this will make it easier to disseminate information and guidance down to a local level, to ensure there is effective coordination and delivery of initiatives to reduce alcohol harm.

It is essential that clarification is provided on what the Government seeks to achieve through its alcohol policies. In order for employers, community organisations and individuals to champion any strategy or support initiatives aimed at tackling alcohol misuse, the issue needs to be made relevant to them and the objectives made clear. At present there seems to be no clear message to the public about what the government's objectives are in relation to alcohol, or what we as a society should be aiming to achieve.

Alcohol & young people: The role of the CMO and schools

We welcome the statement that the Chief Medical Officer (CMO) will play a central role in providing independent advice to the Secretary of State and the Government on the population's health. We also welcome the emphasis on adopting a lifecourse approach to public health, focusing on children and young people.

Given these two commitments, we would like confirmation of whether the CMO's advice on alcohol consumption and young people will form part of the overarching framework around alcohol messaging and what the Government hopes to achieve in its alcohol strategy. This advice states that children under the age of 15 should avoid alcohol completely, as there is strong evidence to show that a delay to the onset of drinking will decrease an individual's chances of becoming a risky drinker in later life¹. If the CMO's advice is not going to form part of the messaging, we would like clarification on whether the Government is going to develop a new set of guidelines as part of the national alcohol strategy.

We would also recommend that the role of schools is addressed as part of the lifecourse approach whilst involving local communities and adhering to the Big Society agenda. Research has shown that alcohol education in schools is patchy and a report from the Rowntree Foundation recommended that in order to maximize the impact of alcohol education

programmes in schools it is important to involve parents or target parents through parallel education programmesⁱⁱ. We see schools as key stakeholders in helping to deliver an effective alcohol strategy and recommend their engagement in the process is prioritized.

We strongly endorse the recommendation in the AHA response that “the nation’s alcohol problems should not be led by the drinks industry”. This particularly applies to alcohol education in schools where “socially responsible” educational activities of the drinks industry are likely to normalize sensible drinking levels, reinforcing the view that alcohol consumption is the norm leading to pressures on children and young people to conform to this norm.

Health Inequalities

We welcome the recognition in the new public health strategy that reductions in life expectancy and disability-free life expectancy are related to neighbourhood income deprivation and the significant variation in health outcomes across regions of the UK. At this time of economic downturn with decreased employment opportunities and tightening restrictions on family incomes these levels of inequality, as measured by Gini Coefficients, will increase, raising levels of social exclusion and the need for supported accommodation and rehabilitation programs. Such services are currently addressed by Supporting People funding, which is being scaled back.

In the Department of Health *priorities and planning framework 2003-6*ⁱⁱⁱ the identified need of homeless people was addressed as exemplified in the Wanless Report, *Securing Good Health for the Whole Population*^{iv}, resulting in key outcomes to improve healthcare for homeless families, and providing primary care and treatment for homeless people, together with targeted health support. Good practice in working with these increasingly marginalized groups can be seen in London, Birmingham and other major cities where community health services are integrated into provision of homeless services, mainly provided by the third (voluntary) sector.

The impact of Local Authority spending cuts on the third sector needs to be carefully balanced by an appropriate response which is not apparent in the proposed new health strategy. Alcohol problems are common amongst these individuals and families. Clearly a cross-departmental alcohol strategy should be a significant component of the new health strategy.

Strengthening the evidence base: The General Lifestyle Survey

As stated in the AHA response to this consultation, we support the creation of a new National Institute for Health Research (NIHR) School for Public Health Research and a Policy Research Unit on Behaviour and Health. We acknowledge the importance of transparency in data reporting of public health research and outcomes.

However, we have serious reservations that public health initiatives, carried out at a local level, will not have the rigor of design to allow us to determine their effectiveness. We strongly recommend that there remains an emphasis on collection of data at a national level. The ending of the General Household Survey presents a serious threat to improvements in public health through data collection and appears to be in direct conflict with the White Paper’s objective to improve the evidence base for effective public health interventions.

Measuring success: The need to expand upon existing indicators

As stated in the AHA response, we applaud the inclusion of targets to reduce rates of mortality from liver disease and hospital admissions from alcohol related harm. These are essential indicators and must remain in the published Public Health Outcomes framework.

We would welcome additional indicators related to alcohol related health and social problems in the Public Health Outcomes Framework. We would like to see such indicators go further than liver disease mortality rates alone, addressing the impact alcohol has on quality of life, disabilities and society at large. An approach to monitoring Disability Adjusted Life Years (DALY’s) is recommended to address health inequalities as highlighted in the Marmot 2010 report^v.

The indicators outlined in previous Public Service Agreements (PSAs) can be seen as good examples of how to expand the scope for measuring success in alcohol harm reduction. Examples include: to reduce the percentage of people who perceive drunk and rowdy behavior to be a problem in their area (PSA 25); to reduce the number of young people frequently using drugs, alcohol or volatile substances (PSA 14); to reduce alcohol related violent crime and disorder, especially assault with injury (PSA 23). We would like clarification on whether these PSA delivery agreements are going to be carried forward by the Coalition Government and if so, how they are going to be integrated into the national alcohol strategy.

Furthermore we would like clarification on the future of Local Strategic Partnerships, created to establish and monitor Local Area Agreements (LAAs). This is a key issue in the light of the recent report from the Alcohol Harm Reduction National Support Team^{vi} that reported on the Alcohol Improvement Programme (AIP) set up in 2008. This report contains a series of criticisms about the AIP, including: the “lack of SMART objectives”, “did not reflect local needs”, “confusion regarding governance and partnership arrangements”, “core members... not at an appropriate level of seniority”, “... not attending meetings”, “lack of designated champions in partnership organisations”, “commissioning structure for alcohol were immature and local commissioning skills and expertise was not being deployed”, “lack of a full understanding of funding streams..”. If the new localism approach is to be effective these pivotal deficiencies must be addressed.

The partnership approach: Working with the alcohol industry

We have already written to the Secretary of State for Health outlining our concerns regarding the Public Health Responsibility Deal for Alcohol (RDA), a summary of which can be found in the AHA response to this consultation. We must take this opportunity to stress however, our grave concerns about the approach taken by Government in developing the RDA and repeat our stance that we cannot endorse a process in which the alcohol industry is invited to co-create and self-regulate health policy.

There is clearly a conflict of interest between industry economic objectives and public health goals of reducing alcohol consumption and associated harms, which has been highlighted by two parliamentary select committees^{vii} and the WHO^{viii}. We call upon the Government to ensure that alcohol policy is guided by public health interests and the best available evidence, not influenced by competing commercial interests.

Institute of Alcohol Studies

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ⁱ Guidance on the consumption of alcohol by children and young people. A report by the Chief Medical Officer, Department of Health 2009

ⁱⁱ Valentine, G; Jayne, M; Gould, M; 2010; Alcohol consumption and family life. Joseph Rowntree Foundation

ⁱⁱⁱ Improvement, expansion and reform, the next 3 years: priorities and planning framework 2003-2006, DH 2002

^{iv} Securing good health for the whole population: final report 2004, DH 2004

^v Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010, www.marmotreview.org

^{vi} Supporting Partnerships to Reduce Alcohol Harm: Key Findings, Recommendations and Case Studies from the Alcohol Harm Reduction National Support Team, Department of Health, 2010

^{vii} House of Lords European Union Committee Report 2002; House of Commons Health Committee First Report on Alcohol vol I, January 2010

^{viii} WHO Expert Committee report, 2007