House of Commons
Health Committee

Alcohol

First Report of Session 2009–10

Volume I

HC 151–I

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Report, together with formal minutes

Ordered by the House of Commons
to be printed 10 December 2009

HC 151–I
Published on 8 January 2010
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, and these can be found in HC 151–II, Session 2009–10. Written evidence is cited by reference in the form 'Ev' followed by the page number; Ev x for evidence published in HC 368–II, Session 2008–09, on 23 April 2009, and AL x for evidence to be published in HC 151–II, Session 2009–10.

Contents

Report

Summary

Over the last 60 years English drinking habits have been transformed. In 1947 the nation consumed approximately three and a half litres of pure alcohol per head; the current figure is nine and a half litres. According to the General Household Survey data from 2006, 31% of men are drinking hazardously (more than 21 units per week) or harmfully (more than 50 units) of whom 9% are drinking harmfully. 21% of women are drinking hazardously or harmfully of whom 6% are drinking harmfully. While the consumption of alcohol has increased, taxation on spirits has declined in real terms and even more so as a fraction of average earnings.

The rising levels of alcohol consumption and their consequences have been an increasing source of concern in recent years. These involve not only the consequences of binge drinking which are a cause of many serious accidents, disorder, violence and crime, but also long term heavy drinking which causes more harm to health. The President of the Royal College of Physicians told us that alcohol was probably a significant factor in 30 to 40,000 deaths per year. The WHO has put alcohol as the third most frequent cause of death after hypertension and tobacco. UK deaths from liver cirrhosis increased more than five fold between 1970 and 2006; in contrast in France, Italy and Spain the number of deaths shrank between two and four fold; this country's deaths from cirrhosis are now above all of them.. In 2003 the P M's Strategy Unit estimated the total cost of alcohol to society to be £20 bn; another study in 2007 put the figure at 55 bn.

Faced by a mounting problem, the response of successive Governments has ranged from the non-existent to the ineffectual. In 2004 an Alcohol Strategy was published following an excellent study of the costs of alcohol by the Strategy Unit. Unfortunately, the Strategy failed to take account of the evidence which had been gathered.

The evidence showed that a rise in the price of alcohol was the most effective way of reducing consumption just as its increasing affordability since the 1960s had been the major cause of the rise in consumption. We note that minimum pricing is supported by many prominent health experts, economists and ACPO. We recommend that the Government introduce minimum pricing.

There is a myth widely propagated by parts of the drinks industry and politicians that a rise in prices would unfairly affect the majority of moderate drinkers. But precisely because they are moderate drinkers a minimum price of for example 40p per unit would have little effect. It would cost a moderate drinker 11p per week; a woman drinking the recommended maximum of 15 units could buy her weekly total of alcohol for £6.

Opponents also claim that heavier drinkers are insensitive to price changes, but as a group their consumption will be most affected by price rises since they drink so much of the alcohol purchased in the country. Minimum pricing would most affect those who drink cheap alcohol, in particular young binge-drinkers and heavy low income drinkers who suffer most from liver disease. It is estimated that a minimum price of 50p per unit would save over 3,000 lives per year, a minimum price of 40p, 1,100 lives.

Minimum pricing would have other benefits. Unlike rises in duty minimum pricing would

benefit traditional pubs which sell alcohol at more than 40p or 50p per unit; unsurprisingly it is supported by CAMRA. Minimum pricing would also encourage a switch to weaker wines and beers. With a minimum price of 40p per unit, a 10% abv wine would cost a minimum of £2.80p, a 13% abv. wine £3.60p.

However, without an increase in duty minimum pricing would lead to an increase in the profits of supermarkets and the drinks industry. Alcohol duty should continue to rise year on year, but unlike in recent years duty increases should predominantly be on stronger alcoholic drinks, notably on spirits. The duty on spirits was 60% of male average manual weekly earnings in 1947; in 1973 (when VAT was imposed in addition to duty) duty was 16% of earnings; by in 1983 it was 11% and by 2002 it had fallen to 5%. We recommend that the duty on spirits be returned in stages to the same percentage of average earnings as in the 1980s. The duty on industrial white cider should also be increased. Beer under 2.8% can be taxed at a different rate and we recommend that the duty on this category of beer be reduced.

An increase in prices must be part of a wider policy aimed at changing our attitude to alcohol. The policy must be aimed at the millions who are damaging their heath by harmful drinking, but it is also time to recognise that problem drinkers reflect society's attitude to alcohol. There is a good deal of evidence to show that the number of heavy drinkers in a society is directly related to average consumption. Living in a culture which encourages drinking leads more people to drink to excess. Changing this culture will require a raft of policies.

Education, information campaigns and labelling will not directly change behaviour, but they can change attitudes and make more potent policies more acceptable. Moreover, people have a right to know the risks they are running. Unfortunately, these campaigns are poorly funded and ineffective at conveying key messages; people need to know the health risks they are running, the number of units in the drink they are buying and the recommended weekly limits, including the desirability of having two days drink-free each week. The information should be provided on the labels of alcohol containers and we recommend that all alcohol drinks containers should have labels containing this information. We doubt whether a voluntary agreement, even if it is possible to come to one, would be adequate. The Government should introduce a mandatory labelling scheme.

Expenditure on marketing by the drinks industry was estimated to be c. £600–800m in 2003. The current system of controls on alcohol advertising and promotion is failing the young people it is intended to protect. Both the procedures and the scope need to be strengthened. The regulation of alcohol promotion should be completely independent of the alcohol and advertising industries; this would match best practice in other fields such as financial services and professional conduct. In addition, young people should themselves be formally involved in the process of regulation: the best people to judge what a particular communication is saying are those in the target audience.

The current controls do not adequately cover sponsorship or new media which are becoming increasingly important in alcohol promotion. The codes must be extended to address better sponsorship. New media presents particular regulatory challenges, including the inadequacy of age controls and the problems presented by user generated content. Expert guidance should be sought on how to improve the protection offered to young

people in this area. Finally, there is a pressing need to restrict alcohol advertising and promotion in places where children are likely to be affected by it.

Alcohol-related crime and anti-social behaviour have increased over the last 20 years, partly as a result of the development of the night time economy with large concentrations of vertical drinking pubs in town centres. The DCMS has shown extraordinary naivety in believing the Licensing Act 2003 would bring about 'civilised cafe culture'. In addition, the Act has failed to enable the local population to exercise adequate control of a licensing and enforcement regime which has been too feeble to deal with the problems it has faced. Some improvements have been made through the Policing and Crime Act 2009, in particular the introduction of mandatory conditions on the sale of alcohol. We urge the Government to implement them as a matter of urgency, but problems remain. It is of concern that section 141 of the Licensing Act 2003is not enforced and we call on the police to enforce it.

The 2009 Act has made it easier to review licences, giving local authorities the right to instigate a review. We support this. However, we are concerned that local people will continue to have too little control over the granting of licences and it will remain too difficult to revoke the licences of premises associated with heavy drinking. The Government should examine why the licences of such premises are not more regularly revoked.

In Scotland legislation gives licensing authorities the objective of promoting public health. Unfortunately, public health has not been a priority for DCMS. We recommend that the Government closely monitor the operation of the Scottish licensing act with a view to amending the Licensing Act 2003 to include a public health objective.

The most effective way to deal with alcohol related ill-health will be to reduce overall consumption, but existing patients deserve good treatment and a service as good as that delivered to users of illegal drugs, with similar levels of access and waiting times. As alcohol consumption and alcohol related ill health have increased, the services needed to deal which these problems have not increased; indeed, in many cases they have decreased, partly as a result of the shift in resources to dependency on illegal drugs.

Early detection and intervention is both effective and cost effective, and could be easily be built into existing healthcare screening initiatives and incentives for doing this should be provided in the QOF. However the dire state of alcohol treatment services is a significant disincentive for primary care services to detect alcohol related issues at an early stage before the serious and expensive health consequences of regular heavy drinking have developed. These services must be improved.

The alcohol problem in this country reflects a failure of will and competence on the part of government Departments and quangos. In the past Governments have had a large influence on alcohol consumption, be it from the liberalisation which encouraged the eighteenth century 'Gin Craze' to the restrictions on licensing in the First World War. Alcohol is no ordinary commodity and its regulation is an ancient function of Government.

It is time the Government listened more to the CMO and the President of the RCP 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.

Terminology used in this report

Category	Alcohol consumption in men	Alcohol consumption in women
Low risk or 'sensible'	Up to 21 units/week	Up to 14 units/week
Increasing risk or 'hazardous'	22-50 units/week	15-35 units/week
High risk or 'harmful'	>50 units/week	>35 units/week

A unit of alcohol is defined as 8g or 10 ml of alcohol

The Government's suggested daily limits are 3-4 units for men and 2-3 units for women but as this potentially blurs the distinction between low risk and hazardous drinking we have used the weekly guidelines above for consistency.

Low risk alcohol use
This refers to drinking within legal and medical guidelines, which is not likely to result in alcohol-related problems.

Alcohol misuse
Alcohol misuse is a general term for any level of risk, ranging from hazardous drinking to alcohol dependence.

Hazardous drinking
A pattern of drinking alcohol that increases the risk of harmful consequences for the person. This term is used for males who regularly consume more than 21 units per week and females who regularly consume more than 14 units per week

Harmful drinking
A pattern of drinking alcohol that causes harm to a person's health or wellbeing. The harm may be physical, psychological or social. In the absence of evidence of harm, this term is used to describe males who regularly consume more than 50 units per week and females who regularly consume more than 35 units per week.

Binge drinking
Binge drinking refers to high intensity drinking during a single drinking session. It is strongly associated with intoxication or drunkenness. Binge drinking was defined in the 1995 UK government report as drinking twice the daily limit for alcohol consumption (i.e. 8+ units for men/ 6+ for women) in one day.

Alcohol dependence
Alcohol dependence (syndrome) is a psychobiological condition characterized by an inner drive to consume alcohol, continued drinking despite harm and commonly a withdrawal state upon stopping drinking.

Alcohol use disorder
An alcohol use disorder has been defined as hazardous, harmful or dependent drinking.[1]

1 For a more detailed discussion of terminology, see AL 27.

1 Introduction

1. Over the last 60 years English drinking habits have been transformed. In 1943, a Mass Observation survey noted that young people represented the lowest proportion of pub goers, preferring to frequent milk bars and coffee shops.[2] In 1947 the nation consumed approximately three-and-a-half litres of pure alcohol per head; the current figure is nine-and-a-half litres.[3] According to the General Household Survey data from 2006, 31% of men are classified as drinking hazardously (more than 21 units per week) or harmfully (more than 50 units per week); of these 9% drink harmfully. 21% of women are drinking hazardously (more than 14 units per week) or harmfully (more than 35 units per week); of these 6% drinking harmfully. While the consumption of alcohol has increased, taxation has declined in real terms and even more so as a fraction of average earnings. The rate of duty on spirits per litre of pure alcohol in 1947 was more than the weekly average manual earnings of a woman and almost 60% of a man's. If the rate of duty on spirits had been increased in line with average manual male earnings since 1947, it would have stood at about £200 in 2002; it was £19.56.[4]

2. The rising levels of alcohol consumption and their consequences have been an increasing source of concern in recent years. Media headlines emphasise the consequences of binge drinking which are a cause of many serious accidents, disorder, violence and crime. However, long term heavy drinking causes more harm to health. The President of the Royal College of Physicians told us that alcohol was probably a significant factor in 30 to 40,000 deaths per year. The WHO has put alcohol as the third most frequent cause of death after hypertension and tobacco. UK deaths from liver cirrhosis increased more than five-fold between 1970 and 2006; in contrast, in France, Italy and Spain the number of deaths shrank between two- and four-fold. UK deaths from cirrhosis are now above the other three countries.

3. Since 2000 a number of key studies have examined in more detail the scale of the damage done to health and society and considered the effectiveness of measures to reduce the harm.[5] Among these was the Prime Minister's Strategy Unit's highly regarded study of the costs of alcohol to the NHS and society entitled *Alcohol misuse: How much does it cost?*', which was published in 2003.

4. Following these studies, in March 2004 the Government produced its long-awaited alcohol strategy: *Alcohol Harm Reduction Strategy*. However, many of those who had pressed for the strategy were disappointed by it. It was thought that there was too much reliance on the provision of information while the most effective policy, increasing the price, had been ignored. Indeed, the duty on spirits was frozen from 1997 to 2007.

2 Q 26

3 Statistical handbook 2007 (British Beer and Pub Association, 2007)

4 We would like to thank the House of Commons Library and the Scrutiny Unit for providing these figures and undertaking the calculations.

5 For example see the CMO's report in 2001; *Alcohol: Can the NHS Afford It?* (RCP 2001); *Alcohol No Ordinary Commodity: Research and Public Policy* (Thomas Babor et al, 2003); *Calling Time* (Academy of Medical Sciences, March 2004).

5. After 2004 a series of reports, several commissioned by the Government, increased our understanding of the causes of alcohol consumption and the effectiveness of measures to counter them and threw further doubt on the Government's strategy.[6] The RAND Corporation's study, *Early Adolescent Exposure to Alcohol Advertising and its Relationship to Underage Drinking* (2007) found that children exposed to high levels of alcohol advertising were more likely both to drink and to intend to drink than those with low levels of exposure. KPMG undertook a *Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks* (commissioned by the Home Office from KPMG, April 2008), which found that the standards were widely breached and often inadequate. In 2008 work commissioned by the Department of Health from Sheffield University concluded that setting a minimum price of 50p for the sale of a unit of alcohol would prevent over 3,000 deaths a year and reduce the number of hospital admissions by 98,000.[7]

6. Given the scale of the problem and the widespread feeling that the Government's response has been inadequate we decided to undertake an inquiry.[8] We received memoranda from over 80 organisations and held seven evidence sessions. The witnesses included the authors of many of the recent important reports, clinicians, economists, historians, the drinks industry, supermarkets, advertisers, media agencies, PR firms, a range of quangos, including the Ofcom, the OFT and NICE, an official from HM Treasury, Ministers from the Home Office and the Department for Culture, Media and Sport, the Chief Medical Officer and the Minister of State for Public Health.

7. We asked a number of drinks companies, advertising agencies, PR firms and media organisations for internal documents relating to the marketing of a number of brands. These were examined for us by one of our advisers, Professor Hastings. We recognise the amount of work this involved and would like to thank all those who supplied us with information and Professor Hastings for analysing it. We would also like to thank a number of supermarkets for supplying us in confidence with information about their sales of alcohol.

8. As part of our inquiry we visited Scotland to examine the Scottish Government's very different approach to alcohol, which proposes the introduction of minimum pricing and a determination to address total alcohol consumption rather than concentrate on the minority of problem drinkers, which is the policy in England. We would particularly like to thank Dr Evelyn Gillan, Project Director, Scottish Health Action on Alcohol Problems,.for her help in organising a very useful series of meetings and Professor Sir Neil Douglas, the President of the RCPE, for hosting them. We also spent a day and a half in Paris discussing the restrictions on alcohol advertising and sponsorship. We were able to meet the Commission des Affaires Sociales of the Senate, policy specialists from the Health Ministry and the public health organisation INPES, an addiction psychiatrist and hospital director and a representative of the Ligaris advertising agency. We would like to thank them all for their help. During our visit to New Zealand earlier in the year in connection with several inquiries we found similar problems to those in England. A number of measures were

6 See below, chapter four.

7 *Independent Review of the Effects of Alcohol Pricing and Promotion* (independent review commissioned by the Department of Health from the School of Health and Related Research at the University of Sheffield, ScHARR, December 2008).

8 For the terms of reference, http://www.parliament.uk/parliamentary_committees/health_committee/hc0809pn08.cfm

being considered to improve the situation, including a comprehensive review of the legislative framework for the sale and supply of liquor which the New Zealand Law Commission was undertaking. We would like to thank the FCO, in particular Georgina Hill and Kate Jarrett in Paris and Jonathon Jones and Kendyl Oates in Wellington for organising the visits.

9. We would also like to express our gratitude to our advisers: Professor Christine Godfrey of York University, Department of Health Sciences, University of York, Professor Gerard Hastings of Stirling University, Institute for Social Marketing, Stirling and the Open University and Dr Nicholas Sheron, Head of Clinical Hepatology University of Southampton and Southampton University Hospitals Trust..[9]

10. During the inquiry it became clear that there is a great deal of evidence about the risks of drinking and the effectiveness of various policies to reduce the harm caused by alcohol. Because of the thorough research undertaken there is general agreement about the facts. However, their interpretation and the policy implications are disputed by health professionals, the alcohol industry and the Government. The main question we have had to address is whether Government policy is firmly based on the extensive evidence it has gathered.

11. In the report, chapter two looks at the history of alcohol consumption. The chief characteristics are the huge decline in consumption from the late 19th century to the mid-twentieth and its subsequent rise. Chapter three considers the impact of alcohol on health, the NHS and society as a whole, including the costs of crime and loss of work. Chapter four analyses the Government's alcohol strategy. Chapters five to nine consider respectively NHS policies on prevention and treatment; education and information policies, the marketing of alcohol, pubs and licensing; and off-licence sales, particularly in supermarkets. Chapter ten looks at the key issue of the price of alcohol, considering arguments for minimum pricing and rises in alcohol duty. Finally, in chapter eleven, we put forward a new alcohol strategy.

12. One of the historians who gave evidence to this Committee pointed out that there is a long history of select committees examining the problems associated with alcohol. A select committee, which reported in 1834, was described by contemporaries as the 'Drunken Committee'. Its recommendations were ignored at the time, but became part of Government policy much later in the century.[10] We trust it will not take so long for our own recommendations to be implemented.

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9 Professor Christine Godfrey declared her remunerated interest as adviser to the Institute of Alcohol Studies. Professor Godfrey's research group at the University of York also receives funding from the Department of Health and the NHS National Institute for Health Research (NHS NIHR).

Dr Nick Sheron declared his interest as Head of Clinical Hepatology University of Southampton and Southampton University Hospitals Trust, various memberships and unremunerated advisory work for the EU, national and local governments and as an unremunerated trustee of the Drinkaware Trust. Research grants from MRC, Wellcome Trust, British, Liver Trust, Alcohol Education Research Council and various other funding bodies. He has undertaken paid consultancy work and received travelling expenses from pharmaceutical companies developing drugs for the treatment of inflammatory bowel disease and liver disease. He has been paid for medico-legal work in the area of Hepatitis C and alcohol related liver disease.

Professor Hastings declared his interest as member of the Alcohol Education and Research council and other interests associated with his role as Professor of Social Marketing at Stirling University; involved with the BMA in its *Under the Influence* report.

10 Q 72

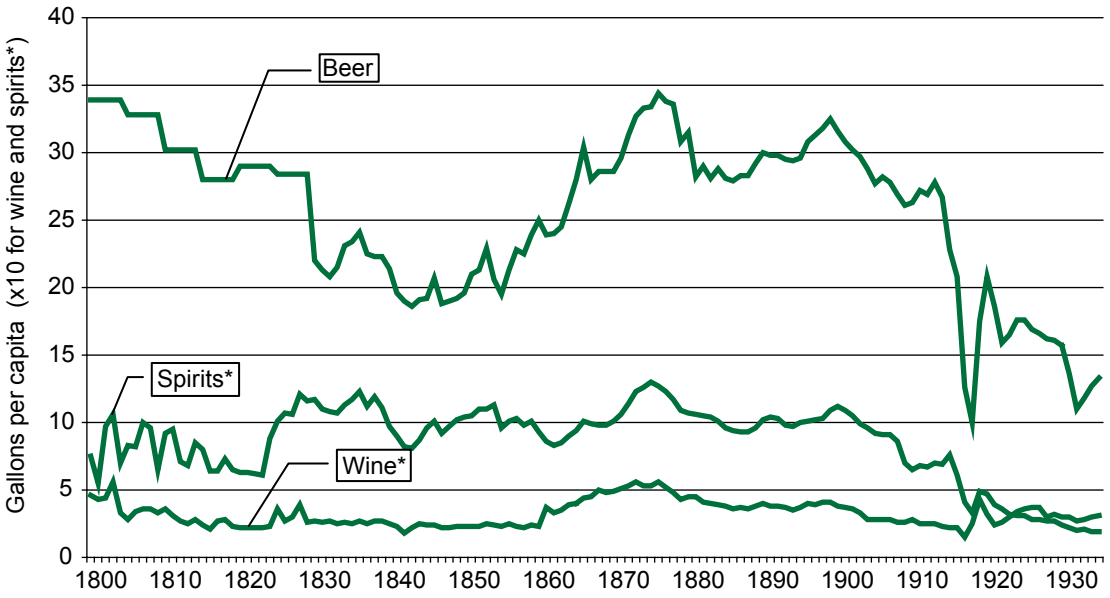
2 History

From the seventeenth century to the middle of the twentieth

13. Striking images of drunkenness such as Hogarth's "Gin Lane" have encouraged a widespread belief that the English have always been a nation of drunks. To examine the truth of such beliefs we sought written and oral evidence from a number of historians of alcohol.[11] Their evidence shows that far from being a story of perpetual drunkenness, English drinking habits fluctuated widely around a long term trend which was downward to the mid 20th century before the extraordinary increase in consumption over the last 50 years. Dr Nicholls told us that:

> It is important to bear in mind that in Britain drinking has had peaks but it has also had troughs; it has had some very low troughs. My personal concern about this is that if we overstate the idea that the British just like to drink that may have a negative consequence in the sense that it reinforces a certain expectation.[12]

Figure 1: Estimated per capita consumption 1800–1935[13]



Source: G. Wilson, Alcohol and the Nation

14. The historians who gave evidence to us differed slightly in their emphasis but essentially presented the same picture which is summarised in the box below. We were told that there was a long decline in alcohol consumption from the late 17th century with a blip in the first half of the 18th century associated with the gin craze. Levels rose again in the mid-nineteenth century but fell rapidly and significantly later in the century. They reached low levels in the inter-war years and remained low until the 1960s. The last thirty or forty

11 The historians were Dr James Kneale, UCL, Dr Angela McShane, V and A Museum, Dr James Nicholls, Bath spa University, Dr Phil Withington, University of Cambridge.

12 Q 67

13 AL 59

years have seen a significant shift in these long-term trends, not just because consumption levels are rising again, but because of the growing popularity of stronger drinks (wine and spirits).

History of alcohol consumption

1550-1650: commercialisation of domestic brewing industry; tobacco a commodity of mass consumption and an accompaniment to drinking; increased market for French wines—higher per head until present day [14]

1650-1750: the period 'when Europeans took to soft drugs', including coffee, tea and chocolate; the intermittent gin craze from the 1730s to the 1750s masks a stabilisation or decline in alcohol consumption over the period.[15] Beer was promoted by many anti-gin campaigners as the patriotic (and sober) alternative to gin. Despite this, beer consumption fell significantly throughout the 18th century, largely due to the increasing popularity of tea, coffee and chocolate .[16]

1750 to 1850: fall in alcohol consumption up to about 1840, particularly wine, increase in tea, which replaced beer as the popular staple of every day consumption.[17]

1850 to late 19th century: large increase in consumption; the 'consumption of beer, wine and spirits all peaked around 1875. The consumption of tea also grew'. These trends were associated with rising living standards.[18]

Late 19th century to mid-20th century: decline in consumption per head—associated with temperance movement, alternative leisure activities, including public parks and libraries.[19]

Mid-20th century onwards: increase in consumption from 3.5 litres per head to 9.5 (with slight falls in the early 1990s and 2005 onwards)

15. Like the myth that the English have always been drunk, the contrast between English drunkenness and civilised Mediterranean habits may also be something of a myth. While there is a good deal of literature in the past complaining about binge-drinking, the historians pointed out that little is known about the origins of the modern Mediterranean approach to drinking and it is therefore difficult to say how far back the contrast can be taken.[20]

16. Within the overall trends, different groups in Great Britain had very different drinking patterns. People in the countryside drank less than those in towns. Some groups were teetotal. According to the historian, James Kneale, it is not particularly helpful to talk of a

14 AL 57
15 AL 57
16 AL 59
17 AL 57, AL 59
18 AL 57
19 Q 72
20 Q 66

'British attitude to drinking', as there have always been large geographical variations in alcohol consumption:

> there has been considerable geographical variation as well as a good deal of historical change. As noted above… Across the UK urban dwellers tended to consume more alcohol than their rural counterparts, and areas dominated by trades like mining and dock work also recorded higher levels. In 1900 the average per capita expenditure on alcoholic drink was estimated to be £4 10s 4d a year; the average dock worker was thought to spend 8s 4½d on drink every week…, nearly five times as much as the average figure for the country.[21]

17. We asked the historians about the causes of changes in consumption. They pointed to two main groups of, sometimes contradictory, factors:

- Economics: the affordability of alcohol and the liberalness of the licensing regime have clearly had an impact on consumption: for example, the 18th century gin craze was linked to the Government's encouragement of gin production and restriction of brandy imports; the rise in consumption in the 19th century was associated with rising living standards. On the other hand, Government can bring about significant reductions in consumption:

> the First World War, which marks a significant moment because of the Government's efforts to control alcohol production and consumption—the most sustained attempt to come to grips with drink in British history. Measures included shorter opening hours, higher duties on beer, and significant reductions in both the production and strength of beer. The amount of beer consumed in 1918 was nearly half of the pre-war total, despite rising incomes, and arrests for drunkenness in England and Wales fell from 190,000 to 29,000 between 1913 and 1918.[22].

- Culture: some changes in culture have been encouraged by changes in affordability and availability, but at other times, changes in culture have nullified increases in affordability; Kneale observes the decline in drinking in the late 19th century:

> By the 1880s there were many counter-attractions for working-class consumers (music halls, football, cigarettes, and holidays); this decline seems to be a question of changing tastes.[23]

He adds that in the inter-war years

> While the Depression undoubtedly kept demand low in some areas, the majority of workers saw real wages increase between the wars. However, spending on alcohol did not increase, because drink had many rivals now: radios and gramophones, gardening, cinema and the pools.[24]

21 AL 55

22 AL 55

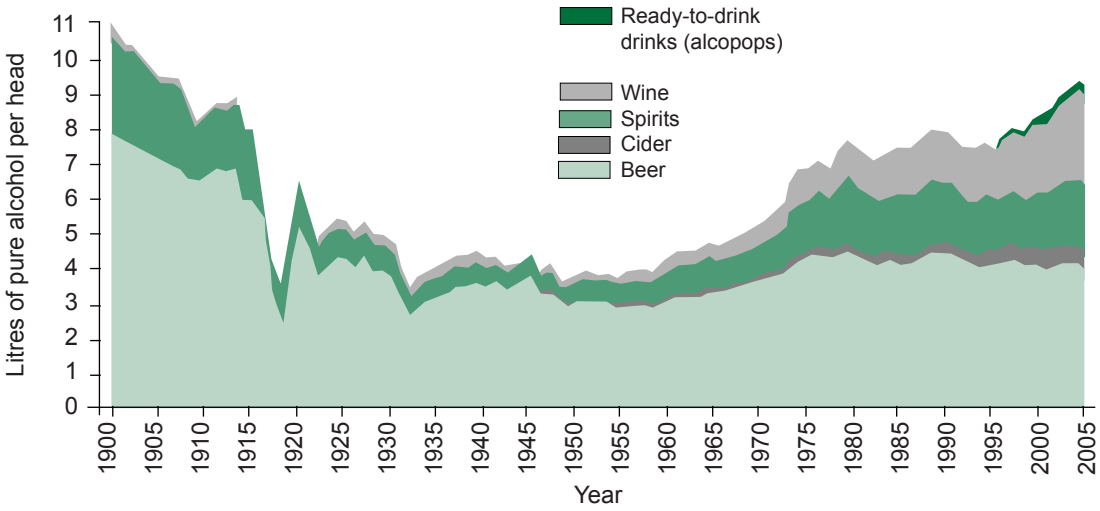
23 AL 55

24 AL 55

From the 1960s to the present day

18. Over the last half century there has been a massive increase in drinking, not just because consumption levels are rising again, but because of the growing popularity of stronger drinks, in particular wine and spirits and more recently strong white cider. As graph one shows, we now drink about three times more per head than in the years of lowest consumption.

Figure 1 – per capita alcohol consumption in the UK (litres of pure alcohol)



Source: Statistical handbook 2007 (British Beer and Pub Association, 2007)

19. The changes of the last half century have been associated by witnesses with the factors listed below, which are the same as the factors which influenced drinking in the past, ie. economics (affordability and availability) and changes in culture. They are discussed in more detail in the chapters below.

20. Affordability is a key influence on alcohol consumption and alcohol has become more affordable because of rising incomes, the failure of duty, notably the duty on spirits, to rise in step even with general inflation (let alone incomes) and aggressive promotions and discounts, particularly by supermarkets competing for business. It has been estimated that between 1980 and 2007 alcohol became 69.4% more affordable, relative to household incomes.[25] Alcohol has become more available because of the huge growth in the number of supermarkets which sell alcohol, an increasingly liberal regime for off-licence sales and a more liberal on-licence regime. There has also been a change in fashion over the last 40 years; as we have seen, in the 1940s young people preferred milk bars and coffee bars to pubs. These issues are discussed in more detail in the chapters below. [26]

21. We received a good deal of evidence about who drinks what. According to the Department of Health 10 million adults drink more than the recommended limits.[27] These 10 million drink 75% of all alcohol consumed in the country. 2.6 million adults (8% of men and 6% of women) drink above the higher-risk levels, ie more than double the

25 AL 59

26 Q 26

27 AL 01

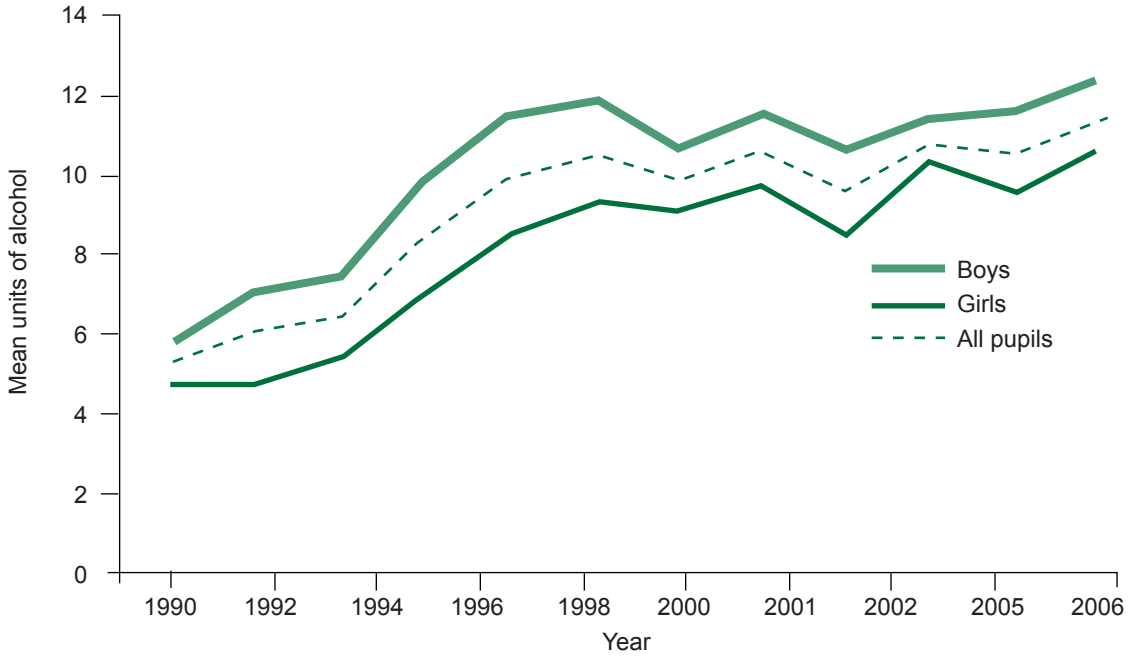
Government's guidelines (6 units for women, 8 units for men daily), drinking a third of all alcohol consumed in the country.[28] Data on alcohol consumption from the latest General Household Survey showed that over a third of adults (37%) exceed the recommended maximum alcohol guidelines on their heaviest drinking day of the week.[29]

22. One of the biggest change in the last 50 years has been in the drinking habits of women and young people:

> Whatever their social and cultural standing—i.e. Ugandan 'youths', medieval knights, the Victorian urban 'poor'; 20th century 'post-modernists', 16th century 'wits', Somali village elders—drinking, especially to excess, has been a masculine preserve. What is striking about current trends in Britain is that women are now engaging in many of the same drinking practices as men, and consuming similar if not more amounts of alcohol in the process.[30]

Teenagers drink twice as much as they did in 1990;[31] The following figure shows the sharp rises in consumption:

Figure 2 – mean alcohol consumption (units) in the last week, by sex in pupils aged 11 to 15, England, 1990–2006



Source: Smoking, drinking and drug use among young people in England in 2006: headline figures (Information Centre for Health and Social Care, National Centre for Social Research, National Foundation for Educational Research, 2007)

23. Professor Plant, who has been involved in surveys of 15 and 16 year olds across Europe from Greenland to Russia., told us that British teenagers

28 AL 01

29 http://www.statistics.gov.uk/pdfdir/ghs0109.pdf

30 AL 57

31 Q 85

> have consistently reported very high levels of periodic heavy drinking, very high levels of intoxication, they also report exceptionally positive views of what their expectations are going to be about when they go out to drink

In the latest survey UK teenagers reported 'high levels binge drinking, intoxication and alcohol-related individual, relationship, sexual and delinquency problems', ranking third just after Bulgaria and the Isle of Man.[32]

24. The drinking habits of young people of university age is widely commented on. During the course of our inquiry, our attention was drawn to reports of student "binge drinking", particularly during the annual "Freshers' Week" in September. The most high profile of these reports featured the trial of one inebriated student that had urinated on a war memorial, while taking part in a commercially-organised student event. As a result of this and other controversies, we invited written evidence from university representatives and student events promoters.

25. The National Union of Students[33] argued that "students' unions are some of the most responsible retailers of alcohol". However, it accepted that unions needed to maintain alcohol sales in order to fund student services, and that this had led to drinks promotions and consequently binge drinking and anti-social behaviour in some cases.[34] Universities UK[35] insisted that universities "did not have a duty of care for their students" but it recognised that they had a "significant interest in their welfare". It accepted that there is "clearly a problem in some parts of the country with aggressive external promoters targeting young people".[36]

26. Varsity Leisure Group Limited is the owner of the "Carnage UK" brand which has become, unfairly or otherwise, a notorious example of a promoter of nightclub events for students. Despite the brand name, Varsity Leisure Group told us that "Carnage UK events are based around collective identity, meeting new people and having fun". It stressed that there were no offers on alcoholic drinks at its events, and soft drinks are provided to students free of charge. Nevertheless, the organisation concluded that "students are being immersed into a culture which is focussed around the culture of alcohol. The culture may need to change; the offering of cheap drinks promotions and alcohol-led events may need to be addressed".[37]

27. According to HM Revenue and Customs data, since 2004 when consumption peaked, there has been a slight decrease in alcohol consumption in terms of litres of pure alcohol. UK per capita consumption rose by 27% between 1995 and 2004, but then until 2007 fell by 3%. There has not been a clear and consistent pattern of falling consumption since 2003 as shown in the figure below. It is unclear whether the recent fall in consumption

32 Q 81

33 The national body representing 600 affiliated students' unions across the UK.

34 AL 82

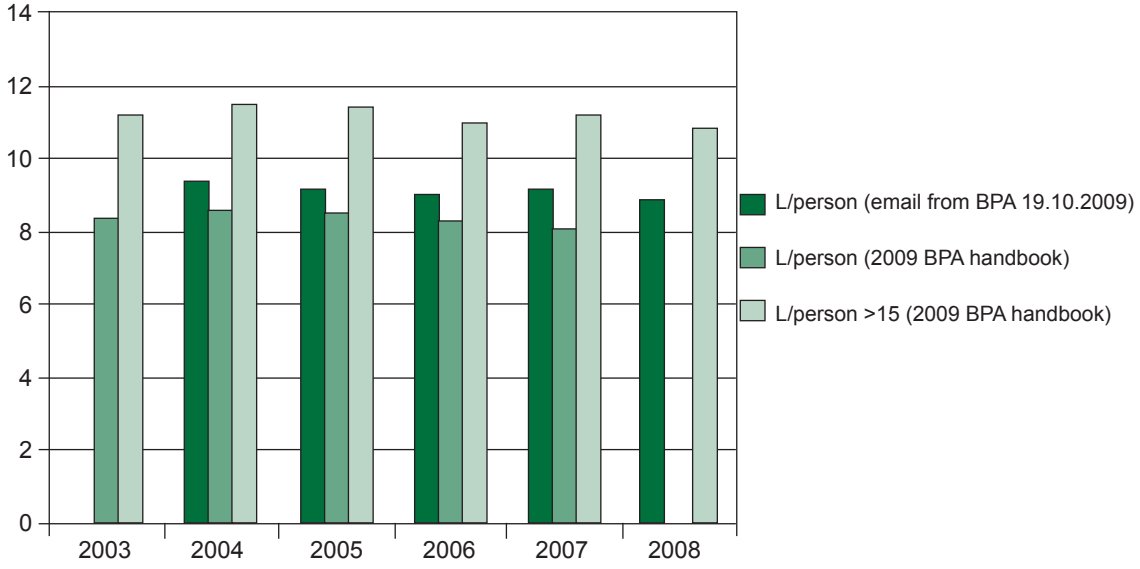
35 The representative organisation for the heads of universities.

36 AL 83

37 AL 64

represents a watershed or is merely a temporary phenomenon. There was also a dip in the early 1990s.

Figure 3: Consumption of pure alcohol



Source: Data from BPA handbook but based on HM Revenue and Customs data[38]

28. The Portman group and industry representatives state that 29% of the male population drank more than 21 units a week in 2000, but that the figure was 23% in 2006.[39] On the other hand, the latest ONS figures show that hazardous drinking had in fact increased between 2000–2008 from 24% to 28% in men, and from 15% to 17% in women.[40] The BMA has urged caution in interpreting the recent figures as reflecting a real long-term change in drinking habits:

> It is important to note that it is not yet possible to determine whether these recent trends in alcohol consumption are genuine long-term changes in drinking habits. It may be that there is an increased tendency to under-report consumption due to the recent extensive publicity about binge drinking and the dangers of heavy consumption. Data from future years will provide a clearer indication of any long-term trends.[41]

Conclusions and recommendations

29. **The history of the consumption of alcohol over the last 500 years has been one of fluctuations, of peaks and troughs. From the late 17th century to the mid-19th the trend was for consumption per head to decline despite brief periods of increased consumption such as the gin craze. From the mid- to the late 19th century there was a sharp increase in consumption which was followed by a long and steep decline in consumption until the mid 20th century.**

38 The e-mail was sent from the BPA to our adviser, Dr Nick Sheron by Mark Hastings.

39 AL 35

40 ONS, *Drinking: adults' behaviour and knowledge in 2008*, Opinions (Omnibus) Survey Report No. 39, 2009, table 2.1.

41 BMA, *Alcohol misuse: tackling the UK epidemic.* February 2008.

30. **The variations in consumption are associated both with changes in affordability and availability, but also changes in taste. Alternative drinks such as tea and alternative pastimes affected consumption. Different groups drank very different amounts. Government has played a significant role both positive and negative, for example in reducing consumption in the First World War as well as in stimulating the 18th century gin craze by encouraging the consumption of cheap gin instead of French brandy.**

31. **From the 1960s consumption rose again. At its lowest levels in the 1930s and -40s annual per capita consumption was about 3 litres of pure alcohol; by 2005 it was over 9 litres. These changes are, as in past centuries, associated with changing fashion and an increase in affordability, availability and expenditure on marketing. Just as Government policy played a part in encouraging the gin craze, successive Government policies have played a part in encouraging the increase in alcohol consumption over the last 50 years. Currently over 10 million adults drink more than the recommended limits. These people drink 75% of all the alcohol consumed. 2.6 million adults drink more than twice the recommended limits. The alcohol industry emphasises that these figures represent a minority of the population; health professionals stress that they are a very large number of people who are putting themselves at risk. We share these concerns.**

32. **One of the biggest changes over the last 60 years has been in the drinking habits of young people, including students. While individual cases of student drunkenness are regrettable and cannot be condoned, we consider that their actions are quite clearly a product of the society and culture to which they belong. The National Union of Students and the universities themselves appear to recognise the existence of a student binge drinking culture, but all too often their approach appears much too passive and tolerant. We recommend that universities take a much more active role in discouraging irresponsible drinking amongst students. They should ensure that students are not subjected to marketing activity that promotes dangerous binge drinking. The first step must be for universities to acknowledge that they do indeed have a most important moral "duty of care" to their students, and for them to take this duty far more seriously than they do at present**.

33. **Since 2004 there has been a slight fall in total consumption but it is unclear whether this represents a watershed or a temporary blip as in the early 1990s.**

34. We now turn to look at how much of a problem the levels of drinking described in this chapter are. What health risks are people running in drinking over the recommended limit or even double the limit?

3 The impact of alcohol on health, the NHS and society

35. Over recent years the public have been exposed to mixed messages from the media with some articles promoting the benefits of alcohol, especially wine, in preventing cardiovascular disease, others stressing the harm done in causing cancer and liver disease and others the consequences of binge-drinking.

36. Doctors tend to stress the harm done. The BMA points out that whilst alcohol may indeed have some moderate beneficial cardiovascular effects in older men and women with low intake, 'these are insignificant compared to the dangers of excessive intake'.[42] Sir Liam Donaldson, the Chief Medical Officer informed the committee that there were no safe limits of drinking.[43] and that "alcohol is virtually akin to smoking as one of the biggest public health issues we have to face in this country".[44]

37. The acute intoxicating effects of alcohol are the most visibly shocking to the public. Brian Hayes, a London Ambulance Paramedic, drew our attention to the consequences of binge-drinking:

> We are talking about people that because of alcohol have jumped on a wall because they think it is a bravado thing to do with their mates, not realising that the drop on the other side is 60 feet and they have gone down it. Their one massive night has ended up with a family with someone who is deceased….. the injuries we have been faced with have been so horrific, due to a bus driver who had kicked somebody off his bus and his head had been used as a football by about five or six blokes who were all drunk, and he ended up in intensive care. This is happening week in, week out; it does not have to be a Friday or Saturday…….We went to one female who was found staggering down a road in south-east London, completely out of it on alcohol. When we got her into the ambulance we went to remove her jacket to take her blood pressure and she had nothing on underneath, and did not have a clue what had happened to her.[45]

Alcohol also causes accumulating harm to a large sector of society in much more subtle, long term ways. Alcohol contributes to liver cirrhosis, acute and chronic pancreatitis, heart failure, hypertension, depression, strokes and cancer and can harm developing foetuses.

38. Furthermore alcohol is addictive, with 3.5m people in the UK dependent on it.[46] It severely impairs the physical, mental and social well-being of the user, their families and others.

42 Ev 20

43 Q 1018

44 Q 1029

45 Q 200

46 Psychiatric morbidity among adults living in private households, 2000, ONS. http://www.statistics.gov.uk/downloads/theme_health/psychmorb.pdf

Alcohol harms health through three mechanisms:

- acute intoxicating effects, occurring after a single binge.
- chronic toxic effects, following years of drinking at harmful levels.
- propensity for addiction leading to physical and psychological dependency.

39. Alcohol impacts on the entire range of services the NHS provides, from neonatal care to healthcare for the elderly. Liver disease, a useful marker of alcohol related harm, is soaring in the UK, with a five-fold increase since 1970. There were 863,300 alcohol related hospital admissions per year. Alcohol costs the NHS £2.7 billion per annum.[47]

The impact of alcohol on health

Physical health by age

40. Acute intoxication with alcohol following a single 'binge' can cause alcohol poisoning, injuries and accidents, with young people being disproportionately affected. Alcohol is strongly associated with an increased risk of acquiring sexually transmitted infections (STIs). The rates of STIs increased 63% in the UK between 1998 and 2007 and as many as 76% of people in one genitourinary clinic in 2006 reported having unprotected sex as a result of drinking.[48]

41. The figures below show deaths attributable to alcohol consumption.

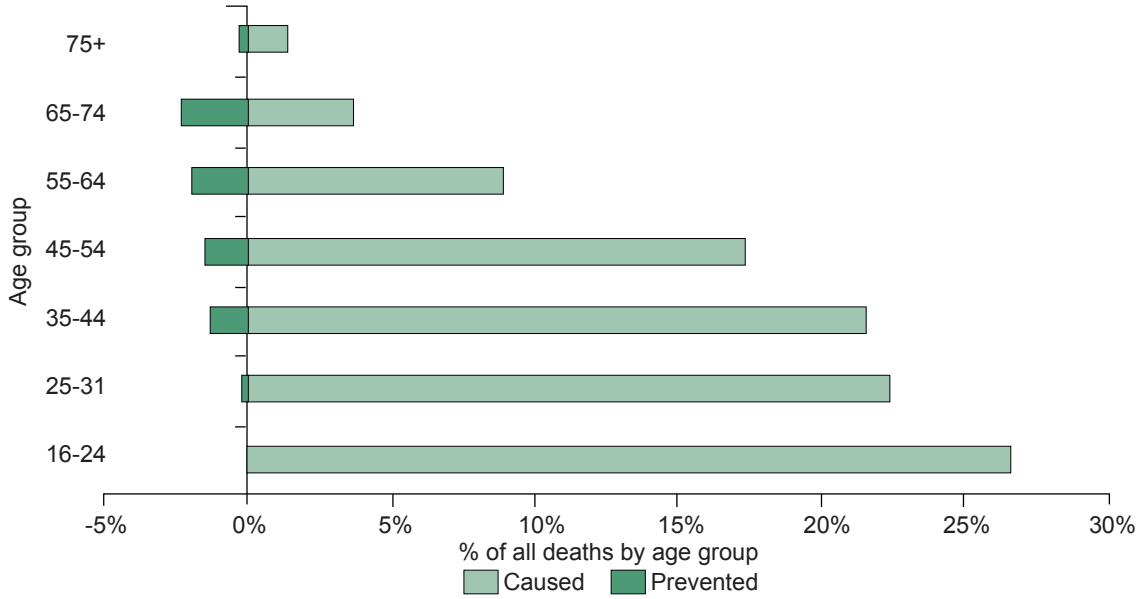


Figure 4: Percentage of male deaths attributable to alcohol consumption (2005)[49]

47 The NHS Information Centre, *Statistics on Alcohol: England, 2009,* 2009, p 8.

48 Ev 62: Standerwick K, et al. 2007. Binge drinking, sexual behaviour and sexually transmitted infection in the UK. International Journal of STD and AIDS, no. 18, 810-813.

49 Jones L, Bellis MA, Dedman D, Sumnall H, Tocque K. *Alcohol attributable fractions for England; alcohol attributable mortality and hospital admissions.* North-West Public Health Observatory and Dept of Health; 2008, p 26..

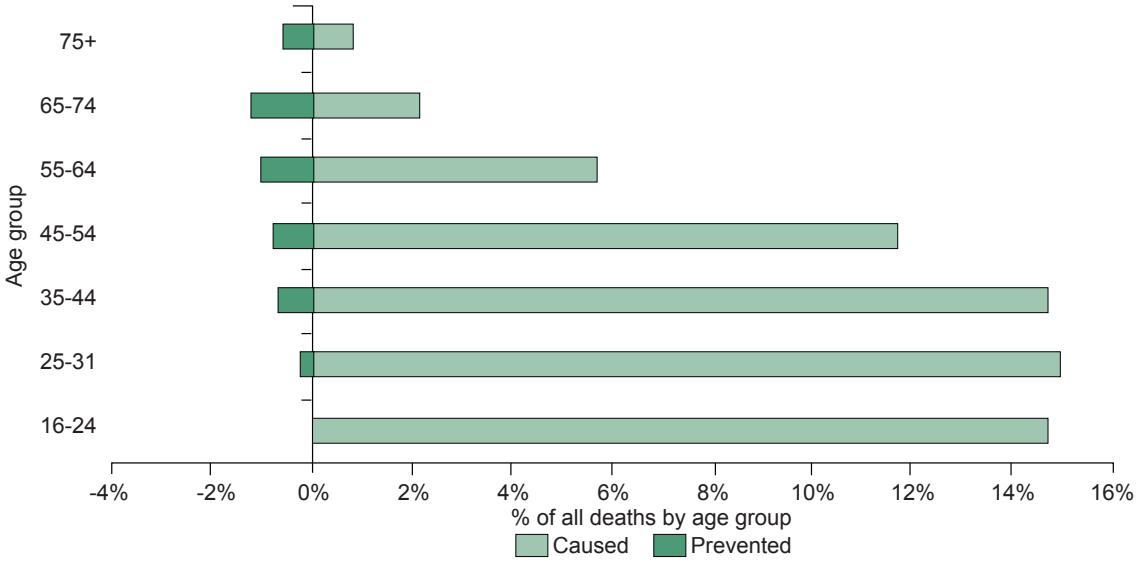


Figure 5: Percentage of female deaths attributable to alcohol consumption (2005)[50]

They show how alcohol affects different age groups. Between the ages of 16 and 34, more than 20% of male deaths, and 14% of female deaths are attributable to alcohol consumption. In this age group the main causes are road accidents, injuries and poisoning, including suicides. Overall between one third and one seventh of accidental deaths are alcohol related—amounting to 1,700 deaths each year.[51]

42. In people over 35 the main alcohol related causes of death are firstly liver disease, and then cancer and high blood pressure. Alcohol is the second biggest risk factor for cancer after smoking. Alcohol especially contributes to cancers of the mouth and throat, liver, laryngeal, colon (in men) and breast cancer. It is responsible for many cancer deaths each year; of these perhaps the most worrying is breast cancer—alcohol accounts for 6% of breast cancer in the UK amounting to around 3,000 cases each year.[52]

Mental health

43. Problem drinking is heavily associated with mental illness (from anxiety and depression through to schizophrenia) and personality difficulties, with each driving the other. Heavy drinkers are more than twice as likely to commit suicide as non-drinkers.[53] Between 16 and 45% of suicides are thought to be linked to alcohol and 50% of those 'presenting with self harm' are regular excessive drinkers.[54]

44. The known association between alcohol and cognitive decline has been neglected by most of the recent inquiries into alcohol. Some researchers have recently warned against a

50 Ibid., p 27.

51 Prime Ministers Strategy Unit. Interim Analytical Report. 2003.

52 Key J, Hodgson S, Omar RZ, Jensen TK, Thompson SG, Boobis AR, et al. Meta-analysis of studies of alcohol and breast cancer with consideration of the methodological issues. Cancer Causes Control 2006 Aug;17(6):759-70.

53 Tatsuo A, Iwasaki M, Uchitomi Y, et al, Alcohol consumption and suicide among middle-aged men in Japan, British Journal of Psychiatry, 2006, 188: 231–236

54 Prime Minister's Strategy Unit. Strategy Unit Alcohol Harm Reduction Project: Interim Analytical Report. London. Cabinet Office, 2003

possible surge in alcohol-related dementia in the future, compounding the expected boom in dementia due to an ageing population.[55]

The health of others

45. The Royal College of Physicians provided a dramatic summary:

> The passive effects of alcohol misuse are catastrophic—rape, sexual assault, domestic and other violence, drunk driving and street disorder—alcohol affects thousands more innocent victims than passive smoking.[56]

46. According to the British Crime Survey, in 2007, 46% of violent offenders in England and Wales were perceived by their victims to be under the influence of alcohol.[57] During 2002 there were 1.2 million incidents of recorded alcohol-related assault in England and Wales, but it is estimated that only 20% of such assaults were recorded by police as crime[58] 76,000 facial injuries in the UK each year are linked to drunken violence.[59] In 2006 6% of all road casualties and 17% of road deaths and serious injury from road traffic crashes in the UK were due to drivers being under the influence of alcohol.[60]

47. Alcohol harms the developing foetus. The Royal College of Midwives informed us that 6,000 babies are born with Foetal Alcohol Syndrome in the UK each year.[61]

> Foetal Alcohol Syndrome (FAS) is the term used to describe the visible birth defects and invisible organ/brain/nervous damage that can result from exposure to alcohol during pregnancy. It is used to describe the most severe form of a wide range of permanent physical, mental and behavioural problems that begin before birth. From malformed faces and limbs to heart problems and diminished intellectual capacity.[62]

48. The National Society for the Prevention of Cruelty to Children (NSPCC) highlighted the alcohol problems which are associated with parental neglect and physical abuse and affect up to 1.3 million children in the UK.[63] In the year ending March 2008 the NSPCC told us they received more than 80 calls per week from children where alcohol misuse by what they described as a 'significant other' (ie a parent or someone close to them) was the main reason for their call. The National Association for the Children of Alcoholics (NACOA) in claimed that alcohol was a factor in 40% of domestic violence cases, 40% of child protection cases, and 74% of child mistreatment cases, and supplied evidence that

55 Gupta S & Warner J, *Alcohol-related dementia: a 21st century silent epidemic*, British Journal Psychiatry, 2008, 193: 351–353

56 Ev 156

57 Ev 2

58 Ev 25

59 Ev 2

60 Ev 21

61 Ev 26

62 Ev 108

63 Ev 44

children of alcohol dependent parents were much more likely to have psychiatric, behavioural and substance misuse problems.[64]

Mortality and disease

49. ONS data (published in January 2009)[65] estimated there were 8724 alcohol related deaths in England and Wales in 2007, double the rate in 1991. However Professor Ian Gilmore, President of the Royal College of Physicians explained that this was almost certainly a gross under-estimate, with better estimates suggesting alcohol-related deaths may be 30–40,000 which is as much as half that of smoking related deaths:

> Those 8,000 are the ONS figures and that is where alcohol is named on the death certificate as the cause of death. Nearly all of those are alcohol induced liver cirrhosis. It does not pick up the accidents, the violence and so on. If you include cases where alcohol is named on the death certificate as a contributory cause, then the figures rise to about 15,000, but if you actually take the percentage of oesophageal cancer that can be attributed to alcohol etc, using the attributable fraction (which is a well recognised and scientifically reputable way of doing it) the figure comes out between 30,000 and 40,000.[66]

50. Dr Peter Anderson told us that 'Disability Adjusted Life Years' (DALYs[67]) were a more useful measure of health impact than simple mortality rates since they accounted for morbidity leading to disability as well. Worldwide, alcohol is estimated to cause 3.3% of deaths and 4% of DALYs.[68] However its effect is much more pronounced in developed countries where it causes 9.2% of lost DALYs, not far behind tobacco's 12.2%.

51. Professor Gilmore pointed out that alcohol was a source of health inequalities and Dr Anderson explained that people from lower socio-economic groups were more harmed by a given level of alcohol consumption.[69] In the most deprived areas of the UK, men are 5 times more likely and women 3 times more likely to die an alcohol related death than those in the least deprived areas.[70] This is discussed in more detail in the chapter on pricing below.

Risk

52. Most research has examined 'relative risk', i.e. the proportional increased prevalence of illness in drinkers compared to non-drinkers. The 'absolute risk' increases as the relative risk but it also depends on how common the problem is. Data from a large study of 10,000

64 Ev 28

65 Ev 156

66 Q 5

67 The disability-adjusted life year (DALY) is a measure of overall disease burden, originally developed by the World Health Organization. It is designed to quantify the impact of premature death and disability on a population by combining them into a single, comparable measure. In so doing, mortality and morbidity are combined into a single, common metric

68 J, Room R, Monteiro M et al, 2003, *Alcohol as a risk factor for global burden of disease*. European Addiction Research; 9(4), 157–164

69 Q 4

70 Office of National Statistics, *Health Statistics Quarterly 33* (Spring **2007**)

people in Copenhagen[71] showed that the relative risk of clinically apparent liver disease increased by 50% above 20 units/week, 350% above 40 units/week and 900% above 90 units/week. The increase in relative risk was the same for someone in their thirties as in their fifties, but the absolute risk of being admitted to hospital was much higher for a 50 year old. So for example, for 50 year man drinking more than 90 units per week, the risk of dying or being admitted to hospital with liver disease over the next 10 years was 15-18%, whereas for a 30 year old man it was 4-6%.

53. Similarly with women and breast cancer, because it is very common—110 women in every 1,000 will get breast cancer at some stage in their lives—the absolute risk from alcohol is quite substantial. The World Cancer Research Fund International estimate that for every thousand women drinking a bottle of wine each week throughout their lives, approximately ten i.e. 1% will develop breast cancer as a direct result of the alcohol. If they drank two bottles of wine each week the number increases to 15-20 women per 1,000, i.e. 1.5 -2%.

54. These risks may seem low, but for comparison purposes the Health and Safety executive quote some comparative absolute risks: the risk of dying from a scuba dive is 1 per 100,000 i.e. 0.0001%, from a base jump (jumping off a building with a parachute) is 1 in 2,000, i.e. 0.05%.

55. Dr Anderson explained that "when you look at alcohol the risks in relation to harm are pretty well monotonic or linear meaning that the risk starts at zero and it goes upwards. The more you drink, the greater the risk"..[72] Nevertheless, the Government has thought it useful to provide advice about the risks of drinking. Its latest advice was drawn up in 1995. It is unclear how the recommended units were decided upon, but it seems to be the point at which the benefits of alcohol from reducing cardiovascular disease are outweighed by the risks of cancer, liver disease and other harms. Essentially, drinking at this level can be seen to do harm at a population level, but the risks to an individual are quite low. However, once people drink at double the recommended limits the risks to an individual become more substantial. The following table sets out the Department of Health's different 'risk' categories associated with different levels of drinking

Table 1: categories of drinkers

Category	Alcohol consumption in men	Alcohol consumption in women
Low risk or 'sensible'	21 units/week	14 units/week
Increasing risk or 'hazardous'	22–50 units/week	15–35 units/week
High risk or 'harmful'	>50 units/week	>35 units/week

A unit of alcohol is defined as 8g or 10 ml of alcohol

71 Becker U, Deis A, Sørensen TI, et al. 1996. *Prediction of risk of liver disease by alcohol intake, sex, and age: a prospective population study*. Hepatology. 1996 May,1025–9

72 Q 14

The impact of alcohol on the NHS

Primary care

56. GPs are presented with a range of chronic physical, mental and social problems arising from alcohol. Problem drinkers consult their GPs twice as often as the average patient.[73] Dr Paul Cassidy, a GP in Gateshead, told the committee:

> Often, when GPs think alcohol they think alcohol dependence. They are the patients who seem to give us the biggest problem, because we have problems getting them into treatment and it is a chronic illness. I see the non-dependent drinkers, of whom there are a lot, in every day practice, and the challenge for me is to pick those people up. The impact is often felt on the more dependent end, but there are the more subtle effects of raising people's blood pressure or leading to small injuries that affect the normal patient who comes through the door. Certainly it is a common and routine part of clinical practice.[74]

Accident and Emergency Departments and the Ambulance Service

57. Estimates of the proportion of alcohol related emergency attendance vary. A national survey of most of the UK's Emergency Departments by Drummond found that 70% of night time attendances and 40% of daytime attendances were caused by alcohol. A study from Cambridge found the lowest proportion of alcohol related attendances was 24% at night and 4% during the day.[75] The College of Emergency Medicine informed us:

> Significant numbers of adults and children attend Emergency Departments in the UK as a direct result of alcohol consumption. Short-term harms include serious accidents (some resulting in death and permanent disability, particularly road traffic collisions), assaults, domestic violence, collapse and psychiatric problems. Furthermore, all Emergency Departments also admit, on a daily basis, patients suffering from the longer-term health effects of sustained alcohol use, for example acute withdrawal fits secondary to alcohol dependence, pancreatitis and liver failure.[76]

58. Brian Hayes, a London Ambulance Paramedic, told us about the added costs of treating alcohol intoxication:

> The first thing most of them do as we leave the scene is vomit. That then renders the ambulance off the road for an hour once that call has been finished because it has to be deep cleaned because of infection and so on. Hopefully none of the vomit has gone over the ambulance crew because if that happened—shower, change your uniform. So you can be looking at that ambulance being unavailable to deal with anything else for two hours, two and a half hours because of alcohol. Then you will

73 Ev 40

74 Q 109

75 Ev 24

76 Ev 24

> get the ones where the ambulance crews have been assaulted…We have had cases of paramedics being sliced with knives, punched, kicked, ambulances being nicked just as a prank through somebody being drunk and driving it into a row of cars.[77]

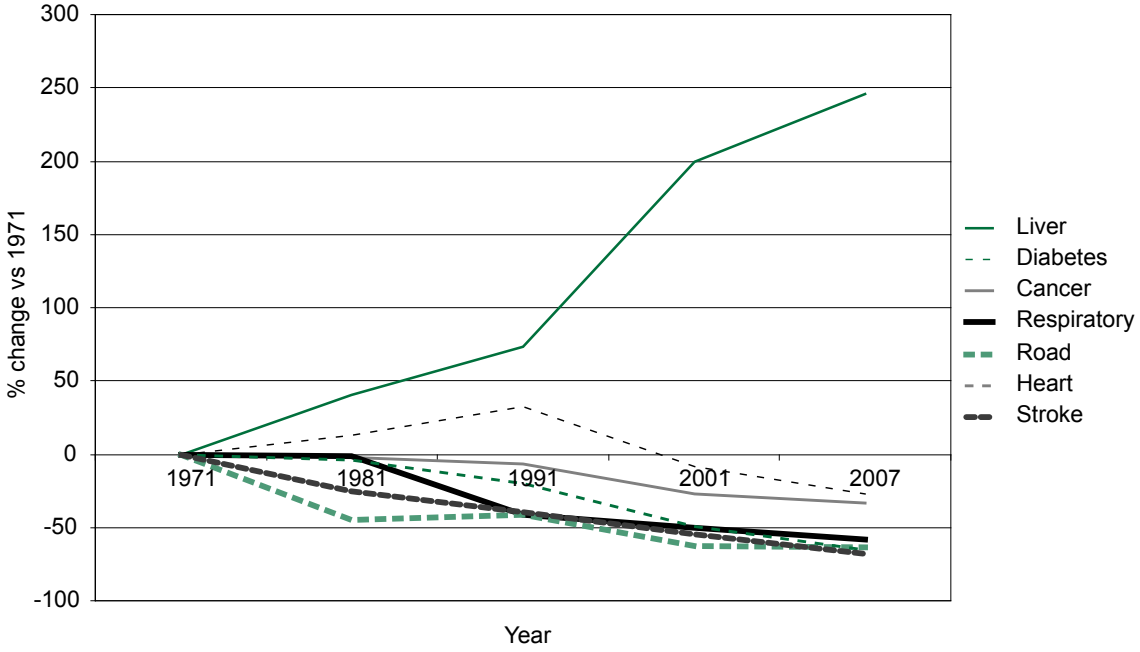
Hospital admissions

59. When secondary diagnoses of an alcohol related disorder are included, 863,300 alcohol-related admissions occurred in England in 2007/2008.[78] This is more than 6% of all admissions and a 69% increase from 2002/2003 and rising by around 70,000 per year.[79] There has been a two-thirds increase in alcohol-related admissions in over 65s in past 4 years, from 197,584 in 2002 to 323,595 in 2007.[80]

Liver services

60. Mortality from liver disease is regarded as one of the best barometers of alcohol related ill health. Between 1970 and 2000 deaths from liver disease in people aged under 65 increased fivefold, while death rates from other diseases have declined, as figure 6 shows.[8182]

Figure 6: Movements in mortality 1971–2007 (Deaths per million of population)[83]



77 Q 254

78 NHS Information Centre for Health and Social Care, *Statistics on Alcohol: England, 2009*, p 8.

79 Ev 2

80 Ev 157

81 Ev 66

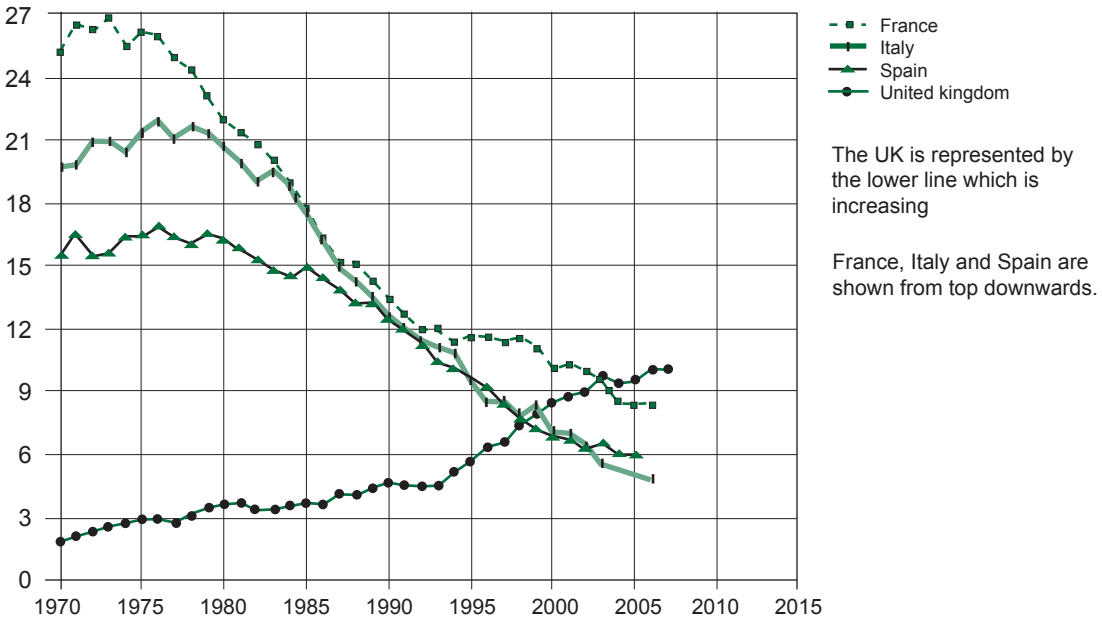
82 Ev 157

83 British Liver Trust analysis of Office for National Statistics mortality statistics covering all deaths related to liver dysfunction covering ICD K70–76 and other codes including C22–24 (liver cancer), and B15–B19 (viral hepatitis), January 2009

The British Society of Gastroenterology (BSG) and the British Association for Study of the Liver (BASL) highlighted:

> While the wine drinking countries of Southern Europe always had historically very high levels of liver deaths from alcohol related cirrhosis (figure 7 below); deaths in these countries have been dropping whereas UK deaths are still rising inexorably. The UK finally overtook Spain, Italy and France for liver deaths in 2004.[84]

Figure 7: SDR, chronic liver disease and cirrhosis, 0–64 per 100000



Source: WHO, Europe, European HPA Database, January 2009

Overall costs to the NHS

61. Alcohol cost the NHS £2.7 billion in England in the year 2006–2007 according to the Department of Health.[85] The NAO found that:

> Most of these costs are borne by the front-line and mainstream NHS: hospital services (inpatient and outpatient) account for 56% of the total. Ambulance services and accident emergency services, taken together, bear almost a third … of these estimated costs, while hospital services account for over a half … of the total. Specialist alcohol treatment services, provided by non-NHS organisations, account for only two per cent of the total estimated costs.[86]

The figure below highlights the huge disparity between the vast indirect costs of alcohol for the NHS and the small amounts spent on services to treat alcohol problems.[87]

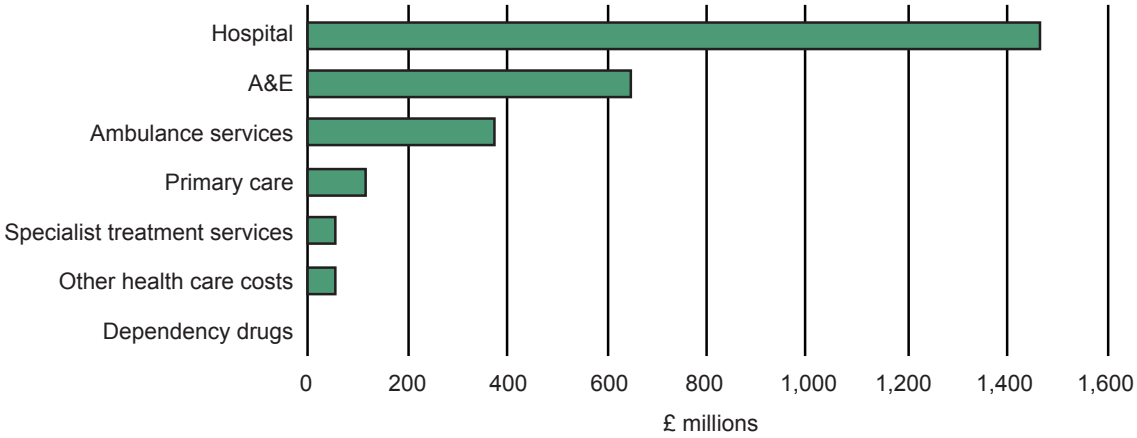
84 Ev 65

85 Ev 2

86 National Audit Office, *Reducing Alcohol Harm: Health Services in England for Alcohol Misuse*, 2008, p 12.

87 Ibid., p 12.

Figure 8: Annual estimated costs of alcohol harm to the NHS, 2006–07



Source: Department of Health Improvement Analytical Team report, The cost of alcohol harm to the NHS in England: An update to the Cabinet Office (2003) study, July 2008

NOTES: 'Hospital' includes inpatient visits directly and partly attributable to alcohol misuse and outpatient attendances. 'Other healthcare costs' include alcohol-related counselling, community psychiatric nurse visits and health visits.

The expenditure on Dependency Drugs is estimated to be at least £2.14 million per annum.

The overall cost of alcohol to society

62. Health is just one of many Government departments which foot the bill for alcohol-related harm. The total cost to society including costs to the criminal justice system, the economy and social care were estimated by the Cabinet Office in 2003 to be £20 billion.[88] This estimate was composed of £1.7 billion in health costs, £7.3 billion for crime and public disorder[89] plus an estimated £4.7 billion for additional human and social costs of crime, and £6.4 billion from loss of productivity and profitability in the workplace.

63. However, in 2007 the National Social Marketing Centre produced a much higher estimate of £55.1 billion.[90] This estimate was composed of £21 billion cost to individuals and families/households, £2.8 billion cost to public health and care services, £2.1 billion cost to the Criminal Justice System, Education and Social Services, £7.3 billion cost to employers and £21.9 billion in human cost (reduced quality of life adjusted years). The box below shows the different estimates for the costs.

88 Prime Minister's Strategy Unit. Strategy Unit Alcohol Harm Reduction Project: Interim Analytical Report, London, Cabinet Office, 2003

89 The £7.3 billion Includes £3.5 billion to services as a consequence of alcohol-related crime, £1.7–2.1 billion to services related to crime, for example extra security staff to prevent disorder, burglary alarms, shops spending on extra security, £1.8 billion to the criminal justice system and £0.5 billion from drink-driving

90 Lister G, *Evaluating social marketing for health—the need for consensus*. Proceedings of the National Social Marketing Centre, 2007.

Estimated annual costs of alcohol-related harm in England

The National Social Marketing Centre estimated that the total annual societal cost of alcohol misuse in England to be £55.1 billion including:

- £21 billion cost to individuals and families/households (eg loss of income, informal care costs)
- £2.8 billion cost to public health services/care services
- £2.1 billion cost to other public services (eg criminal justice system costs, education and social services costs)
- £7.3 billion cost to employers (eg absenteeism)
- £21.9 billion in human costs (DALYs).

The 2004 PMSU report estimated the overall annual cost of alcohol-related harm in England to be £20 billion including:

- Up to £1.7 billion for the healthcare service
- Up to £7.3 billion from alcohol-related crime and public disorder (£3.5 billion to services as a consequence of alcohol-related crime, £1.7–2.1 billion to services in anticipation of alcohol-related crime, £1.8 billion to the criminal justice system, £0.5 billion from drink-driving)
- Up to £6.4 billion from loss of productivity and profitability in the workplace (£1.2–1.8 from alcohol-related absenteeism, £2.3–2.5 billion from alcohol-related deaths, £1.7–2.1 billion from lost working days).

Conclusions

64. **The fact that alcohol has been enjoyed by humans since the dawn of civilization has tended to obscure the fact that it is also a toxic, dependence inducing teratogenic and carcinogenic drug to which more than three million people in the UK are addicted. The ill effects of alcohol misuse affect the young and middle aged. For men aged between 16 and 55 between 10% and 27% of deaths are alcohol related, for women the figures are 6% and 15%.**

65. **Alcohol has a massive impact on the families and children of heavy drinkers, and on innocent bystanders caught up in the damage inflicted by binge drinking. Nearly half of all violent offences are alcohol related and more than 1.3 million children suffer alcohol related abuse or neglect.**

66. **The costs to the NHS are huge, but the costs to society as a whole are even higher, all of these harms are increasing and all are directly related to the overall levels of alcohol consumption within society.**

4 The Government's strategy

67. In the face of the increasing consumption of alcohol and growing alcohol-related problems, Governments were surprisingly inactive from the 1970s onwards, allowing alcohol to become more affordable and restricting their actions to undertaking occasional studies such as that undertaken by an Inter-Departmental Working Group which was published as *Sensible Drinking,* in 1995.[91]

Key documents relating to alcohol since 2000

2001 Annual report of the CMO (drew attention to the extent of alcohol-related harm.)[92]

2001 *'Alcohol: Can the NHS Afford It'?* (Royal College of Physicians)

2004 *'Calling Time'* (The Academy of Medical Sciences)

2003 *Alcohol No Ordinary Commodity: Research and Public Policy* (Thomas Babor et al—funded by WHO)

2003 Alcohol misuse: How much does it cost? (The PM's Strategy Unit)

2004 'The Alcohol Harm Reduction Strategy for England' (The PM's Strategy Unit)

2005 *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (Dept. of Health);

2006 *Alcohol in Europe* (A report for the European Commission)

2007 *Early Adolescent Exposure to Alcohol Advertising and its Relationship to Underage Drinking* (RAND)

2007: *Safe. Sensible. Social. The next steps in the National Alcohol Strategy* (DH and Home Office, 2007

2008 *Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks* (commissioned by Home Office from KPMG)

2008 *Independent Review of the Effects of Alcohol Pricing and Promotion* (independent review commissioned by the Department of Health from ScHARR)

2009 Annual report of the CMO (which called for minimum pricing)

2009 *Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol,* Anderson et al (Lancet)

2009 *Under the influence* (The BMA)

2009 *Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people?* – (Science Group of the European Alcohol and Health Forum)

68. However, over the last decade, pressure on the Government to act has mounted with the publication of a series of reports by leading clinicians at the beginning of this millennium, including the Chief Medical Officer, the Royal College of Physicians, and the

91 The study reviewed both the medical and scientific evidence on the long term effects of drinking and the sensible drinking message; it recommended setting a daily rather than weekly limit.

92 The CMO's report drew attention to the extent of alcohol-related harm, in particular cirrhosis of the liver.

Academy of Medical Sciences. The box above lists a number of the key publications of the last decade.

69. In 2003 the Government published *Alcohol misuse: How much does it cost?* which was a detailed and impressive assessment of the costs of, and harm done by, alcohol. Then, in March 2004 the Government published *The Alcohol Harm Reduction Strategy for England* The Government's strategy "aimed to:

- tackle alcohol-related disorder in town and city centres
- improve treatment and support for people with alcohol problems
- clamp down on irresponsible promotions by the industry
- provide better information to consumers about the dangers of alcohol misuse', including advice about daily units."

70. In a foreword the Prime Minister wrote:

> increasingly, alcohol misuse by a **small minority** [our emphasis] is causing two major, and largely distinct problems: on the one hand crime and anti-social behaviour in town and city centres, and on the other harm to health as a result of binge- and chronic drinking.[93]

71. These comments were surprising unless the Prime Minister was only referring to those who caused the crime and disorder and those who were clearly alcoholics since the report showed that misuse was not a problem for a small minority: it stated that "a quarter of the population drink above the weekly guidelines of 14 units for women and 21 units for men. It also observed that 5.9m adults were 'binge drinking'. The Prime Minister himself acknowledged that 'The Strategy Unit's analysis last year showed that alcohol-related harm is costing around £20bn a year, and that some of the harms associated with alcohol are getting worse'.

72. The Strategy proposed that progress be reviewed in 2007. The review was published in *Safe. Sensible. Social. The next steps in the Government's Alcohol Strategy* (Dept of Health and Home Office). The document stated that significant progress had been made.[94] Levels of violent crime had fallen, and levels of alcohol consumption were no longer rising, but public concern about the harm caused by alcohol had risen as had the incidence of liver disease and deaths caused by excessive drinking. While the strategy remained essentially the same, there were perhaps some differences in emphasis. In 2007 alcohol was not a problem for a small minority, but rather there was a "**significant** [our emphasis] minority who don't know when to stop drinking".

73. The renewed alcohol strategy announced that the Government would carry out three reviews of industry practice and then consult on whether there was a need for further regulation of alcohol retailing. These were:

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93 Our bold

94 The Government stated that of the 41 actions in the original strategy, 26 have been delivered and a further 14 are underway.

> an independent national review of evidence on the relationship between alcohol price, promotion and harm, [which], following public consultation, [would] consider the need for regulatory change in the future, if necessary
>
> A review and consultation … on the effectiveness of the industry's Social Responsibility Standards in contributing to a reduction in alcohol harm … following public consultation, [this would] consider the need for regulatory change in the future, if necessary
>
> Consultation … in 2008 on the need for legislation in relation to alcohol labelling, depending on the implementation of the scheme to include information on sensible drinking and drinking while pregnant on alcohol labels and containers

74. The Department of Health's description of the strategy is set out in the box below.[95]

Informing and supporting people to make healthier and more responsible choices

- public health education campaigns to improve understanding of alcohol units and health risks; and to challenge binge drinking and tolerance of drunkenness
- planned campaigns from 2009 for children and their parents
- publication of The Chief Medical Officer's Guidance on the Consumption of Alcohol by Children and Young People.

Creating an environment in which the healthier and more responsible choice is the easier choice:

- a review of the provisions of the Licensing Act published in March 2008
- toughened enforcement to clamp down on alcohol fuelled crime and disorder and under-age sales
- an independent review commissioned by the Home Office of the effectiveness of the alcohol industry's social responsibility standards published in July 2008
- an independent review commissioned by the Department of Health on the effects of alcohol pricing and promotion, published in December 2008
- proposals in the Policing and Crime Bill for a mandatory code for alcohol retailing …

Providing advice and support for people most at risk:

- development of the evidence on effectiveness of brief advice and specialist alcohol treatment

A delivery system that effectively prioritises and delivers action on alcohol misuse:

- a new Public Service Agreement (PSA) indicator ..to ..address alcohol-related hospital admissions
- the Alcohol Improvement Programme, central and regional support for PCTs to help them commission and deliver improvements… linking to the World Class Commissioning programme.

95 AL 01

75. Subsequently, a number of other changes have been made. In July 2009 on the day that the Minister for Public Health appeared before this Committee, the 'Biggest ever campaign to encourage responsible drinking' was announced. It had been agreed that the Drinkaware Trust would run the Campaign for Smarter Drinking.[96]

76. The most important changes are made by the Policing and Crime Act 2009 which, according to the Government, seeks to prevent the sale of alcohol to young people, introduces a mandatory code in respect of promotions and allows local authorities to act against irresponsible premises. Health campaigners welcomed the Bill, but were disappointed that a number of additional measures which had originally been planned were dropped. The Bill is discussed in more detail in chapter 8.

77. The Government claimed that its strategy was starting to work:

> We are delivering the commitments we made in those publications (the 2004 strategy and 2007 renewed strategy) and the latest data available (2007) show a small fall in the numbers of alcohol-related deaths in England. Total consumption may have plateaued since 2005.[97]

78. However, health professionals who had pressed for the alcohol strategy were critical of it when it appeared in 2004 and the 2007 review was thought to be little better. Many submissions to this inquiry, for example those of Duncan Raistrick, Alcohol Concern and NICE itself were critical.

79. In response to claims that the recent fall or levelling out in consumption suggested the strategy was working, critics argued, first, as we have seen, that it was unclear whether the decline was a temporary phenomenon and, secondly, that there was no evidence that the fall was caused by the Government's strategy. Moreover, the level of consumption still remained considerably higher than it had been even in the 1990s.

80. Health professionals argued that it was clear what policies were effective and surprising that they had not formed part of the strategy: Professor Anderson told us that the Government had failed to make use of the available evidence:

> We can learn that there is overwhelming evidence for what kind of policy options work….What we know is that price is very, very important. If the price of alcohol goes down, consumption and harm go up and vice versa. … We know that the availability matters. In general the more available alcohol is in terms of the number of outlets, the density of outlets and the days and hours of sale, the more consumption and harm there is. The converse is that availability is restricted and there is less harm. We also know that marketing has an impact. It is smaller than the impact of price and availability but there is an impact. … Finally, the other very important area is the work done by the healthcare system and service. There are a lot of people who do have hazardous and harmful patterns of drinking for whom some

96 http://www.drinkaware.co.uk/ /biggest-ever-campaign-to-encourage-responsible-drinking-announced

97 AL 01

> early identification and brief advice from a GP or a practice nurse or someone else is effective in helping them change their drinking.[98]

Professor Gilmore told us:

> "In 2004 in building up towards the alcohol harm reduction strategy for England they got a very good evidence base together but they failed to deliver on some of the evidence around price and availability and emphasised too much the voluntary partners in industry".[99]

81. A comprehensive strategy was necessary, using all the tools available to Government. Information should be part of the strategy, but it would not change behaviour on its own. More emphasis should have been given to more effective policies, namely increases in price, restrictions on availability and control of marketing.

82. While some observers have claimed that much of the difference between the Government and health professionals in their approach to the price mechanism reflects lobbying by the drinks industry and supermarkets and electoral considerations, it is also underpinned by a different philosophy. On the one hand Government and the industry stress that the problem is down to a minority of irresponsible drinkers. Accordingly, increasing prices would penalise the vast majority of sensible drinkers; the best policy is to change the habits of the small minority through better information, education and enforcement along the lines used in the drink-driving campaign.[100] In contrast, health professionals argue that we are not dealing with a small minority of the population, pointing out that over 10m adults drink more than the recommended limits and 2.6 m drink at even riskier levels of double the limits. Alcohol Concern informed us that the Strategy "mistakenly viewed alcohol misuse as the preserve of a small minority".[101]

83. Health professionals also point to the 'whole population theory' first propounded by the French mathematician, Ledermann, who argued that there was a fixed relationship between average per capita consumption of alcohol and the number of problem drinkers and the amount of alcohol related harm. Thus alcohol is a societal problem: the more drinking is seen as the norm, the more those prone to drink are likely to become problem drinkers. Ledermann predicted that doubling or trebling average consumption would lead to a four or nine fold increase in the numbers of problem drinkers.[102] Professor Sir John Marsh noted that the problems associated with alcohol were

> deeply related to cultural norms within society. Cultural patterns have changed to reduce the constraints on alcohol abuse. Incomes have risen allowing members of cultural groups where excess drinking is acceptable to consume more alcohol.[103]

84. In contrast, the industry's view, as the Portman Group put it, is that

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98 Q 45

99 Q 51

100 Ev 124-6

101 AL 13

102 DH, *Sensible Drinking: The Report of an Inter-Departmental Working Group*, 1995.

103 Ev 34

> policy approaches that seek to tackle the problems of alcohol misuse by making the population as a whole drink less are untargeted, unfair and unlikely to succeed. Instead, measures should focus on addressing the minority that drink irresponsibly.[104]

The different philosophies are reflected in different approaches by the Governments in England and Scotland: in England the minority is targeted, in Scotland society as a whole.

85. We were told that the Government's Alcohol Strategy put the interests of alcohol producers and retailers above the health of UK citizens.[105] The Government's strategy is seen as closer to the policies put forward by the drinks industry than those proposed by health professionals. Our adviser, Nick Sheron, examined the industry's memos to the Committee and found that they supported the policies which are seen as least effective by clinicians:

> No more regulations
>
> Partnership approaches
>
> Information campaigns
>
> Education

These are also the main policies promoted by the Alcohol Strategy. The World Health Organisation reviewed the effectiveness of a range of alcohol policy approaches in 2003 (Babor et al 2003). The Royal College of Psychiatrists compared the Alcohol Harm Reduction Strategy for England with the WHO findings, arguing that the Strategy eschewed the most effective policies and adopted the least effective.

104 AL 35

105 AL 20

Table 2: The Alcohol Harm Reduction Strategy mapped against Babor et al. (2003) analysis of effective alcohol strategies[106]

Strategy	Impact	Alcohol Harm Reduction Strategy and Licensing Act
Taxation and Pricing	High	"More complex than price"
Restricting availability	High	24 hour availability
Limiting density of outlets	High	"Local planning"
Lower BAC driving limits	High	No change
Graduated licensing for young drivers	High	No
Minimum drinking age	High	No
Brief interventions/treatment	Medium	"Lack of evidence"—needs assessment; evidence review, Alcohol service framework
Safer drinking environment	Medium	Voluntary codes: safer glasses
Heavier policing	Medium	Antisocial behaviour orders, on the spot fines
Public education campaigns	Low	Change safe drinking message, unit labelling
School based education	Low	More education
Voluntary advertising restrictions	Low	Yes

Source: Drummond and Chengappa 2006

86. Thus health professionals are concerned that the drinks industry supports those policies which are least likely to lead to a reduction in the sale of drinks and are least likely to be effective.

87. Since about 10 million people drink more than the recommended levels and 75% of all the alcohol consumed is drunk by people who drink more than the recommended limits, there are doubts about how keen the industry really is on encouraging sensible drinking. Petra Meier of Sheffield University calculated for the Committee the drop in sales if everyone kept to the recommended limits. She concluded that if everyone who currently drinks over the limit became just compliant with moderate drinking guidelines, the total alcohol consumption would drop by 40%.[107] The figure is enormous. Since UK alcohol sales were worth £33.7 billion in 2006/07, if sales also fell by 40%, this would amount to over £13 bn.

88. **We congratulate the Government on the impressive research it has undertaken and commissioned and its analysis of the effects and costs of alcohol. It has analysed the**

106 Ev 171

107 AL 62A

health risks and shown them to be significant and found the costs of alcohol to society to be about £20 bn each year. It has also commissioned research into the effectiveness of a range of policies for reducing consumption.

89. **Unfortunately, the Government's Alcohol Strategy failed to take account of this research. Despite all the evidence to the contrary, in its 2004 Strategy the Government stated that alcohol was a problem for a small minority; we assume it meant that a small minority committed alcohol-related crime and were chronic alcoholics. We are pleased that it has subsequently recognised that the problem affects a significant minority as medical opinion indicates.**

90. **Unfortunately, too, the Government has given greatest emphasis to the least effective policies (education and information) and too little emphasis to the most effective policies (pricing, availability and marketing controls); in fact, by freezing the duty on spirits from 1997 to 2007 the Government encouraged consumption.**

91. **We are concerned that Government policies are much closer to, and too influenced by those of the drinks industry and the supermarkets than those of expert health professionals such as the Royal College of Physicians or the CMO. The alcohol industry should not carry more weight in determining health policy than the CMO. Alcohol consumption has increased to the stage where the drinks industry has become dependent on hazardous drinkers for almost half its sales.**

92. **In view of the scale and nature of the problem, we agree with the health professionals that a more comprehensive alcohol policy is required, which makes use of all the mechanisms available to policy makers: the price mechanism, controls on availability and marketing and improvements in NHS services as well education and information. There is a relationship which needs to be addressed between how much we drink as a society and the number of people who drink too much.**

93. In the following chapters we deal first with the role of the NHS and then look at the other measures to reduce harmful consumption.

5 NHS policies to address alcohol related problems

94. Alcohol imposes an ever increasing burden on the health service. Such is the scale of this burden that small reductions in the number of people misusing alcohol could save the NHS large sums of money. Unfortunately, despite recent initiatives and improvements the NHS remains poor at dealing with alcohol-related problems. Clinicians are poor at detecting alcohol abuse and urgently need to do better, but this will only be done effectively if there are specialist services which patients can be referred to. These are poorly funded and commissioning alcohol services remains a low priority for PCTs, despite the long-term returns it could produce.

95. The NAO report in 2008 found that many PCTs had no strategy for alcohol, no idea of local needs or of their spending on services. There was a wide variation on the provision of services.[108] The NAO recognised that specialist treatment for dependency was effective and cost effective and criticised the reliance of PCTs on local Drug (and Alcohol) Action Teams (DATs);[109] pointing out that the Home Office holds the main DAT budget and ring fences it illegal drugs. The NAO were also concerned over possible limitations of the PSA indicator on alcohol related hospital admissions, and pointed out that more than a third of PCTs have not included the alcohol target in Local Area Agreements Recent Initiatives.

96. When asked why alcohol services are so unimpressive, Gillian Merron, Minister of State for Public Health, replied:

> The truth and simple answer: yes, local services are patchy; yes, we can do better, but I think we have now got the things in place that will allow that to happen.[110]

The improvements include:

i) Drug and Alcohol Action Teams (DAATs) which were set up to take the lead in commissioning services to tackle drug and alcohol harm.. They are partnerships of professionals from local authorities, Primary Care Trusts (PCTs), police, probation and from private and voluntary sector providers. Initially they tended to focus on drug misuse, but following encouragement by the 2004 National Alcohol Strategy the proportion commissioning alcohol services has increased to 81%.[111]

ii) In 2006 the DH and the National Treatment Agency (NTA) published 'Models of Care for Alcohol Misusers' (MoCAM)[112] outlining best practice guidance on commissioning of alcohol services.

108 National Audit Office, *Reducing Alcohol Harm: Health Services in England for Alcohol Misuse*, 2008

109 Drug Action Teams (DATs) are funded by the Home Office via the National Treatment Agency (NTA) to provide intervention and treatment for users of illegal drugs, some DATs focus purely on drugs, others now include some alcohol treatment services and have changed the name to Drug and Alcohol Action Teams (DAATs).

110 Q 1065

111 NAO, *op. cit.,* p 20. 2008

112 The National Treatment Agency, *Models of care for alcohol misusers (MoCAM)*, 2006.

iii) In April 2008 the DH introduced two strategies in an attempt to direct commissioners to address alcohol needs. The first was a new Public Service Agreement (PSA-25) on alcohol and illegal drugs. This included 5 'vital signs' indicators to measure progress, which can be selected by PCTs. One of these aims to secure a reduction in the rate of increase of alcohol-related hospital admissions, whilst the others focus on the effects of illegal drug use and alcohol related social disorder. Secondly, Local Area Agreements (LAAs), which are developed by local councils through negotiation with the Regional Government Offices, can include an alcohol measure.

iv) In November 2008, an Alcohol Improvement Programme was set up by the DH. This included initiating a National Alcohol Treatment Monitoring System, an Alcohol Learning Centre and a new network of Regional Alcohol Offices (with £2.7 million funding per year), each with a Regional Alcohol Manager to support commissioners in delivering the PSA.[113]

The state of alcohol services

97. Despite these initiatives and the growing awareness that alcohol is a serious problem, services remain poor, as we describe below.

Commissioning services

98. Although the DH encourages them to do so, PCTs are not required to commission any alcohol-specific services or assess local alcohol related needs. The Operating Framework, which applied to all PCTs from 2005 to 2008, included 36 national targets, but made no specific reference to alcohol.[114]

99. Many memoranda welcomed MoCAM's introduction, but the Royal College of GPs noted that no assessment had been made of its effectiveness.[115] The respondents to the recent 2009 inquiry by the All Party Parliamentary Group on Alcohol Misuse gave mixed views about MoCAM's usefulness, with some feeling it had helped to focus on need for better alcohol provision in the area, but others saying it had made little difference to the work of their organisation.[116]

100. The NHS Confederation informed us that all the 36 PCTs (about 25%)responding to a survey it had undertaken in November 2008 had a strategy for alcohol related harm.[117] In contrast, the NAO survey conducted about the same time found that only 65% of PCTs had adopted the PSA-25 alcohol vital signs indicator and only 52% of the Local Area Agreements, also introduced in April 2008, included this measure. It recommended that the DH should assist PCTs further in aiding their ability to commission services more effectively.[118]

113 Ev 6 and Q 233

114 NAO, *op. cit.,* p 17.

115 Ev 56

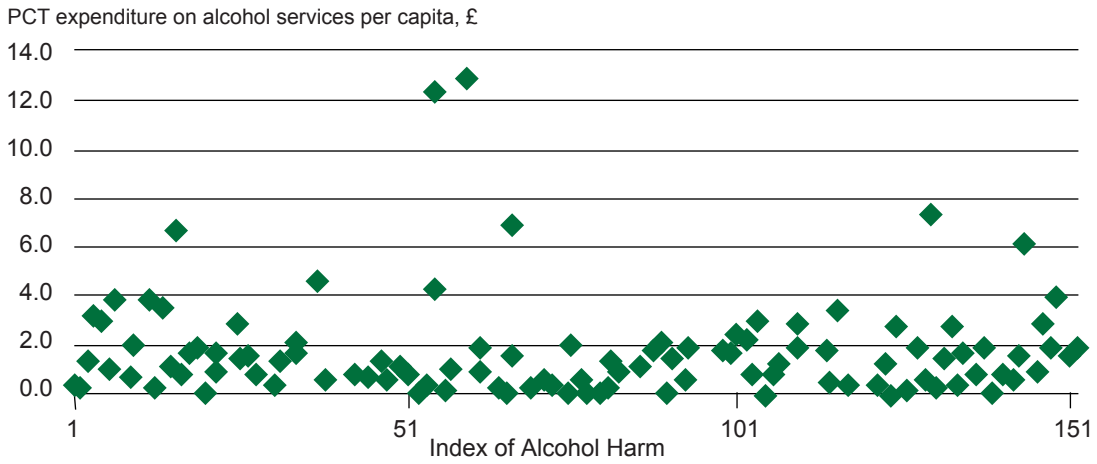
116 All Party Parliamentary Group on Alcohol Misuse. *The future of alcohol treatment services,*. Alcohol Concern. 2009

117 Ev 142

118 NAO, *op. cit.,* p 21, 8-9.

101. PCTs spent an average of just £600,000 on commissioning alcohol services in 2006–07, representing just over 0.1% of a typical PCT's total annual expenditure.[119] This figure included funding the provision of brief advice from GPs and weekly alcohol clinics as well as more intense specialist treatments. There was little correlation between PCTs spending on alcohol services and the extent of alcohol problems in their local population, as shown in figure 9.[120]

Figure 9: PCT expenditure patterns for services to reduce alcohol harm



Source: National Audit Office

NOTES:

1. The PCT expenditure figure includes dedicated alcohol-specific funding from PCTs to Drug and Alcohol Action Teams.

2. The Index of Alcohol Harm, developed for the National Audit Office by the North West Public Health Observatory (NWPHO) which compiles the Local Alcohol Profiles for England, combines a number of indicators of alcohol harm. A score of 1 indicates the lowest level of alcohol harm and 152 the highest.

102. PCTs give a much higher priority to drug than alcohol services. The DH established that in 2004 an average of just £197 was spent on each dependent drinker, compared to £1744 for each dependent drug users.[121] In 2009–2010 the pooled budget for drugs and alcohol services is £406m, but most of this is ring-fenced for drug treatment.

103. DAATs' overriding concern is also drug abuse, with their main source of funding (a budget of £385 million in 2006–07) ring-fenced for that purpose.[122] The Royal College of GPs informed us that:

> Still too much responsibility lies with the DAATs, many of whom do not have the capacity or capability to respond. Many DAATs do not have sufficient links with

119 NAO, *op. cit.,* p 17.

120 NAO, *op. cit.,* p 18.

121 Ev 176

122 NAO, *op. cit.,* p 20.

primary or acute hospital care to commission effective alcohol interventions in these areas.[123]

Primary care services

104. Alcohol has a big effect on a GP's workload. They have to cope with a host of medical problems, from raised blood pressure or depression through to increased cancers, liver problems and skin problems, to minor injuries and domestic abuse. Paul Cassidy, a GP, told us that treating the effects of alcohol misuse is a routine part of his clinical work.[124]

105. Despite the workload alcohol creates for GPs and although some GPs have a special interest in alcohol-related problems, the Royal College of GPs admitted that both screening and the provision of 'Brief Advice' were only rarely provided by GPs.[125] The BMA commented that presently there is no system for routine screening and management of alcohol misuse in primary or secondary care settings in the UK.[126] Furthermore very few GPs offer formal interventions to encourage people to cut down their drinking.

106. However a new Directed Enhanced Service (DES), in which newly registered GP patients will be screened for alcohol consumption, with an additional £8 million incentive for GPs to undertake screening and brief advice has been set up.[127] Additionally the DH has developed a new E learning programme available from February 2009 for GPs wishing to give brief interventions.

107. It remains to be seen how much effect these initiatives will have. In the meantime, most GPs struggle to do anything due to cynicism and pessimism about the help available beyond primary care.[128]

Specialist alcohol treatment services

108. People with established alcohol dependency need much more intensive treatment than a simple brief intervention, and these treatment modalities are delivered by specialist alcohol treatment services. There is a wide regional variation in their prevalence, which is not related to the size of the region's population, ranging from an estimated 198 organisations in London and 130 in the South East to just 32 in the North East and 20 in the East Midlands.[129] The best evidence of regional variation is from the Alcohol Needs Assessment Research Project (ANARP) report in 2004 which showed the level of support expressed as a ratio of those in need. In the. North East only one in 100 of those in need are treated which reflects both the small size of service provision and high levels of alcohol

123 Ev 56

124 Q 109

125 Ev 57

126 Ev 23

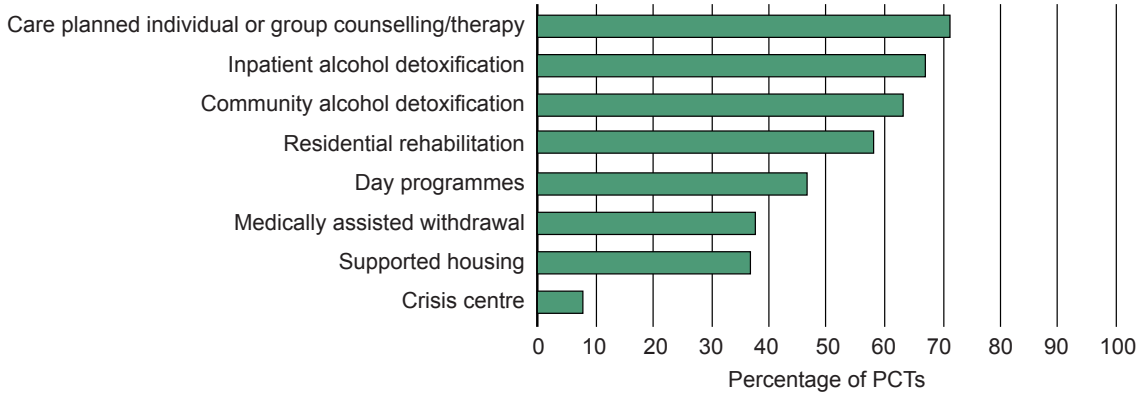
127 Ev 5 and Ev 23

128 Q 113

129 The Department of Health's Alcohol Needs Assessment Research Project (ANARP) 2004

misuse The proportion of PCTs providing each type of specialist treatment is shown below[130]:

Figure 10: Provision of specialist services by PCTs



Source: National Audit Office survey of PCTs

NOTE: Medically assisted withdrawal or relapse prevention relates to the prescribing of the drugs acamprosate and disulfiram.

109. Specialist Alcohol services are currently poorly planned and poorly funded. The NAO found that:

> "Only a small minority of dependent drinkers were receiving treatment, estimating that approximately 1 in 18 (5.6%) alcohol dependent people were accessing specialist alcohol treatment in England each year. These figures are low, both in comparison to other countries and to the treatment of illegal substance misuse. A study in North America found an access level of 1 in 10 (10%) which the researchers considered to be 'low'. The study considered a level of access of 1 in 7.5 (15%) to be medium and 1 in 5 (20%) to be high. In England, an estimated 1 in 2 (55%) problem drug misusers gain access to treatment each year."[131]

110. According to Gillian Merron MP, Minister of State for Public Health, the Government has:

> increased the number of treatment places up from 63,000 to over 100,000, so we are now reaching 10% of the numbers that we need to.[132]

However, according to the National Treatment Monitoring Service, in February 2009 there were just under 55,000 people in treatment for alcohol use disorders in England. PCT priorities are reflected in the better provision of drug treatment services: more than 190,000 people were engaged in drug treatment at some point in the past year.

130 NAO, *op. cit.,* p 33.

131 Ev 43

132 Q1020

Detoxification and rehabilitation in the community

111. Dependent patients may present with symptoms of acute withdrawal, requiring acute detoxification, whereby a drug, usually cholordiazepoxide is given in a reducing dose regime over several days to prevent serious withdrawal symptoms. In some areas patients are 'detoxed' at home, but the lack of community detox resources means that hospitals are increasingly being used as detox centres.[133]

The voluntary sector

112. In 2003, of £95 million spent each year on specialist alcohol services, £71 million of this was spent by the voluntary sector.[134] A wide range of services is provided, from rehabilitation programmes in residential centres and in prisons to community support and counselling services.

113. However, some witnesses had concerns about the voluntary sector's ability to manage alcohol problems. Dr Duncan Raistrick told us:

> I think there possibly is an over enthusiasm by some non-statutory sector services to go for contracts that possibly they are not likely to be competent to deliver; indeed, that has happened recently somewhere I know, where a non-statutory agency got a contract to deliver an arrest referral scheme and then phoned a specialist service saying, "Our staff do not know how to deal with alcohol problems; how do we refer to you?" So there is, I think, a bit of a problem. Having said that, the staff in the NHS are not always competent to deal with these problems either.[135]

114. Alcohol Concern commented:

> The voluntary sector plays a key role in delivering social care and psycho-social interventions for treating alcohol problems. The vast majority of treatment provision is delivered in the voluntary sector and good links exist between voluntary and statutory health providers. However, the voluntary sector suffers from short-term funding, excessive competitive tendering and client loads that are increasingly complex and multi-faceted.[136]

Both Alcohol Concern and the Socialist Health Association recommended the voluntary sector be awarded 5-year commissioning contracts, mirroring the long time a patient will be in treatment.[137]

115. Alcoholics anonymous is an independent self help organisation with an outstanding track record in helping people with alcohol dependency using the 12 step approach. The experience of clinicians in the field is that when AA works for an individual person it can be highly effective, and can offer very high levels of lifelong support, but the approach does

133 Ev 140

134 The Prime Minister's Strategy Unit, 2003 interim report

135 Q 219

136 Ev 41

137 Ev 41 & Ev 55

not suit everyone and is not a substitute for properly funded NHS alcohol treatment services.

Hospital based services managing alcohol related harm

116. In a survey undertaken for the Royal College of Physicians and the Royal College of Nursing, 88% of doctors and nurses replying said that NHS investment in staff and services for treating alcohol related harm had not kept up with demand or was suffering from serious under-investment and was currently inadequate.[138]

Over-stretched Liver Services

117. The rise in alcohol consumption and other factors have led to dramatic increases in the incidence of liver disease in the UK. The British Society of Gastroenterology (BSG) and the British Association for the study of the liver (BASL) stated in their submissions:

> Services for patients with liver disease have developed in an unplanned manner as an offshoot of general gastroenterology, and many liver patients are managed at District General Hospital level by general gastroenterologists, many of whom have had no training in a specialised liver unit. The service structure developed at a time when liver disease and death from liver was relatively uncommon and the 10 fold increase in young liver deaths over the last 30 years has not been matched by the development in services needed to cope.[139]

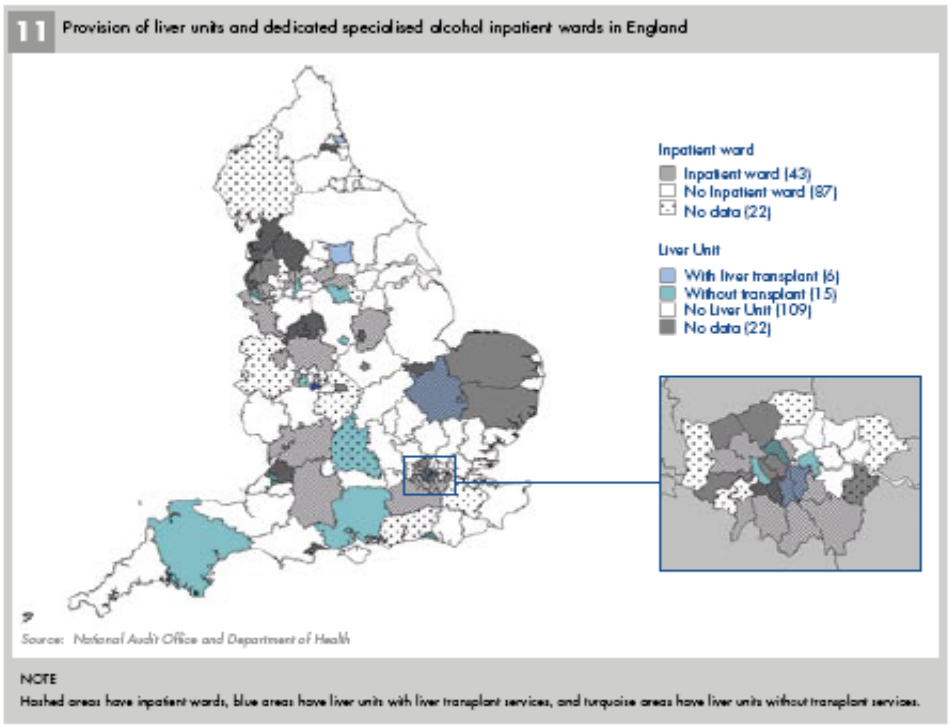
There are significant variations in the distribution of liver units in the UK. Certain regions have neither liver units nor inpatient alcohol units, as shown below:[140]

138 Ev 105

139 Ev 69

140 NAO, *op. cit.,* p 33.

Figure 11: Provision of liver units and specialised inpatient alcohol wards



118. The proportion of liver transplants to people with alcoholic liver disease has increased from 14% to 23% from 1997–8 to 2007–8.[141] However, the British Liver Trust stated that the true number of alcohol related liver disease patients who could benefit from a transplant is much higher.[142] The British Liver Trust told us that the average wait before diagnosis and referral for treatment for alcoholic liver disease is 564 days.[143]

How to improve the situation

Commissioning

119. Alcohol Concern recommended that PCTs be obliged to produce an Alcohol Needs Assessment for their areas.[144] The Alcohol health alliance UK and Alcohol Concern recommended the DH should encourage local commissioners to ensure that waiting time targets for alcohol treatment match target for drug treatment in the next NHS operating framework.[145]

120. However, the Minister of State for Public Health told us that alcohol treatment should not be compared with drug misuse treatment and further pointed out that it was for PCTs

141 HC Deb, 10 February 2009, col 1924W

142 Ev 33

143 Ev 34

144 Ev 43

145 Ev 43 & 176

to choose how much to spend on alcohol treatment and vary this depending on their local needs.[146]

Prevention

Stopping people drinking too much in the first place

121. During the past few years the DH has stressed the importance of prevention and public health measures. They are prominent in the White Paper, *Choosing Health* (2004), and in Lord Darzi's review of the future of the NHS, '*High Quality Care for All*' (June 2008). The most important of these measures are public education campaigns, which are thought to be inadequate. They are discussed in the next chapter. In this chapter we look at measures the NHS has taken.

Better data collection

122. Better health data collection has an important role to play in better prevention. The NHS Confederation provided us with an example of how this works: members of the South Central Ambulance Service have been filling out patient report forms after each emergency response, which are scanned into a reporting system. The information can then be used by PCTs and other commissioners to identify gaps in provision and unmet patient needs. This system led to the change of licence conditions for a club where many alcohol related assaults had occurred, leading to a reduction in emergency responses by 90% in the following 12 months. [147]

123. Alcohol Concern indicated how good data could play a wider role:

> Licensing authorities should have access to a nationally standardised collection of A&E, ambulance, hospital admissions and treatment data. This would allow local authorities the power to refuse additional licenses or extensions if local alcohol-related health harms were increasing or a matter of significant concern.[148]

Helping to reduce the intake in people already drinking too much

124. If hazardous and harmful levels of drinking can be detected, there is scope for intervening before patients either acknowledge their own drinking problem or seek help. Detection should be a matter for all parts of the NHS. A health practitioner may notice signs of alcohol abuse in the history, physical examination or investigation results of a patient and there are number of 'tools' for improving screening. We were told:

> The routine use of a structured brief assessment tool can help clinicians to detect problem drinking. The National Treatment Agency (NTA) reviewed the management of alcohol use disorders in 2006[149] and recommended their use. There

146 QQ 1057 and 1066

147 Ev 141

148 Ev 43

149 Heather, Raistrick & Godfrey, *Review of the Effectiveness of Treatment for Alcohol Problems,*. National Treatment Agency for Substance misuse, 2006

> are a number of screening tools available, such as the [Alcohol Use Disorder] Identification Test (AUDIT), Fast Alcohol Screen Test (FAST) or Paddington Alcohol Test (PAT).

The British Liver Trust recommended that Liver Function Tests (LFTs)[150] should be included in the vascular health checks being introduced for over 40s in primary care, which already include a cholesterol blood test.[151]

125. There are estimated to be 10m hazardous or harmful drinkers in the UK, all of whom could potentially benefit from 'Brief Interventions'. These are short, focused discussions, taking between 5 and 10 minutes, designed to promote awareness of the negative effects of drinking and to motivate change. 'Extended brief advice', is a longer version of this. According to Professor Mike Kelly of NICE the evidence for brief interventions is unusually strong for such public health interventions, with numerous systematic reviews showing that they reduce alcohol consumption, injury, mortality, morbidity and the social consequences of drinking.[152] Under sceptical questioning a GP, Paul Cassidy, insisted that brief interventions by GPs were effective:

> We can get the biggest gains early on with the hazardous/harmful [drinkers]. We use the expression "numbers needed to treat": we need to treat eight patients with a Brief Intervention to get one of them to drink healthily. That is much better than for smoking cessation with the use of patches. The evidence is that it is incredibly effective.[153]

126. A single brief intervention reduces drinking effectively in 1/8 of those approached for up to 2 years and possibly 4 years[154] but, as Dr Raistrick explained, brief interventions work best if repeated by several different health workers:

> If everybody in the Health Service every time they saw somebody with a drink problem did something motivational, even if it was just the one question, the cumulative effect would add to the impact of these interventions.[155]

127. A meta-analysis has shown that Brief Intervention is not only clinically effective, but also cost-effective.[156] By supporting early interventions on alcohol misuse, such as 'brief advice', the NHS may avoid or reduce the costs of later, more intensive and specialist support for people who develop dependency or suffer from an alcohol-related illness.

128. Professor Ian Gilmore told us that GPs could be given incentives to improve early detection of problem drinkers by including a measure for alcohol consumption in the Quality and Outcomes Framework (QOF), which provides financial incentives for GP

150 LFTs are a blood test which can detect signs of liver damage.

151 Ev 34

152 Q 114

153 Q 113

154 National Audit Office report: Reducing Alcohol Harm: Health Services in England for Alcohol Misuse, 2008

155 Q 225

156 Kaner EFS, Beyer F, Dickinson HO, et al. *Effectiveness of brief alcohol interventions in primary care populations*. Cochrane Database of Systematic reviews, 2007.

practices.[157] The evidence for implementing brief interventions outside of primary care is less well established, but its use in A&E and criminal justice settings is currently being evaluated in the Screening and Intervention Programme for Sensible Drinking, commissioned by the DH and led by Professor Colin Drummond.[158]

129. Some witnesses proposed using brief interventions in maxillofacial clinics (25% of 'maxfax' admissions are alcohol related, often glass injuries), hepatology wards, gastro units and prison healthcare centres.[159] The Royal Pharmaceutical Society of Great Britain recommended that pharmacists administer Brief Interventions for alcohol.[160]

130. Some criticisms of Brief Interventions were raised. Dr Duncan Raistrick suggested that their inexpensiveness may underpin their popularity, diverting attention from investing in more expensive treatment for dependent drinkers.[161] Furthermore, if they work in 1:8 people, they can at best reduce problems by around 13%;[162] raising the price of alcohol would be more effective.

Nurse Alcohol Specialists

131. In 2001 the Royal College of Physicians recommended that every acute hospital should have a consultant or senior nurse *lead* for Alcohol Misuse, plus alcohol *nurse specialists*, who should educate, audit and liaise with community services.[163] The specialists would administer brief psychological interventions. The Socialist Health Association recommended that alcohol advisors should be extended to polyclinics.[164]

132. Dr Lynn Owens, Nurse Consultant informed us of an innovative nurse-led alcohol service she developed in an acute hospital in Liverpool. The service trains Trust staff and runs clinics in both the hospital and GP surgeries. Dr Owens reported that a follow-up study demonstrated both its effectiveness and cost-effectiveness (due to saving bed-days) compared to treatment as usual in a neighbouring trust.[165] She highlighted the benefits of using nurses rather than generic, non-medically trained 'alcohol workers', as nurses can manage the comorbid medical problems and nurse consultants can prescribe detoxification medication.[166]

133. The Alcohol Education and Research Council (AERC) funded a study which revealed that A&E attendants who were referred on to an alcohol health worker, after screening positive for alcohol misuse, had on average fewer visits to the A&E department over the

157 Q 46

158 Q 1070

159 Ev 16 & Ev 57

160 Ev 12

161 Q 221

162 Chief Medical Officer, *On the state of the public health,* 2001.

163 Ev 176

164 Ev 55

165 Q 158

166 Q 170

following 12 months. At 6 months they were drinking 23 units per week less than those just given an information leaflet. At 12 months the difference was 14 units.[167]

134. However, as the Royal College of Nursing pointed out, there are no nurse alcohol specialists in most acute hospitals and there is a dearth of nurse-led alcohol services in most of the country.[168]

Bridge Funding for commissioners

135. Southampton Commissioner Carole Binns explained that her PCT spends just short of £1 million on alcohol services per annum. It plans to shift some of the unallocated £4 million per annum spent on treating the impact of alcohol towards investment in prevention and early intervention, but various factors obstruct this. She argued for transition or bridge funding (ie the DH would provide initial funding for prevention and early intervention services which would cease once the services were established).

136. Carole Binns also argued for joint investment:

> Most planning cycles and most targets you are expected to deliver change within two, three, perhaps five years. Some of the changes that lots of people have been arguing about today would not show impact for much longer than that, so you are talking about impacts over ten, fifteen years. Very good but long term health gains, so difficult to fit into planning and funding cycles that only last two or there years. Also, I think probably the answer to investment is to get a number of agencies to act together—criminal justice agencies and agencies like police, probation, health and social care. It is a complex area where lots of people are spending in an unproductive way and it is a question of getting all of those agencies to join together in a joint investment plan to all spend their money together in a more productive way.[169]

Improve treatment of specialist alcohol services

137. Better specialist alcohol services would not only bring advantages through the services themselves, but would also encourage GPs to put more effort into detecting alcohol misuse since better detection of problem drinking is of little use unless there are services to which drinkers can be referred.[170]

Investment in alcohol treatment services

138. The DH agreed that investment in alcohol treatment services would yield net savings for the NHS.[171] Analysis by the UKATT[172] led the NTA to conclude that overall for every £1 spent on treatment, £5 is saved elsewhere and that provision of alcohol treatment to 10% of

167 Ev 15

168 Ev 106

169 Q 232

170 Q 135

171 Ev 5

172 UKATT Research Team, , *Cost effectiveness of treatment for alcohol problems. Findings of the UK Alcohol Treatment Trial*, BMJ, 2005, 544-547

UK dependent drinkers would reduce public sector resource costs by between £109 million and £156 million each year.[173] The BMA recommended that funding for specialist alcohol treatment services should be significantly increased and ring-fenced.[174] The Royal College of Psychiatrists commented in its submission:

> If the government is serious about tackling alcohol misuse as purported in the Alcohol Harm Reduction Strategy and subsequent updates, it will need to make a similar investment in treatment of alcohol misuse as it has done in the case of drug misuse. Alcohol dependence affects 4% of the population and alcohol misuse considerably more, whereas problem drug use rates are closer to 0.5%. Access to treatment is considerably better for drug misusers (1 in 2 gains access to treatment per annum) than for alcohol misusers (1 in 18 gains access to treatment per annum).[175]

139. The bulk of treatment for alcohol dependency is psychological and social support. The NTA review supported the effectiveness of a large range of psychological interventions, many of which are cognitive or behavioural. Planned and structured aftercare is effective after initial treatment, e.g. extended case monitoring. Dr Duncan Raistrick explained to the committee that the UK Alcohol Treatment Trial (UKATT), which he led, found that approximately 40% of people given Social Behaviour and Network Therapy (which draws on people's own social network to support them) were achieving abstinence.[176] Dr Raistrick highlighted the importance of the quality of psychosocial interventions:

> I think it is really important to understand that we are talking about interventions that are fundamentally different to, for example, having a course of Tamiflu. The difference is that we are talking about a process of change and it is the way that the treatment is delivered and when it is delivered that matters as much as the particular treatment.[177]

Improve the management of alcohol-related harm

Relieve the strain on Ambulance Services

140. London Ambulance Paramedic Brian Hayes spoke to the committee about a 'booze bus' he set up 5 years ago, the concept of which is currently being replicated in a few places around the country:

> The problem we were having was that we would be on our way to hospital with someone who was drunk in the back and they would be putting out broadcasts asking for ambulances to free up because we had 60-year-olds, 70-year-olds with chest pains and people involved with RTAs, and I came up with an idea that what we

173 The National Treatment Agency for Substance, *Review of the Effectiveness of Treatment for Alcohol Problems* , 2006.

174 Ev 23

175 Ev 173

176 Q 204

177 Q 202

> should do is put a paramedic and two patient transport people on to one of our patient transport vehicles. So instead of being able to take one person we could take up to five at any one time—especially between the hours of ten and two in the morning, where we would just be directed at calls that had come in and the sole indicator was that this person was drunk.[178]

Mr Hayes explained that at almost £200 per ambulance call and over 60,000 purely alcohol-related call-outs per year in London, the savings for the NHS were probably very large.

The new National Plan for Liver Services

141. BSG and BASL have drafted a National Plan for Liver Services, recommending the appointment of a National Clinical Lead, a national electronic registry of liver patients, major restructuring of services, increased early detection of liver disease, the development of a comprehensive Alcohol Liaison Service across the UK and promotion of research into liver disease.[179] This approach is supported by the DH, and was approved by the National Quality Board in June 2009.[180] A Clinical Director for Liver Services was appointed in November 2009 in order to help develop a national liver strategy, but it remains to be seen if the funding to implement the strategy will be found. BASL/BSG suggest that the funding be found from increases in the duty on alcohol.

Conclusions and recommendations

142. **Alcohol related-ill health has increased as alcohol consumption has increased, but there are no more services to deal with these problems. Indeed in many cases there are fewer, partly as a result of the shift in resources to addressing dependency on illegal drugs. The most effective way to deal with alcohol related ill-health will be to reduce overall consumption, but existing patients deserve at least as good a service as that provided to users of illegal drugs, with similar levels of access and waiting times.**

143. **Early detection and intervention is both effective and cost effective, and could be easily built into existing healthcare screening initiatives. However, the dire state of alcohol treatment services is a significant disincentive for primary care services to detect alcohol-related problems at an early stage before the serious and expensive health consequences of regular heavy drinking have developed.**

The solution is to link alcohol interventions in primary and secondary care with improved treatment services for patients developing alcohol dependency. In time we believe such a strategy will result in significant savings for the NHS but will require pump priming and intelligent commissioning of services. Specifically, the NHS needs to improve treatment and prevention services as follows

<u>Treatment services</u>:

178 Q 250

179 Ev 34 and 69

180 Q 1059

Each PCT should have an alcohol strategy with robust needs assessment, and accurate data collection.

Targets for reducing alcohol related admissions should be mandatory

Acute hospital services should be linked to specialist alcohol treatment services and community services via teams of specialist nurses.

There should be more alcohol nurse hospital specialists

Treatment budgets should be pooled to allow the cost savings from reduced admissions to be fed back into treatment and prevention, with centrally provided 'bridge' funding to enable service development.

Access to community based alcohol treatment must be improved to be at least comparable to treatment for illegal drug addiction

These improved alcohol treatment services must be more proactive in seeking and retaining subjects in treatment with detailed long term treatment outcome profiling.[181]

Funding should be provided for the National Liver Plan

<u>Prevention services</u>:

Improved access to treatment for alcohol dependency is a key step in the development of early detection and intervention in primary care.

Clinical staff in all parts of the NHS need better training in alcohol interventions.

Early detection and brief advice should be undertaken in primary care and appropriate secondary care and other settings. Detection and advice should become part of the QOF.

Once detected patients with alcohol issues should progress through a stepped program of care; seven out of eight people do not respond to an early intervention and it is these people who go on to develop significant health issues.

Research should be commissioned into developing early detection and intervention in young people.

181 Treatment outcome profiling (TOP) is a structured analysis of treatment outcomes used in the UK drug treatment field as a measure to ensure services are performing up to standard. We suggest that the same system is adopted to ensure that the quality of alcohol treatment services match the high standards now provided in drug treatment.

6 Education and information policies

144. In addition to interventions by clinicians to discourage drinking, the Government's Strategy, as we have seen, stresses "the importance of informing and supporting people to make healthier and more responsible choices" through campaigns and the provision of information. The Government told us that this included:[182]

- public health education campaigns to improve understanding of alcohol units and health risks; and to challenge binge drinking and spread awareness of the consequences; the DH drink prevention programme has an overall budget of £10 million in 2008–09 and consists of a 'units campaign' and a 'binge drinking campaign'.
- planned campaigns from 2009 aimed at children and their parents; the Department for Children, Schools and Families (DCSF) told us that it was planning a new social marketing campaign from 2009, aimed at young people and their parents, with £12.5 million funding over the next 3 years.
- The Chief Medical Officer's Guidance on the Consumption of Alcohol by Children and Young People, which will support the DCSF's campaign
- Labelling: the Government told us that it had come to an agreement with the industry to introduce unit and health information; on labels, it was hoped that the majority of labels by market share would have complied by the end of 2008.
- Targeted support aimed at those who drink more than double the Government's guidelines, including web-based support and advice and an improved national helpline and an 'innovative pilot' in the north west to target information to 'neighbourhoods, individuals and their families'.

145. Government spending in 2009/10 on alcohol information and education campaigns is £17.6m. Individual Department's expenditure is as follows:[183]

- DH: £6.85m
- Home Office: £2m
- DCSF: £5m
- DfT: £3.75m

146. In addition, the alcohol industry funds activities to promote sensible drinking. The Portman Group was set up in 1989 by the UK's leading alcohol producers; current members account for the majority of the UK alcohol market. The Group's main role currently is to encourage the industry 'to promote its products responsibly, mainly through

182 The information below is taken from AL 01

183 Source: Department of Health

the operation of the Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks'.[184]

147. The Government set up the Drinkaware Trust, in 2006. Its trustees include health professionals, representatives of the drink and retail industry and others. It is funded producers and retailers. In 2006 it took on the Portman Group's remit for consumer education. During the inquiry the Trust announced a social marketing campaign, spending up to £5m per year for five years, to help tackle binge drinking.

148. Many witnesses were critical of the Government's and industry bodies' information and education measures. The BMA stated that the disproportionate focus upon, and funding of, public information and educational programmes must be redressed.[185] Specific criticisms were:

- the programmes have been shown to have little impact on changing behaviour. Professor David Foxcroft, a chartered psychologist specialising in the science of prevention, told us that

  > a number of different studies had shown that traditional types of alcohol education in schools, just telling people about the risks associated with alcohol...are ineffective. I believe that this is the message put across by the WHO report.[186]

  Dr Peter Anderson added:

  > There is very good scientific evidence that information campaigns and education campaigns on their own do not change behaviour. These campaigns have to be done in association with policy changes or done to help support policy changes. Just providing information is not going to change people's behaviour.[187]

- The sums spent by Government and the Drinkaware Trust are, as Professor Ian Gilmore, President of the Royal College of Physicians, highlighted, insignificant compared with the massive amounts of money spent by the industry; Dr Anderson suggested that public education programmes could only compete if advertising by the drinks industry was reduced to level the playing field.[188]

- campaigns funded by the alcohol industry can backfire, reinforcing heavy drinking due to creating a more favourable impression of the industry;[189] we were told:

184 Ev 123

185 Ev 22

186 Q 614

187 Q 29

188 Q 34

189 Q 29

> The limited available research has shown that industry funded educational programmes tend to lead to more positive views about alcohol and the alcohol industry.

- the campaigns are not very good; Sainsbury thought that there was considerable room for improvement, as we discuss below.

149. Finally, there is concern that education and information campaigns are emphasised and promoted by the industry because it knows they do not work. The British Society of Gastroenterology and the British Association for the Study of the Liver informed us:

> According to the DH, 25% of the UK population are hazardous or harmful drinkers, but this minority consumes 75% of alcohol sales. This phenomenon is well described in other countries and means that the alcohol production and retail industries rely on hazardous and harmful drinkers to supply three-quarters of their profitability. One therefore has to question the motivation of the alcohol industry to reduce alcohol related harm, and their central role in policy making so far.[190]

150. Nevertheless, while the education and information campaigns were much criticised, the critics did not believe that they should be dropped altogether; rather it was thought that while not effective on their own, they could be a useful part of a wider strategy of which they were an element. Dr Anderson told us:

> Providing information and education is important to raise awareness and impart knowledge, but, particularly in a living 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 changes in behaviour. Reviews of hundreds of studies of school-based education have concluded that classroom-based education is not effective in reducing alcohol-related harm. Although there is evidence of positive effects on increased knowledge about alcohol and on improved alcohol related attitudes, there is no evidence for a sustained effect on behaviour.[191]

The provision of good information does not change behaviour, but can justify and lead people to respond better to more powerful interventions such as raising prices. Dr Anderson added:

> warning labels are important in helping to establish a social understanding that alcohol is a special and hazardous commodity.[192]

151. Moreover, it is argued that people have a right to information about a dangerous substance such as alcohol.

152. Other witnesses made suggestions for improving both the campaigns and the information put on labels, arguing for more focus on:

190 Ev 68

191 AL 58

192 Ibid.

- the number of units contained in alcohol containers; the RCP described a significant lack of knowledge amongst the general public about guidelines relating to alcohol:

> Many people underestimate the amount of units they are drinking. A YouGov survey of 1,429 drinkers in England found more than a third did not know their recommended daily limit—2–3 units for women and 3–4 for men.[193]

Similarly, it is not widely known that there are about 9 units in a bottle of 13% wine, which means that a woman drinking half a bottle of wine a day is consuming over 30 units a week, which is more than twice the recommended levels.

- The need to have a couple of days each week alcohol-free.
- The health risks, perhaps including labels such as 'Alcohol causes cancer, liver disease and other illnesses'.

153. Unfortunately, progress in labelling is proceeding painfully slowly. In May 2007, the Department reached a United Kingdom-wide voluntary agreement with the alcohol industry to include specified unit and health information on alcohol labels. The Government made clear their expectation that the majority of labels should be covered by the end of 2008. In November 2009 the Government expected to be able to publish shortly the results of independent monitoring from samples taken in April 2009. The Government was about to look at whether a majority of labels were covered by the expected information and whether the content was consistent with the 2007 voluntary agreement. The Government stated that

> If we find that most labels are still not complying with the voluntary agreement, we will consider what action we can take to improve compliance, including using existing powers under the Food Safety Act to make this a mandatory requirement. We believe that consumers have a right to consistent, agreed information on at least the large majority of alcohol labels, to enable them to assess their intake of alcohol and to relate this to the Government's guidelines.[194]

Conclusions and recommendations

154. **Better education and information are the main planks of the Government's alcohol strategy. Unfortunately, the evidence is that they are not very effective. Moreover, the low level of Government spending on alcohol information and education campaigns, which amounts to £17.6m in 2009/10 makes it even more unlikely they will have much effect. In contrast, the drinks industry is estimated to spend £600-800m per annum on promoting alcohol.**

155. **However, information and education policies do have a role as part of a comprehensive strategy to reduce alcohol consumption. They do not change behaviour**

193 Ev 159

194 HC Deb, 9 November 2009, c107W

immediately, but can justify and make people more responsive to more effective policies such as raising prices. Moreover, people have a right to know the risks they are running. We recommend that information and education policies be improved by giving more emphasis to the number of units in drinks and the desirability of having a couple of days per week without alcohol. We also recommend that all containers of alcoholic drinks should have labels, which should warn about the health risks, indicate the number of units in the drink, and the recommended weekly limits, including the desirability of having two days drink-free each week. We doubt whether a voluntary agreement would be adequate. The Government should introduce a mandatory labelling scheme.

7 Marketing and the drinks industry

Scale and types

156. Expenditure by the alcohol industry on marketing and promotion is large and far more than expenditure on health promotion marketing and advertising. In the UK the total expenditure on alcoholic drinks advertising on television, the radio, in the press, outdoors, and in cinemas is about £200m.[195] Total spending on marketing communications by the alcohol industry was estimated to be £600–800m (including sponsorships, product tie-ins and placements, contests and sweepstakes, and special promotions) by the PM's strategy unit in 2003.[196]

157. In 2006 49% of alcoholic drinks advertising was spent on television advertising. Between 2004 and 2006, there was an increase in the number of commercial spots aired on television: 367,000 in 2004, 412,000 in 2005 and 442,000 in 2006.[197] Lager products had the highest proportion of total commercial spots for alcoholic drinks in both 2002 and 2006 (25% and 30%), with cider/perry accounting for the biggest rise in share of the sector in 2006.

158. Television is only part of the alcohol marketing communications strategy. Several witnesses commented on a growing trend away from traditional forms of direct advertising in the print and broadcast media to other forms such as sponsorship, competitions and special promotions. We were told that new media were becoming more popular, for example text messaging to mobile phones and social network sites. Viral marketing and viral advertising are increasingly important. These terms refer to marketing techniques that use social networks to produce increases in brand awareness or to achieve other marketing objectives (such as product sales) through self-replicating viral processes, analogous to the spread of pathological and computer viruses. The 'virus' can be delivered through word-of-mouth or may take the form of video clips, interactive games, "advergames", ebooks, or text message.[198] During our inquiry Price Waterhouse Cooper reported that the amount companies spent on internet marketing was greater than traditional print advertising for the first time.

159. The sponsorship of sport and cultural events, many with a particular appeal to the young, has become a key promotional vehicle for alcohol. Alcohol drinks companies were the second largest source of sponsorship funding from 2003 to 2006, behind the financial services sector.[199] In 2006, financial sources accounted for 19.2% of sports sponsorship, alcoholic drinks 11.6% and sports goods 10.2% of active deals. Forty-nine of the 71 UK

195 2002: £167 million; 2005: £221million; 2006: £194 million (Nielsen Media 2006, as cited by Ofcom & ASA 2007; year ending June 2007: £172.7m (Nielsen Media Research cited in the Key Note Ltd (2008) Drinks Market report—total main media advertising expenditure on alcohol)

196 http://www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/su%20interim_report2.pdf, p.129. and see WHO report http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.1.pdf)

197 Nielsen Media 2006, as cited by Ofcom & ASA 2007

198 BMA, *Under the Influence,* 2009.

199 Market data on sports sponsorship collected by Ipsos MORI (Key Note 2007b).

sports sponsorship deals included in the analysis were paid for by the brewing industry, with the rest by other alcohol producers.

Below we list a number of alcohol industry sports sponsorship deals.

Table 3: Examples of alcohol industry sports sponsorship deals, 2008

Brand	Sport sponsorship deal
Carling lager	Title sponsorship of the Football League cup in England and shirt sponsorship of Glasgow's Celtic and Rangers Football Clubs
John Smith's ale	Title sponsor of the Grand National plus other race days at the majority of UK racecourses
Magners Irish Cider	Sponsors two British rugby union teams, was title sponsor of a rugby union league championship for Ireland, Scotland and Wales, and hosted a golf championship in Wales and in Scotland
Guinness stout	Title sponsor of an English rugby union league
Johnnie Walker whisky	Formula One McLaren Team sponsors
Stella Artois lager	Title sponsor of a London tennis tournament for 30 years, ending 2008[200]
Carlsberg lager	For 17 years, until September 2009, Carlsberg sponsored Liverpool FC

Source: BMA, Under the Influence (2009) (modified)

160. Both the Football League and the Premier League are sponsored by the drinks industry. The Football League currently relies more heavily on such sponsorship and has been sponsored by Carling since the beginning of the 2003–2004 season; its involvement is set to continue until the end of the 2012 season.[201]

161. In addition, Carling sponsors the Football League's Carling Cup. The partnership between The Football League and Carling's parent company, The Molson Coors Brewing Company (UK) Ltd, is the longest running competition sponsorship in domestic football; having sponsored the Carling Cup competition for nine seasons and the Worthington Cup for a further five.

162. According to its website, Carling's involvement with the Football League has supported fan interaction with the competition through initiatives such as "The Fan's Final"—with all of Carling's contractual tickets being made available to fans at the 2006 and 2007 finals and the introduction of fan perimeter designed boards at the 2009 Final.

163. The Premier League has organised the top-flight football competition in England since 1992. In that period attendances have grown by 60%. Media rights are now sold to

200 Source: Key Note Ltd (2007) Sports Sponsorship. Market Report November 2007. Hampton: Key Note Ltd.

201 According to the Football league it receives a seven-figure sum from its sponsor ('It is about a third of our total sponsorship income'), QQ 1268-9.

every territory in the world, generating £1 bn per year and the Premier League has become the world's most-watched regular domestic sporting competition.

164. The Premier League website is sponsored by Budweiser which also sponsors the Fantasy Premier League component of the site. The Premier League website does not carry Budweiser advertising beyond the brand name and logo and a link to Budweiser's own site.

165. Of the teams in the Premier league only Everton FC is currently sponsored by an alcohol producer. Liverpool FC has recently announced that it will end it association with Carlsberg as its shirt sponsor from the end of the current football season in May 2010. Earlier this year Everton and the Thai-based Chang Beer struck a second sponsorship deal, valued at £8 million over three years. The current deal, worth £4.5 million, expires at the end of the season.[202]

166. There is little shirt sponsorship by alcohol companies. Within the last few years Tottenham Hotspur has ended its sponsorship arrangement with Holsten and Newcastle United, which until May 2009 was a premiership club, was sponsored by Newcastle Brown Ale, but is now sponsored by Northern Rock).

167. Commercial arrangements with alcohol companies include:

- Pouring rights—the exclusive right to provide alcohol for sale at football grounds
- Official supplier status—the right to be known as the official supplier to or commercial partner of a Club or the Premier League
- Sponsor—the right to be recognised as a sponsor of the Club or the Premier League or of a specific Club or Premier League activity (such as sponsoring a website)
- Shirt Sponsor—the right for the name of the company to appear on the team shirts
- Advertising—the right to commercially acquire advertising space in Club or Premier League media, such as matchday programmes, pitchside displays, websites, and display boards at grounds.

Regulatory codes

168. The regulatory codes are described in the table below. Ofcom regulates television programme sponsorship. The ASA ('the UK self-regulatory for maintaining standards in advertising')[203] regulates advertising, including TV (excluding programme sponsorship), radio, press, poster, direct mail and paid-for advertising on the internet. The advertising codes are written and maintained by CAP and BCAP, which consist of representatives of broadcasting and advertising organisations.[204] Their membership is shown in the Box below. The Portman Group regulates packaging and various other forms of promotion, including sponsorship (excluding programme sponsorship), branded merchandise, press

202 http://www.eufootball.biz/Sponsorship/Everton-Chang-Beer-sponsorship-deal.html

203 Ev 145

204 Ev 146

releases, and non-paid for advertising on the internet. In other words, the Portman Group seeks to regulate any marketing which is not otherwise regulated by Ofcom or the ASA.

169. David Poley, Chairman of the Portman group, told us that

> "The regulatory system may appear fragmented but the division of responsibilities, however, is logical. The ASA regulates all advertising in 'paid-for' space; it cannot, for example, take over responsibility for regulating alcoholic drinks packaging without simultaneously taking on responsibility for regulating all product packaging including that of food, electrical goods, etc. The Portman Group, meanwhile, cannot for example take over responsibility for regulating alcohol advertising on TV because, apart from anything else, the ASA has a legal responsibility for this. This fragmentation does not mean, however, that there are necessarily any shortcomings with the present regulatory system."[205]

Table 4: Summary of UK regulatory system applying to drinks producers' marketing activities

Regulator	**Ofcom**	**Advertising Standards Authority**	**Portman Group**
Remit:	Television programme sponsorship [Also broadcast editorial standards]	All advertising, e.g.: ▪ television ▪ radio ▪ press ▪ poster ▪ cinema ▪ direct mail ▪ paid-for internet advertising ▪ mobile phones (SMS and Bluetooth)	All other alcohol producer marketing activities, e.g.: ▪ naming ▪ packaging ▪ sponsorship (excluding TV programme sponsorship) ▪ sampling ▪ press releases ▪ brand websites ▪ producer-generated point-of-sale materials
Nature of system:	Statutory	Co-regulatory (broadcast) Self-regulatory (non-broadcast)	Self-regulatory
Rules written by:	Ofcom	BCAP, but approved by Ofcom (broadcast) CAP (non-broadcast)	Portman Group
Adjudicating body:	Ofcom	Independent ASA Council chaired by the Rt Hon Lord Smith of Finsbury	Independent Complaints Panel chaired by Sir Richard Tilt
Funded by:	Government	Advertising industry	Drinks producers

205 Ev 34A

Composition of the BCAP Committee

According to the ASA the BCAP is a listed company made up of: Advertising Association • British Sky Broadcasting Limited • Channel 4 Television Corporation • Channel 5 Broadcasting Limited • Clearcast • Direct Marketing Association • Electronic Retailing Association UK • GMTV Limited • Incorporated Society of British Advertisers • Institute of Practitioners in Advertising • ITV plc • Radio Advertising Clearance Centre • RadioCentre • S4C • Satellite & Cable Broadcasters' Group • Teletext Limited • Virgin Media TV

Composition of the CAP Committee

According to the ASA the CAP Committee is made up of: Advertising Association • Cinema Advertising Association • Clearcast • Direct Marketing Association • Direct Selling Association • Directory and Database Publishers Association • Incorporated Society of British Advertisers • Institute of Practitioners in Advertising • Institute of Sales Promotion • Internet Advertising Bureau • Mail Order Traders Association • Mobile Broadband Group • Mobile Marketing Association • Newspaper Publishers Association • Newspaper Society • Outdoor Advertising Association • Periodical Publishers Association • Proprietary Association of Great Britain • Radio Advertising Clearance Centre • Royal Mail • Scottish Daily Newspaper Society • Scottish Newspaper Publishers Association

170. We were told that following the publication of the 2004 Alcohol Strategy, in 2005 Ofcom and the ASA strengthened both the broadcast and non-broadcast advertising codes significantly and the ASA was consulting again.[206]

171. The ASA told us that its rules were

> exceptionally robust, especially in relation to the protection of young people and vulnerable groups. They were tightened significantly in October 2005, in response to the 2004 Alcohol Harm Reduction Strategy, which suggested a possible link between young people's awareness and appreciation of alcohol advertising and their propensity to drink.[207]

The ASA added that it did not 'just wait for complaints to come in, but pro-actively monitors ads on a daily basis across all media for compliance with the Codes. It concentrates its activities on high profile sectors (such as alcohol) or sectors with low compliance'.[208] In addition, CAP provides a free pre-publication advice service for

206 Ev 146–9

207 Ev 146

208 Ev 148

advertisers, agencies and media, called Copy Advice. The team dealt with about 225 alcohol ad queries in 2008.[209]

172. Advertisers that breach the Codes face financial loss from having an ad campaign pulled and damage to reputation through the publication of upheld adjudications, which attract media attention. Compliance with ASA adjudications is extremely high. For those few advertisers who refuse to comply, industry and other pressures can be brought to bear. For example, poster pre-vetting can be imposed and direct marketing companies can have benefits such as Royal Mail bulk mailing discounts removed. Although very rare, in serious cases of non-compliance, advertisers can be referred to the statutory authorities, for example to the OFT for action for unfair or misleading advertising, or to Ofcom for action against broadcasters.[210]

173. The Portman Group informed us:

> The Portman Group's Code of Practice applies to the naming and packaging of alcoholic drinks and the promotional activities of drinks producers, including press releases, websites and sponsorship. It ensures that such activities are carried out in a socially responsible way.
>
> All complaints made under our Code are heard by an Independent Complaints Panel. This Panel is chaired by Sir Richard Tilt, former Director General of the Prison Service; none of the Panel works in the alcohol industry.
>
> Since the Code was introduced in 1996, over 70 drinks have been found to be in breach of the Code. Failure to comply with our Code results in a drink being removed from sale.[211]

The views of supporters of the existing regulatory regime

174. Supporters of the existing regulatory regime, which includes the drinks and advertising industries as well as the regulators, argue that

- the codes work
- the codes ensure that advertising is not 'targeted on young people'
- the Sheffield University study of the effect of price and promotions on alcohol consumption shows advertising does not have much affect on sales: advertising is about persuading people to switch between brands.[212]

These views are much disputed.

209 Ev 147

210 Ev 148

211 Ev 125

212 Ev 125

Effectiveness of codes

Advertising

175. The ASA and Ofcom argue that complaints about alcohol adverts are few and not many are upheld. The ASA told us that their guidelines were robust and there was not much of a problem. Guy Parker, the Chief Executive of ASA, told us: "we received just short of 400 complaints about advertising last year. Those complaints were not just about alleged problems under the specific and strict alcohol rules; most were complaints that ads were misleading or offensive under the general rules in the codes. Of those 400 complaints 200 related to alcohol ads or campaigns. Those 200 cases represent about 1% of the total and equate almost perfectly with the proportion spent on alcohol ads."[213]

176. He added that the vetting of adverts on TV and radio before they went out was a particularly effective way of ensuring that the codes were effective:

> Our content, scheduling and placements rules are strict. They were further strengthened in 2005, in part as a result of the government's alcohol harm reduction strategy. We do a lot more besides just assessing and if necessary investigating and upholding complaints. TV and radio advertising, not just alcohol, is pre-cleared by two organisations: Clearcast and the radio advertising clearance centre. On the non-broadcast side we operate a copy advice service that gives a lot of advice to advertisers etc who want to check whether their ads and campaigns are okay under the rules. Last year we received over 200 written inquiries from alcohol advertisers and agencies wanting to make sure that their ads and campaigns complied with the rules, but we also put a lot of emphasis on the more proactive side of things, for example regular monitoring of all ads particularly those relating to alcohol. In 2006, 2007 and 2008 we undertook fairly extensive alcohol compliance surveys where we looked at a representative sample of alcohol ads and assessed them against the rules to check compliance. Compliance rates have varied a little. In 2006 the rate was 95%. That is the lower end of what we regard as acceptable. We put quite a lot of effort and resource in talking to the industry to explain where we think it is going wrong and how they can ensure that its ads and campaigns comply with the codes. The compliance rate picked up a bit in 2007; it was 97%."[214]

New Media

177. However, many witnesses recognised that regulations on "new marketing" (e.g text messaging, social network sites etc) were lax and needed tightening. The ASA informed us:

> The ASA and the advertising industry are aware of the need to future-proof advertising self-regulation so that online marketing material is regulated with the same sense of social responsibility as in traditional media.[215]

213 Q 460

214 Q 461

215 Ev 149

Sponsorship

178. The main focus of our evidence on sponsorship in this inquiry was football sponsorship. The Premiership defends its involvement with alcohol sponsors:

> We consider that it is appropriate for the Premier League and its Clubs to be active in this market provided that full regard is given to both the spirit and letter of the relevant regulations. Although income from alcohol-related sources is only a small proportion of total revenues it contributes to the continuing economic success of professional football in England. Deloitte estimate that total revenues of the 92 professional Clubs in the Premier and Football Leagues were over £2.5bn in 2008/09. This income led to a contribution to Exchequer finances of around £860m in that year. It is likely that with continued growth in income and with changes in tax rates the Exchequer contribution will reach £1bn in 2010/11.

179. According to its submission, the Premier League and its clubs always seek to operate in a socially responsible manner:

> We have a conservative interpretation of compliance with Portman Group and related codes, seeking to be clearly within the rules at all times. We do not test the boundaries of those rules nor do we lobby to have them changed. During the consultation around the question of alcohol branding on child-size replica shirts we noted the absence of any evidence linking such branding with alcohol consumption by the young but nevertheless fully comply with the subsequent changes to the Code.

The Football League told us:

> I cannot comment on the exact amount because it is a commercially confidential contract, but it would be fair to say it is a significant seven-figure sum that we receive from our alcohol sponsor… It is about a third of our total sponsorship income.[216]

> We only have one of our clubs that has an alcohol brand on its shirt, and that is Chesterfield. … We work very responsibly with them [Carling] to ensure that the messages they send out are targeted at people who are allowed to drink and it promotes sensible drinking. At the Football League we have a veto on anything that we would find inappropriate.[217]

> the benefits that a sponsoring company gets are enhanced by the way they activate it. In our case we work very closely with our sponsors to make sure that sponsorship is activated responsibly and promotes messages about sensible drinking.[218]

Targeting young people

180. There is widespread agreement that there must be effective controls on advertising to young people. A review by the advertising regulators Ofcom and the Advertising Standards

216 QQ 1268–9

217 Q 1262

218 Q 1267

Authority (ASA), published in October 2007, found that current controls have been effective in preventing advertising that is targeted at young people. However, it also found that young people were more likely to say that adverts made drinks look appealing and that they would encourage people to drink.[219]

Effect on sales

181. The drinks industry claimed that the Sheffield study showed that marketing had little effect on sales, but the author of the report told us:

> The focus of our attention on both adults and youngsters, rather than just young people. This is in recognition that advertising may play a larger role in influencing the **continuation of drinking behaviours** in existing consumers than in the **inception** of new drinker groups. From a population harm perspective, this distinction is crucially important. However the evidence base on advertising effects on adults is both smaller and weaker than for underage drinkers.
>
> I think this explains why our evidence statements are overall more cautious than that of authors who focused on under-18s only.[220]

Evidence statement 5 of the Sheffield report: states:

> There is conclusive evidence of a small but consistent association of advertising with consumption at a population level. There is also evidence of small but consistent effects of advertising on consumption of alcohol by young people at an individual level.[221]

The views of health experts

182. Several of the witnesses to our inquiry disagreed with the drinks industry and regulators. Their argument was that the codes are ineffective because the rules, albeit enforced by the ASA and others are not adequate to protect the young: the quantity rather than the content of advertising has greatest effect. This is particularly true for children. Moreover, advertising has a cumulative effect in the long term—even if sales don't show immediate response.

Advertising, promotion and young people

183. Even if the codes are followed, it does not necessarily mean that advertising does not encourage people to drink, especially young people. Professor Anderson, who has undertaken a review of studies of the links between consumption and advertising, noting that alcoholic drinks sales were driven by vast promotional and marketing campaigns, told us:

219 ASA/Ofcom, *Young People and Alcohol Advertising: An investigation of alcohol advertising following changes to the Advertising Code*, 2007, p 9.

220 AL 62A

221 See also evidence statements 7 and 8 of the report.

> "Alcohol is marketed through increasingly sophisticated advertising in mainstream media, as well as through linking alcohol brands to sports and cultural activities, through sponsorships and product placements, and through direct marketing such as the Internet, podcasting and mobile telephones. The Science Group of the European Commission's Alcohol and Health Forum recently concluded that alcohol marketing increased the likelihood that non-drinking young people will start to drink, and the likelihood that existing young drinkers will drink in a more risky fashion."

According to the BMA too, a substantial body of research has found that alcohol advertising and promotion influences the onset, continuance and amount of alcohol consumption among young people.

184. Professor Foxcroft told us about a review of studies of the effects of alcohol advertising:

> She [Dr Smith] concluded that the data from these studies included in the systematic reviews "suggest that exposure to alcohol advertising in young people influences their subsequent drinking behaviour. The effect was consistent across studies. A temporal relationship between exposure and drinking initiation was shown, and a dose response between amount of exposure and frequency of drinking was clearly demonstrated in three studies. It is certainly plausible that advertising would have an effect on youth consumer behaviour as has been shown for tobacco and food marketing."[222]

185. This evidence about the effects of the drinks industry's promotional activities on young people has been drawn from econometric and consumer studies. Early attempts to measure the impact of alcohol advertising on young people relied on econometric studies. These examined the correlation between the amount of advertising taking place in a particular jurisdiction and the amount of alcohol being consumed. These studies have mainly found little or no evidence of advertising influencing young people.[223]

186. Consumer studies examine advertising from the perspective of the young person, thus emulating the commercial marketer who uses consumer research to both guide the design of advertising and measure its effect on the target group. The measurement of effect involves looking for connections between exposure to, and appreciation of, advertising, and drinking knowledge, attitudes and behaviour. Such studies have shown consistent links between marketing communications and young people's drinking.[224]

187. In particular, longitudinal studies, which follow up respondents over time and are therefore capable of teasing out cause and effect, have demonstrated that advertising does encourage young people to drink sooner and more heavily. All the major forms of mass media advertising—press, television and billboards—have been found to have an effect. A longitudinal study currently being undertaken as part of the National Prevention Research

222 Q 609

223 BMA, *Under the Influence*, 2009, p 18

224 Ibid.

Initiative (NPRI),[225] illustrates just how pervasive communications about alcohol have become. The research has interviewed a cohort of 1,000 teenagers at age 13 and again at 15 years old. Three quarters of the teenagers surveyed at age 13 were familiar with television advertisements, and two thirds sports sponsorship. Nearly half were found to own alcohol branded merchandise and, when shown masked prompts, the vast majority could name the leading brands: Carling (95%), Smirnoff (93%) and WKD (91%). Research conducted as part of the NPRI study illustrates the extent to which teenagers in the UK are aware of alcohol, alcohol brands and related communications (see figures 12 and 13 below).

225 Ibid., pp19–20.

Figure 12 – The impact of alcohol marketing communications on UK 13 year olds[226]

Quantitative Data*

Awareness

- Adverts on TV: 77%
- Billboards or posters: 53%
- In-store promotions: 55%
- Branded clothing/other items: 66%
- Sponsorship of sports or teams: 61%
- Sponsorship of music events / venues: 34%
- Special price offers: 60%
- Mobile logos or screensavers: 24%
- Web pages or pop-ups: 12%

Involvement

- Owned branded clothing etc: 45%
- Received free branded gifts: 10%
- Received special price offers: 10%

Brand awareness

Able to name masked brands: [1]

Carling 95%

Smirnoff 93%

WKD 91%

Qualitative Data

On the internet I get pop ups for alcohol, and if you go to the Rangers website, or Celtic then a Carling sign comes up. (Female, 14, ABC1)

Rangers and Celtic are sponsored by Carling. It would be hard to find someone who didn't know what Carling was. (Male, 13, ABC1)

I prefer WKD to Bacardi Breezer. It's just because most people would probably rather drink that one and be seen with it, it's got a better image. I've seen them advertised, the WKD. (Female, 14, ABC1)

Smirnoff vodka is cool. (Female, 13, C2DE)

*Source: *Unpublished data from Wave 1 of Hastings et al NPRI study; † Gordon R (2007) Alcohol marketing & youth drinking. 63rd Alcohol Problems Research Symposium, November 7–8, Kendal.*

[1] Respondents are shown colour pictures of five alcoholic drinks that have the name covered up. For each one, respondents are asked by the interviewer what make or brand they think it is.

226 Ibid., p 20.

Figure 13 – Analysis of marketing documents of drinks' industry and their advertising, new media and PR companies

Types of advertising seen	13 year olds (2006)	15 year olds (2008)
Sample size	920 %	636 %
TV/Cinema Sports Sponsorship Clothing (sports tops) Music Sponsorship Sponsorship of TV & Film Social networking sites Mobile communications Websites	77 61 66 34 30 12 24 14	76 76 73 46 32 *34 *21 *7
Any channel	96	97
Number of channels	5.5	6.0

188. The ASA/Ofcom review referred to above makes references to 'kidult marketing' which 'blurs the fixed lines between adults and children' and to 'alcohol advertisements that play on the boundary of adult and teenage behaviour to bring the teenage and adult world closer together appear to have strong appeal for young people'.[227]

Analysis of marketing documents of drinks' industry and their advertising, new media and PR companies

189. In view of concerns raised about the effect of the marketing activities of the industry, we sought from the producers, their advertising agencies, PR companies and new media companies internal marketing documents relating to a number of campaigns. We asked Prof Hastings to analyse these documents and his analysis is published as a memorandum.

190. Professor Hastings found that the documents:

> reveal major shortcomings in the current self regulatory codes covering alcohol advertising. Specifically, the codes do not, as they are supposed to, protect young people from alcohol advertising; prevent the promotion of drunkenness and excess; or the linking of alcohol with social and sexual success. Nor do they even attempt to address sponsorship, and the documents show this is being systematically used to undermine rules prohibiting the linking of alcohol with youth culture and sporting prowess. Finally, the codes are extremely weak in their treatment of new media which are rapidly become the biggest channel for alcohol promotion.
>
> The result is a regulatory system that is impossible to police and vulnerable to exploitation.[228]

227 *Op. cit.,* pp 50–1.

228 AL 81

191. We took oral evidence from some of the organisations which supplied the documents. We were particularly concerned about documents which implied that campaigns set out to get people drunk—*'Pub Man's needs'* seemingly include turning into a comatose *'Alpha Male'* and *'shots'* are *'used to crank up the evening'* and *'to get blasted'*. In the evidence sessions the witnesses from the organisations dismissed these charts as ideas that were rejected at the planning stage.[229]

192. The Committee was also concerned that the Advertising Codes' prescription of any association of drinking with masculinity was being broken by a planning document for an alcopops called WKD which was headed *'Male Targeting'* and talked about ways to communicate maleness and personality. This led to the following exchange with one witness who attempted to parse the difference between maleness and masculinity:

> Sandra Gidley: Turning to page 19, that is a planning brief from earlier this year. This is again the WKD brand. The importance of advertising and campaigns to communicate maleness and personality. Under the code you are not allowed to use masculinity. What is the difference between masculinity and maleness?
>
> Ms Carter: What you need to understand is that RTD [Ready To Drink] as a category has always been predominantly very female focused in terms of a lot of the brands being targeted at women. We saw that there was an opportunity to bring to market a product that had male appeal. For us, it is not about being overtly female as opposed to overtly male. For example, we would not ever do a promotional link with makeup. That is why we would associate with the Nuts football awards that my colleague spoke about earlier. It is about engaging with our male consumers in things that they are interested in.
>
> Sandra Gidley: What is the difference between masculinity and maleness?
>
> Ms Carter: You can be involved in areas that males are interested in without overtly saying, "I, WKD, am a male product." To communicate maleness would be the Nuts football awards. Nuts is part of the male press so that is an opportunity for us to talk to male readers. The fact that it is in a male piece of media means that it is not viewed as being overtly female or girlie.
>
> Sandra Gidley: Why does it not fall into the masculinity category? I am struggling to find the dividing line between maleness and masculinity.
>
> Ms Carter: What we are talking about is that often maleness can be placed into the media. It does not have to be us creatively talking about maleness. It can be the Nuts football awards, using male press. Communicating maleness can be done by using male platforms as opposed to a creative look that says, "I am a male brand."
>
> Sandra Gidley: Is this not in effect though a brief that says, "Go as far down the maleness route as you can without breaching the masculinity code. Push it a bit"?

229 Q 847

> Ms Carter: No, not push it a bit at all. We operate within the codes and the codes are there for a reason. We welcome them because they give us a framework to work within."[230]

We also asked whether the same brands sponsorship of the Nuts football awards contravened both the masculinity/femininity rule and another rule saying alcohol can not be associated with sporting success. WKD's representative denied that there was any problem:

> "Charlotte Atkins: I thought that there was some sort of ASA code which actually talked about not linking up with sport, sex and so on. Would that linkage not transgress those codes?
>
> Ms Fuke: The initiative we are talking about is a sponsorship and the sponsorship is not focused on the brand itself but it is sponsorship of football awards and Nuts football awards are about sponsoring or encouraging people to engage with football and we simply support that and this sponsorship initiative is managed through equally important guidelines, so a marketing activity would be related to that in terms of content, style and tone.
>
> Charlotte Atkins: But you are aware that there is a code which suggests—in fact forbids the association of alcohol with sporting success and with masculinity and sex.
>
> Ms Fuke: This is not about sporting success and masculinity; this is awards which are irreverent that the fans make to the people who have played all through an injury or the best chant on the terraces.
>
> Charlotte Atkins: So basically it is a way of linking up with football without transgressing the code?
>
> Ms Fuke: I am sorry?
>
> Charlotte Atkins: It is a way of linking up men's obsession with football without transgressing the code?
>
> Ms Fuke: I do not believe it conflicts with the code, no."[231]

193. Our other major concern was that protection for young people was inadequate. In the Committee's evidence session of 9 July Howard Stoate MP showed that controls on accessing sites such as Smirnoff and creating user-generated content were lax.

> Q632 **Dr Stoate:** Are you at all worried about the fact that children clearly are able to access this with no difficulty whatsoever? So far as you are concerned, that is fine; whether they should or not is irrelevant; you think it is okay that they do.
>
> **Mr Gill:** No, because the content that is there is for adults only, and that is within the framework and the best working example that everybody has in the industry, not just in the UK or in alcohol, but globally, that is until such point where we can get

230 QQ 867–870

231 QQ 700–703

national identity, perhaps, or biometrics scanning that actually proves that you are over 18.

Dr Stoate: That is clearly nonsense, because anybody can get access to it who wants to, even with a date of birth that does not exist. It certainly does not give me confidence. I think this committee will certainly be taking a view on whether we think the situation is tough enough. Thank you very much, Chairman.

Policy options

194. Witnesses who believed that existing controls on marketing were inadequate proposed two main solutions

- A ban on many forms of marketing
- More effective controls, in particular restrictions on new media and an end to the system of self-regulation.

195. Several witnesses, including the President of the RCP, Professor Anderson and the BMA, proposed a ban on advertising and sponsorship along the lines of the 'Loi Evin' in France. We went on a short visit there to see how effective the ban in France had been. The key aspects of the French legislation, which has been in place since 1991, are

- no advertising is allowed on television or in cinemas;
- no sponsorship of cultural or sport events is permitted;
- advertising is permitted only in the press for adults, on billboards, on radio channels (under precise conditions), at special events or places such as wine fairs, wine museums.

196. However, no thorough evaluation has been carried out of the effectiveness of the ban so it is not known whether the ban has directly contributed to fall in alcohol consumption in France. Alcohol consumption in France was falling before the Loi Evin and is still falling, but the rate of fall has not changed.

197. An additional problem is that new media is increasing in France as elsewhere and is difficult to control.

198. As we have seen, the drinks industry argued that the Sheffield study showed there was no case for a ban. We questioned Dr Meier who said that the evidence was too weak to come to a conclusion:

> "In terms of interventions, codes and bans are typically designed to protect young people and any effects of bans on adults remain largely unknown. In practice, only France has introduced a comprehensive ban but no convincing evaluation was carried out.[232]

199. The Sheffield report stated

There is an ongoing methodological debate on how advertising effects can and should be investigated and there is also a need for further research to establish whether advertising definitely influences consumption. We should have a clearer picture of the effectiveness of current UK controls on alcohol advertising when phase 2 of the ScHARR review is complete. At that point, the Government as a whole will consider whether there is a need for further action.

200. As we have seen, the Sheffield report was concerned with the population as a whole; Professor Gilmore, Professor Anderson and the BMA pointed out that tighter controls on the amount of alcohol advertising will protect young people—and as the Sheffield report itself notes, the effects of advertising are greater on this group.

201. In view of the French ban on the alcohol industry's sponsorship of sporting and other events, we questioned the Minister and the Premier League and Football League about sponsorship. In July, the Sports Minister Gerry Sutcliffe MP indicated to the Committee that he was not persuaded of the need to impose restrictions on alcohol advertising of sport. We questioned him about the possibility of a ban on shirt sponsorship.

Q940 **Chairman:** One of the codes that people are supposed to use states that we should not associate alcohol with sporting success. Why would somebody sponsor a shirt of a Premier League football team if it was not to show that their product, no matter what it is, is concerned with the success of the football team as opposed to Bradford City, I suppose, or Rotherham United? Why would anybody sponsor a team in the football premiership if it was not to relate to sporting success, given that is where the shirt sponsorship is?

Mr Sutcliffe: I accept that they want to advertise their product. Is the next step then to say to Premiership League teams that they cannot have shirt sponsorship? Are we trying to affect the ability of clubs to bring in sponsorship? I think you have to be careful here. I take Howard's point that if the evidence overwhelmingly proves a situation, then the Government has to act, but again we have to have the evidence that proves that. My consistent phrase today is proportionality and making sure that we do the right thing.

Q941 **Chairman:** But we have evidence on tobacco and advertising was banned throughout the United Kingdom. Has it worked?

Mr Sutcliffe: That evidence was clear and it was clear that that was the obviously route to forward.

Q945 **Chairman:** You do not think that having a product on a Premier League football team shirt is advertising? Although I may watch it on my television, you do not describe that as advertising?

Mr Sutcliffe: Not in the way that you are suggesting, that it affects young people.

Q946 **Chairman:** What is it then?

Mr Sutcliffe: It is a sponsorship of that team, is it not?

Q947 **Chairman:** The named brand is there to see. Is it brand promotion? Is brand promotion not advertising? What is it?

Mr Sutcliffe: Clearly it is advertising in the context of sponsorship of that brand. I think the argument here is: does that affect and go outside what is a very strong code in relation to Ofcom and the ASA? Clearly, I am suggesting that we will reinforce the discussions with Ofcom and the ASA about that point and report back to the committee.

More effective controls

202. Two issues were of particular concern As we have seen, there is considerable concern about the effect of new media on the young.[233] We questioned Gerry Sutcliffe MP (Minister of Sport) about this. He rejected proposals to bring closer legal constraint on digital marketing:

> I accept the new media that there and that technology will develop even further in the years to come. DCMS have been looking at Digital Britain and what is likely to happen. As a government, we have continued to encourage voluntary codes. We do not feel that there is at this stage the need to go further but it is something we keep under review and we will obviously reflect on what this committee and others have to say to us.[234]

203. Dr Meier argued that there needed to be more research about the effect of marketing on the young:

> "There is a large evidence base […] around established channels such as the mass media but a shortage of studies evaluating newer media such as the internet and mobile phones. Generally, the vast array of channels and of types of promotional activity (Jernigan and O'Hara 2004) make it difficult to isolate individual effects, and thus target individual strategies, even though they consistently demonstrate an aggregative effect. Policy options should therefore recognise where a common underpinning mechanism exists and apply general principles to target such a mechanism in anticipation of new channels rather than continually attempt to respond to specific evidence on every new medium."[235]

Several witnesses told us that the system of self regulation had to end:

> Given the impact of alcohol misuse on health in the UK, the fact that advertising encourages young people to start drinking and increases their consumption of alcohol, the Alliance feels that decisions on broadcast advertising are too important to be left to a cabal of industry representatives. The Government must review the structure of advertising regulation in the UK—decisions should be made by a transparently accountable public body with strong representation from the health community.

233 Ev 42

234 Q 935

235 Ev 62A

Professor Anderson added:

> The effects of advertising exposure seem cumulative: young people who are more exposed are more likely to continue to increase their drinking as they move into their mid-twenties, while drinking declines at an earlier age in those who are less exposed. The international evidence and experience do not suggest that self-regulation implemented by advertising, media and alcohol producers prevents the types and content of marketing that impact on younger people.[236]

Conclusions and recommendations

204. **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.**

Procedures

205. **The regulation of alcohol promotion should be completely independent of the alcohol and advertising industries; this would match best practice in other fields such as financial services and professional conduct. In addition young people should themselves be formally involved in the process of regulation: the best people to judge what a particular communication is saying are those in the target audience.**

Scope

206. **The current controls do not adequately cover sponsorship, a key platform for alcohol promotion; the codes must be extended to fill this gap. The enquiry also heard how dominant new media are becoming in alcohol promotion and the particular regulatory challenges they present, including the inadequacy of age controls and the problems presented by user generated content. Expert guidance should therefore be sought on how to improve the protection offered to young people in this area.**

207. **Finally, there is a pressing need to restrict alcohol advertising and promotion in places where children are likely to be affected by it. Specifically:**

— **Billboards and posters should not be located within 100 metres of any school (there used to be a similar rule for tobacco).**

— **A nine o'clock watershed should be introduced for television advertising. (The current restrictions which limit advertising around children's programming fail to protect the relatively larger proportions of children who watch popular programmes such as soaps).**

— **Cinema advertising for alcohol should be restricted to films classified as 18.**

— **No medium should be used to advertise alcoholic drinks if more than 10% of its audience/readership is under 18 years of age (the current figure is 25%).**

— **No event should be sponsored if more than 10% of those attending are under 18 years of age**

— **There must be more effective ways of restricting young people's access to new media which promote alcohol**

— **Alcohol promotion should not be permitted on social networking sites.**

— **Notwithstanding the inadequacies of age restrictions on websites, they should be required on any site which includes alcohol promotion—this would cover the sites of those receiving alcohol sponsorship. This rule should also be extended to corporate alcohol websites. Expert guidance should be sought on how to make these age controls much more effective.**

— **Alcohol advertising should be balanced by public health messaging. Even a small adjustment would help: for example, for every five television ads an advertiser should be required to fund one public health advertisement.**

8 Licensing, binge-drinking, crime and disorder

208. The last 50 years have seen several important changes in the sale of alcohol which have led to a great increase in binge drinking with all its harmful consequences. 27% of young male and 15% of young female deaths were caused by alcohol. This is clearly a serious problem.

209. The most notable of the changes have been that:

- An increasing proportion of alcohol has been purchased off-licence rather than from pubs. As a proportion of total expenditure on alcohol, purchases from pubs fell 12% between 1998 and 2007, while supermarket purchases rose 18%.[237] As a result:
    - More people have drunk at home
    - Under-age teenagers have been able to obtain cheap alcohol and drink it outdoors
    - Young adults have begun the practice of 'pre-loading'; ie they get drunk at home before they go out to the pub or other venue
- There has been a major reduction in the number of traditional pubs, although the number of licensed premises, including restaurants, has continued to increase
- From the 1990s the night-time economy was promoted by local authorities and Government; magistrates found it increasingly difficult to block licence applications even where they considered them undesirable; they were no longer able to take any account of the 'need' for a new licence
- As part of the night-time economy there has been a growth in the number of vertical drinking pubs; people standing up drink more quickly.

210. The Alcohol Strategy in 2004 sought to address the problems related to binge-drinking, crime and disorder by a series of measures. It claimed that the main vehicle for improvement was the Licensing Act 2003. This was supported by a set of voluntary Social Responsibility Standards introduced by the alcohol industry in 2005.

211. Three Departments were involved: DCMS which was responsible for licensing, the Department of Health and the Home Office.

237 AL 59

The Alcohol Strategy's measures to address alcohol-related crime and disorder and the Licensing Act 2003

The Licensing Act 2003

212. As well as transferring responsibility for licensing to local authorities, the 2003 Act introduced four statutory licensing objectives:

- preventing crime and disorder;
- securing public safety;
- preventing public nuisance; and
- protecting children from harm.

The Act contained "a number of provisions which seek to protect the public and prevent disorder; for example it is an offence to sell alcohol to a drunk or to a child." However, the legislation also promoted liberalisation, supporting 'proportionate regulation to give business freedom to meet customers' expectations'.

213. At the time the Bill was introduced, the Culture Secretary, Tessa Jowell, was quoted as saying that people would become more sensible drinkers, so the prevalence of illness would decline.[238] The DCMS Departmental Report 2004 claimed that the

> Act reforms archaic licensing laws, strengthens competition and increases choice and flexibility for consumers. It introduces tough new measures to tackle alcohol-related crime and disorder and encourage a more civilised café-style culture in pubs and bars.

214. The operation of the 2003 Act was reviewed by the Government. According to the DH, the review, which was published in March 2008, revealed that the overall volume of crime and disorder had with local variations remained stable. Licensing authorities and enforcement bodies were using the new freedoms conferred by the Act, but had not sufficiently used 'the considerable powers granted by the Act to tackle problems...there was a need to rebalance action towards enforcement'.[239]

215. Other witnesses were more critical, arguing that the Licensing Act had little to do with reducing alcohol-related problems and had failed to adopt a public health approach.[240] Some have claimed that the DCMS's main aim in introducing the Licensing Act was not to reduce alcohol-related crime and disorder but to liberalise the licensing regime. It was pointed out that we had not achieved the civilised cafe-style culture the DCMS had dreamt of in 2004.[241] Crime and disorder might be stable but were spread over a longer period and later into the night which was a dubious advantage. Dr Anderson told us:

238 Independent 23.11.05

239 Ev 04

240 Ev 177

241 Q 433

> pubs stayed open on average only an extra 27 minutes. No real change in alcohol-related crimes was found up until 3am, but a 22% increase in crimes occurred between 3am and 6am. In other words, alcohol-related crimes were shifted until later in the night. In some studies, changes in the Licensing Act appeared to have little impact on the numbers of people treated for injuries sustained through assault, although in other studies, there were large increases in the number of night time alcohol-related attendances in accident and emergency departments.[242]

216. While the principle of giving local authorities the power to control licensing was widely applauded, the Government regulations which governed how they could exercise these powers were criticised for being far too favourable to the large pub chains. Criticism related to the restrictions the Government had placed on licensing authorities, which severely constrained their ability to operate an effective licensing regime; it was too difficult to prevent new licensed premises from opening almost regardless of their effects on existing traditional pubs and the local population. Dr Nicholls informed us:

> Arguably, the more historically significant element of the 2003 Act was the decision to move licensing from magistrates—where it had sat since 1552—to local authorities. In principle, this represented a democratisation of decision-making; in practice, the national guidelines issued to local authorities meant that their discretionary power to reject licence applications was severely curtailed.[243]

Similarly, it was too difficult to remove licences from premises associated with rowdiness and drunkenness. Where local authorities wished to promote the 'night time economy', there were inadequate powers for local people to object despite the consequences in terms of anti-social behaviour and disturbance.

217. We considered a number of other aspects of the Act. Part 7 of the 2003 Act lists various offences relating to drunkenness and disorderly conduct. Under section 141 it is an offence to sell alcohol to a person who is drunk. Unfortunately, this provision has not been effective. We consider why below.

218. Some witnesses argued that too much emphasis had been placed on the effect of the Act on the on-licence trade, too little on off-licence sales.[244] The Act not only failed to tackle the main problem, the increasing volume of off-licence sales, but also exacerbated the situation by permitting shops and supermarkets to sell alcohol at extended opening times. We discuss the off-licence trade in the next chapter.

The voluntary Social Responsibility Standards 2005

219. In 2005 voluntary Social Responsibility Standards were introduced by 16 trade associations and organisations in the alcohol industry. According to the Department these *voluntary standards* were intended to provide a comprehensive statement of the rules, regulations and additional commitments which the various parts of the alcohol industry

242 AL 58; the DCMS review is published as, *Evaluation of the impact of the Licensing Act 2003*, March 2008, summary of findings, pp7–8, http://www.culture.gov.uk/images/publications/Licensingevaluation.pdf

243 AL 59

244 Ibid.

had agreed to adhere to. The standards were based on a set of social responsibility principles that should apply to all activities relating to the production, distribution, marketing and retailing of alcoholic drinks, including the promotion of responsible drinking and 'the avoidance of any actions that encourage or condone illegal, irresponsible or immoderate drinking, such as drunkenness, drink driving or drinking in inappropriate circumstances'.[245]

220. In January 2008, the Home Office commissioned KPMG to undertake a review of the alcohol industry's voluntary standards. KPMG was asked to consider:

- the extent to which on- and off-trade vendors adhered to the standards; and
- whether the standards contributed to a reduction in alcohol-related harm.

221. The KPMG review indicated that the standards were not operating as the Government originally hoped. KPMG recognised that

> Many firms invest relatively large sums in sponsoring programmes and projects that promote responsible drinking, willingly take part in exercises to monitor their performance and are very explicit on their websites about the effects of consuming alcohol. They can point to many initiatives they have taken through their Corporate Social Responsibility work.

Jeremy Beadles of the WSTA claimed that the study had showed that there was a lot of good practice and that breaches of Social Responsibility Standards by the off-licence trade had been few and when they had occurred they had been the fault of usually small organisations which had not signed up to the code.[246]

222. Nevertheless, in many respects the study is damning. Practices which KPMG observed frequently included:

- People who appear to be under-18 frequently being admitted to age restricted venues in which they cannot purchase alcohol legally;

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245 The Code was

- To promote responsible drinking and the 'sensible drinking message'.
- To avoid any actions that encourage or condone illegal, irresponsible or immoderate drinking, such as drunkenness, drink driving or drinking in inappropriate circumstances.
- To take all reasonable precautions to ensure people under the legal purchase age cannot buy or obtain alcoholic drinks.
- To avoid any forms of marketing or promotion that have particular appeal to young people under the age of 18 in both content and context.
- To avoid any association with violent, aggressive, dangerous, illegal or anti-social behaviour.
- To make the alcoholic nature of their products clear and avoid confusion with non alcoholic drinks.
- To avoid any suggestion that drinking alcohol can enhance social, sexual, physical, mental, financial or sporting performance, or conversely that a decision not to drink may have the reverse effect.
- To ensure their staff and those of companies acting on their behalf are fully aware of these standards and are trained in their application in their own areas of responsibility.
- To ensure that all company policies work to support these standards.

Source: KPMG report on the Social Responsibility Code

246 Q 257

- the promotion of alcohol through low price offers, inducements by DJs to consume greater quantities, and glamorisation through links with sexual imagery;
- encouragement to drink more and faster through shots and shooters being "downed in one";
- sales to blatantly intoxicated people;
- several health and safety issues inside bars and clubs e.g. overcrowding, broken glass and spilled alcohol;
- poor dispersal practices (although there is some very good practice);
- several instances of anti-social behaviour and low level crime (fights and assaults, urinating and vomiting in public places, criminal damage).

223. In conclusion KPMG argued that

> Whilst this review has noted the excellent work done by many organisations, especially producers and their representatives, to demonstrate the principles of self-regulation, it has also noted the many poor practices, particularly in the on-trade, going unchecked.
>
> We have not assembled any evidence which suggests there is any direct causal link between the impact of the standards and a reduction in alcohol-related harm. In the current trading climate the commercial imperative generally overrides adherence. Inducements to people to drink more and faster, to allow under-age people entry to restricted premises, and blatantly serving intoxicated people are evidence of this conclusion.
>
> In driving responsible practice they (the standards) are ineffective because of a lack of consistent monitoring and enforcement. We have not assembled any evidence which suggests there is any direct causal link between the impact of the standards and a reduction in alcohol-related harm.

Changes following the 2007 Alcohol Strategy

224. Thus, by the time of the revised Alcohol Strategy in 2007, it was clear that improvements needed to be made. A new plan for dealing with underage drinking was proposed and partnerships and innovative schemes were encouraged. Most importantly, major legislative changes were made through the Policing and Crime Bill 2008 which was enacted in 2009.

Schemes to reduce alcohol harms experienced by under 18s

225. In June 2008, the Department for Children, Schools and Families, the Home Office and the Department of Health published the Youth Alcohol Action Plan (YAAP), which set out measures to address drinking by young people, including working with the police and courts to tackle drinking in public, providing clear information for parents and young people, and working with the industry to tackle underage sales and to promote the responsible sale of alcohol.

226. We took evidence about a number of initiatives to reduce the harm to young people from the industry and the police. The Wine and Spirits Trade Association is part of schemes in St Neots and Canterbury involving the Retail of Alcohol Standards Group (RASG) and Cambridgeshire and Kent Trading Standards. The projects combine "enforcement, education and community involvement to tackle under-age drinking in a holistic way". A key part of the scheme has been stopping and searching young people and confiscating any alcohol they have in their possession. The WSTA was enthusiastic about the significant benefits which the schemes had brought about.[247] The actions taken as part of the St Neots Community Alcohol Partnership, the outcomes and an assessment of the benefits are shown in the table below, which contains an extract of the official WSTA report.

The benefits of the scheme are still being seen. Since its inception the scheme has delivered the following:

> 42% decrease in anti-social behaviour incidents in the St Neots area from August 2007 (pre-project) to February 2008 (post-project)
>
> 94% decrease in under-age people found in possession of alcohol
>
> 92% decrease in alcohol-related litter at key hot spot area.

Joint working between police, Trading Standards and retailers

Actions	Stakeholders	Outcomes
Trading Standards worked with store managers (visiting them during the day) and positioned themselves in retail outlets to advice any alleged offenders (young people or proxy purchasers) of the reason their purchase was refused. 129 young people were stopped and searched by the police	Police, Trading Standards and retailers	First nine joint enforcement operations: 32 young people found to be in possession of alcohol. Tenth enforcement operation: 1 person in possession. Eleventh enforcement operation: 2 in possession. Overall decrease of 94%

Policing and Crime Act 2009

227. The main new means of addressing concerns about failings in the licensing regime and in the consumption of alcohol by underage drinkers, are the measures in the Policing and Crime Act 2009. Aspects of the Bill had been subject to consultation in the summer of 2008 and again in 2009. The Bill was given Royal Assent in November 2009. The regulations to give effect to many of the improvements have not yet been made.

228. According to the Government the legislation:

247 Q365

- Includes measures to prevent the sale of alcohol to young people under 18 and to prevent them from drinking in public places; this filled a gap in the 2004 Strategy which recognised the problem of underage drinking in the street or at home.
- Introduces a mandatory code "to get rid of some of the worst promotions"; this was introduced in response to the failings uncovered in the KPMG study.
- Revises the Licensing Act 2003, to give licensing authorities the powers to allow them to take action pro-actively against irresponsible premises without having to wait for the police or others to complain.

Below we look at the mandatory code and the new power to take action against irresponsible premises.

A mandatory code

229. Following the KPMG Report, in July 2008 the Department of Health's report, *Safe, Sensible, Social – Consultation on further action*, sought views:

> on whether existing voluntary codes should be made mandatory. We intend to discuss what a code might contain with interested stakeholders over the coming months.

Alan Campbell the Home Office Minister, told us that following the consultation in 2008 the Government had decided to introduce a mandatory code:

> What we are doing, of course, is moving beyond a voluntary code because sections of the industry will not face up to their responsibilities as the code has suggested that they should. That is why we are moving to a mandatory code under the Police and Crime Bill to get rid of some of the worst promotions, but also to introduce some local licensing arrangements that can be applied to groups of premises in an area where there is still a persistent problem.[248]

230. The following five mandatory licensing conditions were put out to consultation in the summer of 2009:

- A ban on the most irresponsible promotions, such as "all you can drink" offers
- A ban on alcohol being dispensed directly into customers mouths—so-called "dentists chairs"
- Requiring on-trade premises to make smaller measures available, such as 125ml wine
- Requiring on-trade premises to make free tap water available
- Requiring online and mail order retailers to have robust age verification schemes in place.[249]

248 Q 921

249 Home Office, *Consultation on how alcohol is sold and supplied,* 2009

231. These proposals received much support. The increasing use of larger glasses has meant that customers have been drinking several units in one glass, often without realising it.

232. The Government is still deciding which conditions to implement. The specialist press has reported that the mandatory code is among a raft of regulations affecting business that Lord Mandelson has "ordered" to be delayed due to the recession. However, according to the same reports, the Home Office remains confident that the policy will be implemented.[250]

Local conditions

233. The consultation in the summer of 2009 had also considered making provision for 'locally applied discretionary conditions' on licensees in the Policing and Crime Bill. These were conditions' which licensing authorities would be able to pick and choose to impose on two or more premises in their area if they felt the premises were a) causing a nuisance b) that nuisance was alcohol related c) that nuisance was likely to be repeated and d) it was appropriate to apply conditions to mitigate the nuisance. These were measures like banning happy hours, banning glass containers at certain times and prohibiting discounts over a certain volume.

234. The Government removed the provisions for these conditions from the Bill in light of the feedback received at the regional stakeholder consultation workshops held over the summer where both licensing authorities and the licensed trade expressed concerns about the locally applied conditions. Licensing authorities were concerned about the practicalities of imposing conditions on multiple premises and were worried that any attempt to do so would be automatically appealed by the trade, and the trade were concerned that having conditions imposed on groups of premises meant that responsible premises could be inadvertently caught up and have the conditions imposed.

235. However, the Government claimed to have replaced these conditions with tougher powers for licensing authorities. At Report stage in the House of Lords the Bill was amended to allow members of the licensing authority (i.e. local councillors) to act as 'interested parties' under the Licensing Act 2003. This allowed them to make representations to instigate a licensing review whereas, at present, licensing authorities can only hold a licensing review if the police, trading standards, local residents or other authorities request one. Following a licensing review, the licensing authority can take a range of actions, including adding new conditions to the licence, modifying the hours or suspending or revoking the licence. So, it is claimed, the change will give local authorities much more flexibility in the type of action they can take as well as still allowing them to take action pro-actively without having to wait for the police or others to complain.

Continued weaknesses in the licensing regime

236. While the Policing and Crime Act 2009 has improved the situation, there remain a number of weaknesses in the licensing regime. Two were of particular concern to us:

250 "Code may proceed despite Mandelson", *Morning Advertiser*, 24 September 2009, p6

Selling alcohol to a person who is drunk

237. The effectiveness of legislation relies on enforcement. We were therefore surprised to discover that s.141 of the 2003 Act is scarcely enforced.

238. ACPO informed the Committee that the Police did not need new powers because they relied on softer measures, seeking to develop partnerships:

> **Q450** (Stepehen Hesford) So there is nothing that comes to mind in terms of additional powers?
>
> Mr Craik: No. In fact ACPO's position at the moment is two-strand. We want to get into this and start to develop partnerships, and this end-to-end management of drinking in public places is something we should share together with our partners, and we think that is absolutely right. It should not just be an enforcement thing. The other thing we want to move to is away from all this doom, gloom and disorder.

Chief Constable Craik's submission went further in explaining how the Police could do this:

> Generally the police work in partnership with licensees and the Security Industry Authority to effectively manage people becoming so drunk on licensed premises that they require eviction. If there is a requirement to evict drunken individuals from licensed premises then the police will then use their enforcement powers in relation to any offences pertinent to the individuals concerned.
>
> There are effective Pubwatch schemes running nationally which allow for exclusions to be placed on individuals from entering specific licensed premises due to previous behaviour. Since 1st January 2009 in Northumbria Police alone 144 Pubwatch exclusions have been served. This in itself is a deterrent to the public, and a punishment to those who do offend whilst in licensed premises. The Best Bar None nationally accredited scheme provides an incentive to licensed premises to ensure they act responsibly in relation to the management of their licensed premises.[251]

239. The Home Office submission argues that it has a programme of work in place to address weaknesses in the enforcement of current legislation:

> Last year we trained over 1,300 front-line practitioners in the full range of alcohol related tools and powers available to them and we have recently begun a series of 40 workshops to train a further 2,000 to 2,500 practitioners in our priority areas. Earlier this year we spent £1.5m on targeted enforcement campaigns in the 40 to 50 areas of most concern to us, that is those areas with high levels of alcohol related crime and high public perceptions of drunk or rowdy behaviour, and we have also spent a further £3m supporting local alcohol related partnership activity.[252]

251 Q 450

252 Ev AL 47

240. The Home Office also argues that there are practical difficulties in enforcing the law regarding the offence of selling alcohol to someone who is intoxicated since it requires the police to be present when the sale is made:

> Large-scale enforcement would therefore be extremely expensive and is impractical. Instead, we believe that it is more effective to focus on training those serving alcohol to spot and deal with those who are intoxicated and we are working closely with the industry through schemes such as Pubwatch and Best Bar None to achieve this. We are also considering the issue of training in our public consultation on the new code of practice for alcohol retailers.

241. The Committee questioned Ministers about why the Act was not enforced:

> **Q903 Dr Naysmith:** Following up on what has just been said, given that it is illegal to serve a drunk person in a pub, why is it that the number of prosecutions is so pitifully low?
>
> ***Mr Campbell:*** There are some prosecutions.
>
> **Dr Naysmith:** It is a tiny number.
>
> ***Mr Campbell:*** It is a small number. The simple answer to your question is that it is quite a difficult offence to enforce because the offence is about knowingly selling to someone who is intoxicated. Unless there is a police officer and a huge commitment by the police in an area to see this happen, it is quite difficult to enforce that. There are two other aspects to it which I think would take us further. One is about better training for bar staff to know when to stop serving someone, the signs to see and also the way in which they might go about that. The second point of course is to work with licensees in a particular area, often through something like Pub Watch, where there are some very good schemes of pub watching practice where licensees actually agree to enforce standards.

242. Few people have been prosecuted for transgressions to the Licensing Act 2003. In 2006 only six people were found guilty of supplying alcohol to under 18s.[253] Few people have been prosecuted for, and even fewer found guilty of, selling alcohol to a drunken person.[254]

Licensing and public health

243. Since the Police and the Home Office are unwilling or unable to enforce section 141 of the 2003 Act, we considered other ways of achieving the same result. One contributor to a RAND study on licensing laws stated, with reference to licensing requirements: "[i]f the system has effective power to suspend or revoke a license in the case of selling infractions, it can be an effective and flexible instrument for holding down rates of alcohol-related problems."

253 Ev 162

254 HC Deb, 9 June 2009, col 809W

244. This should be possible because under the 2003 Act the police or the fire authority, or an "interested party", such as a resident living in the vicinity of the premises, may ask the licensing authority to review the licence because of a matter arising at the premises in connection with any of the four "licensing objectives". Presumably, if the police had evidence of persistent unlawful sales, one would expect them to press for a review, making reference to the crime prevention objective, but it is unclear whether they have done this.

245. The licensing system is not working well. Chief Constable Craik of ACPO told us:

> … I think there is an anxiety, that they feel constrained by the legal power of the big organisations. In industry they can turn up with lots of very expensive barristers and challenge decisions,… My view is I would like to see, certainly some of my colleagues would like to see, more licensing authorities at least trying to be more in tune to what local people say.[255]
>
> I would be supportive of that. I would like to see the local community having a more powerful voice in how licences were granted.[256]
>
> the rejections, refusals and revocations are very, very robustly legally challenged, and that puts them in a very difficult position. As much as local councillors may want to provide what local opinion suggests is appropriate for them, they have to get everything right, and that is quite a tough challenge.[257]

246. During our visit to Scotland we discussed the different approach taken there to licensing. The Licensing (Scotland) Act 2005 which comes into force in September 2009, and is in part based on the recommendations of the Nicholson Committee which was charged with reviewing all aspects of liquor licensing law and practice in Scotland. The Nicholson Committee was asked to give particular reference to the implications for health and public disorder and to recommend changes in the public interest. The Act sets out five licensing objectives that Licensing Boards must seek to promote and take into consideration when granting or renewing licences. Four of the five objectives are similar to the objectives in England, but there is an additional fifth objective, namely 'protecting and improving public health'.

247. In practical terms, as we discovered in Scotland, this puts public health at the forefront of policy makers minds in Scotland, and means that the purpose of licensing extends beyond those aspects of alcohol use which are illegal, such as purchase by those under age, or lead to illegal behaviour, like public disorder, and includes actions which actively promote public health, such as tackling low cost alcohol and other marketing practices which lead to increased health harm. It could also enable licensing authorities to once again consider whether there is a need for more licensed premises in an area.

255 Q 434

256 Q 435

257 Q 441

Conclusions and recommendations

248. **Alcohol-related crime and anti-social behaviour have increased over the last 20 years as a result of the development of the night time economy with large concentrations of vertical drinking pubs in town centres; under-age drinkers in the streets have also caused problems. The Alcohol Strategy 2004 recognised these problems and claimed that they were being addressed by a number of measures including the Licensing Act 2003. In addition, the alcohol industry established voluntary standards to govern the promotion and sale of alcohol.**

249. **The worst fears of the Act's critics were not realised, but neither was the DCMS's naive aspiration of establishing cafe society: violence and disorder have remained at similar levels, although they have tended to take place later at night. The principle of establishing democratic control of licensing was not realised: the regulations governing licensing gave the licensing authorities and local communities too little control over either issuing or revoking licences, as ACPO indicated. KPMG examined the alcohol industry's voluntary code and found it had failed.**

250. **Problems remained and the 2007 Strategy introduced new measures. Partnership schemes such as the St Neots Community Alcohol Partnership were established. The main changes are being introduced by the Policing and Crime Act 2009 which gives the police greater powers to confiscate alcohol from under 18s, introduces a mandatory code in place of the industry's voluntary code and has made it easier to review licences, giving local authorities the right to instigate a review. We support the introduction of mandatory conditions and urge the Government to implement them as a matter of urgency.**

251. **Despite the recent improvements, much needs to be done given the scale of alcohol-related disorder. It is of concern that section 141 of the Licensing Act 2003, which creates the offence of selling alcohol to a person who is drunk, is effectively not enforced despite KPMG's finding that this behaviour is frequently observed. We note the police and Home Office's preference for partnerships and training, but do not consider these actions should be an excuse for not enforcing a law which could make a significant difference to alcohol-related crime and disorder. We call on the police enforce s.141 of the Licensing Act 2003 more effectively.**

252. **We note the concerns of ACPO and other witnesses about the difficulties local authorities have in restricting and revoking licences. The Government has made some improvements in the Policing and Crime Act 2009, but must take additional measures.**

253. **In Scotland legislation gives licensing authorities the objective of promoting public health. Unfortunately, public health has not been a priority for DCMS. We recommend that the Government closely monitor the operation of the Scottish licensing act with a view to amending the Licensing Act 2003 to include a public health objective.**

9 Supermarkets and off-licence sales

"I think the biggest change in drinking habits in this country is buying from supermarkets at heavily discounted prices, drinking relatively quietly at home and developing either dependency or physical problems.(*Professor Gilmore*)[258]

"supermarkets are exhibiting the morality of a crack dealer" (*Professor Plant*)[259]

Changing patterns of purchasing

254. Until the 1960s there were a limited number of off-licence outlets. Today alcohol is available in supermarkets and other shops all over England at all times of the day and in many shops for much of the night. According to Dr Kneale, in 1975 90% of all beer consumed in Britain was consumed in pubs and it is now under 50%.

255. The following table from the NHS Information Centre report, *Statistics on Alcohol: England, 2009*, shows the alcoholic drinks consumed inside and outside the home from 1992 to 2007. Consumption in the home in the UK increased from 1992, peaking in 2003/04, since when figures have fluctuated. There have been big increases in the consumption of wines and spirits. In contrast, alcoholic drinks purchased for consumption outside the home (i.e. in pubs, clubs and restaurants) decreased by 31% between 2001/02, when this type of data was first collected, and 2007. Purchases of beers fell by 36% over the period.

Table 6: Household consumption of alcohol drinks, 1992 to 2007 (United Kingdom)

ml per person per week

	All alcoholic drinks	Beer[2]	Cider and perry	Wine[3]	Spirits[4]	Alcopops	Other[5]
Consumption within the home							
1992	527	298	47	152	30	0	–
1993	536	297	44	164	32	0	–
1994	552	311	52	162	28	0	–
1995	627	338	77	180	32	0	–
1996	656	351	82	188	34	0	–
1997	653	365	58	196	32	2	–
1998	645	340	61	212	30	1	–
1999	640	329	60	213	35	4	–
2000	725	388	58	232	37	10	–
2001/02	735	386	55	236	39	18	–
2002/03	726	380	50	239	39	18	–
2003/04	792	416	64	251	41	19	–
2004/05	763	395	55	261	38	14	–
2005/06	739	377	52	262	38	11	–
2006[6]	760	393	59	255	41	12	–
2007	772	384	75	263	42	8	–

258 Q 17

259 Q 82

Consumption outside the home[7]							
2001/02	733	623	21	20	21	34	15
2002/03	704	592	20	20	21	36	15
2003/04	664	557	20	21	22	25	21
2004/05	616	515	18	22	20	20	22
2005/06	597	499	16	22	20	15	25
2006	561	459	24	23	18	11	25
2007	503	400	28	19	17	8	31

1. Data from 1992 to 2000 was collected from the National Food Survey and has been adjusted to allow comparisons to data collected from 2001/02 onwards from the Expenditure and Food Survey

2. 'Beer' includes beers, lagers and continental beers

3. 'Wine' includes table wine, champagne and fortified wines

4. 'Spirits' includes spirits and mixer, liqueurs and cocktails

5. 'Other' includes rounds of alcohol drinks bought and alcohol not otherwise specified

6. From 2006 the survey moved onto a calendar year basis (from the previous financial year basis). As a consequence, the January 2006 to March 2006 data are common between the 2005/06 financial year results and the 2006 calendar year results

7. Data on volumes consumed outside of the home from 1992 to 2000 is not available

Source: Expenditure and Food Survey, DEFRA, historic trend data can be accessed on the internet via the DEFRA website, available at: http://statistics.defra.gov.uk/esg/publications/efs/default.asp

Problems of the increasing cheapness and availability of alcohol

256. Among the consequences of changing patterns of purchasing and consumption have been pre-loading. Mr Benner of CAMRA told us:

> There is evidence from Liverpool, John Moores University, on preloading, that groups of young people, as much as 50 per cent of those groups, are likely to drink at friends' houses or their own houses to save money, because of the huge price differential between on and off-trade, before they go out on the town.[260]

Professor Plant:

> 'What we do know is that teenagers across the country are typically getting alcohol from supermarkets and beginning their evening drinking cheaply at their house or somebody else's. The Canadians call this "pre-drinking"; in Scotland it is "front loading". This is a way of cheapening drinking so that you are pretty much drunk before you go out to drink more expensively in pubs and clubs.[261]

257. Of particular concern to witnesses were

- The increasing number of outlets; and
- Aggressive promotions and significantly discounted alcohol products

260 Q 354

261 Q 104

Availability and density of outlets

258. In the inquiry we examined the link between the availability and consumption of alcohol.[262] The RAND Corporation has looked at the effect of "regulating the physical availability of alcohol" including licensing requirements for the production and sale of alcohol; restrictions on the density of outlets; and reductions in the hours of sale. The organisation reported that evidence from the US indicated that the physical availability of alcohol (i.e. the number of outlets in a given area) was related to alcohol sales, alcohol-related traffic accidents and other alcohol-related harms. Studies from Norway, Finland and Sweden also found some net effect from changes in the number of alcohol outlets, including (in Sweden) the changes in the sale of 4.5% beer in grocery stores. In Canada, provincial alcohol retail monopolies were an effective method not only for restricting hours or days of sale and outlet density, but also for guaranteeing enforcement of minimum legal purchase age. Dr Meier told us:

> It is probably important to see that availability works in two ways. One is in terms of making it easy for people to get hold of alcohol around the clock or in terms of walking distance, outlet density. There is also possibly a cultural signal that at the moment we do not understand very well, there is very little research. If you change the availability of alcohol towards making it more available, is that a signal for especially young people about the acceptability of drinking. That is something that is in urgent need of some proper scientific research.[263]

259. The LGA stressed that the regulation of off licenses was the key to any effort to tackle problem drinking in unregulated environments. Problems were not just associated with supermarket sales:

> Smaller off-licences can though be associated with a number of specific problems in the public realm, for which local authority interventions are central to tackling:
>
> sale of alcohol to street drinkers, who congregate in the area and cause public nuisance and crime and disorder;
>
> sale of alcohol to minors, either directly making underage sales, or by "proxy" sales via adult purchasers; and
>
> crime and disorder in terms of shoplifting (eg alcohol) and robbery at the premises, or other criminal and anti-social behaviour.

260. The Association of Convenience Stores thought the answer lay in stricter enforcement rather than a change to the licensing regime:

> There are now sufficient powers in legislation to allow relevant authorities to take action against premises that they believe could do more to prevent alcohol harms. These laws should be rigorously enforced, ensuring that where negligent practices take place they are ended or the premise is shut down. Though there is evidence that these powers are not being fully utilised the Home Office has undertaken a

262 see Q 45

263 Q 293

> programme to raise awareness among practitioners, including regional seminars and the publication of a toolkit. We question whether making significant changes to the Licensing Act 2003 is necessary and instead would advocate a focus on enforcement of existing laws...ACS' concern is that further regulations will unnecessarily burden responsible retailers, while issues regarding enforcement against problem premises will still remain.[264]

261. On the other hand, the LGA informed us that the system for reviewing licences was inadequate:

> "off-licences are most commonly brought by the police or trading standards, either following sales to underage customers, or due to problems with anti-social behaviour, crime and disorder. The licensing sub-committee considers evidence from the licensee and members of the local community who have made relevant representations, and decides whether to impose stricter conditions on the licence, suspend the licence, remove the premises supervisor, or even revoke the licence completely."

Unfortunately this system does not seem to be coping with the problems and the Association is concerned that

> "conditions in the current draft code proposed in the Policing and Crime Bill are biased towards further regulation of the on-trade and do not sufficiently address the contribution of off-sales to problem drinking."[265]

The introduction of a public health objective in the Scottish licensing regime which we discussed in the last chapter will also apply to off-licences and should make it possible to reduce the density of shops selling alcohol off-licence.

Aggressive promotions by supermarkets

262. Sheffield University provided evidence of off-trade prices.

> Approximately 27% of off-trade alcohol consumption is purchased for less than 30p per unit, compared to 9% in the on-trade. 59% of off-trade consumption and 14% of on-trade consumption is purchased for less than 40p per unit

We contacted a number of supermarkets to gather information on promotions and own brand products. We found that around 30-40% of alcohol sales came from promotions, and about 20% of alcohol sales were from own brand products. Alcohol can be purchased at remarkably low prices:

> If you go out and buy three litres of 8.4% white cider for £2.99 you are getting more than your weekly safe limit in one bottle. That is as cheap as you can get it, about 10 pence a unit.[266]

264 Ev 116

265 Ev 138

266 Q 63

> The ACS added that its members had "well documented competition concern on below cost selling on all products, including alcohol."[267]

Criticisms

263. Many witnesses were critical of supermarkets for their aggressive promotions of alcohol and for using alcohol as a loss leader for pulling in customers. The RCN informed us:

> There is evidence to suggest that alcohol is used as a loss leader in supermarkets. £38.6 m of alcohol was sold below trade price in the 2006 World Cup from supermarkets.[268]

264. Witnesses were particularly concerned that teenagers were able to get access to cheap alcohol:

> Teenagers generally drink the cheapest stuff they can get, not alcopops but cheap cider or cheap wine and the obvious source of very, very cheap alcohol at the moment are the supermarkets who are sometimes selling alcohol as a deliberate loss leader. In my own local supermarket, Sainsbury, last time I was there they had two separate alcohol promotions that involved offering people drinks even though almost everybody had driven to get there. There is alcohol at the end of almost every aisle.[269]

Solutions

265. In view of their concerns about the use of cheap alcohol to compete for customers, critics suggested a number of measures to improve the situation. One was to restrict promotions. Dr Meier told us that Sheffield University had modelled the effect

> of having restrictions on price promotions or a total ban…. Assuming …you had a ban that worked as intended, that would be about comparable with the 40p minimum price in terms of the overall effectiveness in terms of health and crime harms.[270]

However there is a concern

> that if you just banned price promotions it would be very easy to circumvent by making the normal price drop. If you wanted to play devil's advocate you might end up with lower prices if you just banned promotions and did not do anything else. It could be an effective policy if it was in combination with something else [271]

The ACS similarly claimed that 'Even if promotions were banned it is likely that larger retailers would still be able to offer an incentive for shoppers through low product price.'

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267 Ev 139

268 Ev 106

269 Q 86

270 Q 297

271 Q 298

266. There was particular interest in major changes to how alcohol was sold which came into effect in Scotland in September 2009. Under the legislation, which is the first major overhaul of Scotland's licensing law in three decades, ...consumers will only be able to buy alcohol from off-sales between 10am and 10pm. In addition, stores will only be allowed to display alcohol in a specific area which has been set aside for drink: customers used to purchasing alcohol alongside food offers will now find that they can only purchase beers, wines or spirits from specific alcohol aisles. The act also requires places selling alcohol to have a licence for the premises and a designated staff member who has received a personal licence to sell drink after completing training on the new legislation. In addition, promotions such as 'three for two' or 'three for £10' can be banned by local licensing boards if they consider the promotion to be 'irresponsible'. Several witnesses supported the introduction of similar measures in England. Professor Gilmore argued that "it would be very easy to do what has been done north of the border to make alcohol available only in certain areas in supermarkets so you do not have a special offer at the end of every aisle."[272]

267. Other recommendations for addressing promotions included:

- Large health warning notices in stores about the dangers of alcohol and the recommended limits;
- A voluntary code to restrict promotions; and
- A ban on selling alcohol at below the cost of the tax on it.

We questioned witnesses about these proposals, as we describe below.

The supermarkets response

268. We received written submissions from supermarkets and other retail organisations. We questioned four of the major supermarkets about their promotion policies and proposals for dealing with them. The supermarkets emphasised that there was fierce competition for custom and, as a result, they did sell alcohol at very low prices; however, they denied that this encouraged people to drink more and rejected most of the proposed restrictions. We were told that alcohol promotions were popular with customers and were a product of a fiercely competitive market in which different retailers were fighting for business and that

> The prices that we are able to offer customers are partly a response to each other's desire and need to attract more market share, so that is where the prices come from.[273]

269. The box below includes relevant parts of the evidence session which show how intense competition leads to heavy discounting, including at times selling at a price not only below cost but below the level of tax.

272 Q 24

273 Q 1103. The ACS told us: Currently multi-buys of small quantities are used as footfall drivers into store. In fact alcohol is the category most bought on promotion in convenience stores, which means it is a significant footfall driver

Q1134 Chairman: I find that very difficult to accept, even in part, on the basis of how supermarkets—and I am not saying yours particularly—discount it and how price promotions in our supermarkets are. If you walk in now you will trip over a three-for-two offer in most of mine. It must be price sensitive, must it not?

Mr Kelly: As we have all said, we are in a highly competitive market and customers like promotions. That is the reality.

Q1135 Chairman: That is, the price changes?

Mr Kelly: They will switch between brands of alcohol as they will switch between brands of supermarket.

Q1155 Sandra Gidley: Why do supermarkets sell alcohol at below the cost of the duty that is on it from time to time as a loss leader?

Mr Kelly: As we said earlier, we are in a highly competitive market competing for customers and we will sell sometimes loss leaders across a whole range.

Q1156 Sandra Gidley: Do you think it is right to do this with alcohol though? Do you think it is socially responsible?

Mr Kelly: We are in a highly competitive market. There is nothing that currently stops the floor continuing to fall away. There is a legitimate question there for policy makers about whether instruments need to be brought in to stop that happening.

Mr Fisher: It is not something that we make a habit of doing. We have done it twice in the last year. …

Q1159 Sandra Gidley: So you do not feel the need to slash things as much as ASDA then, because from ASDA we have just heard that it is a commercial environment and that is why it is okay to do it?

Mr Grant: It is slightly circular, I guess, but we remain competitive so that we offer a universal appeal. We are not in Waitrose's position of being able to price to a very precise type of customer. We do have to cater for everyone from low, fixed income to the wealthy, and that is our mission as a commercial organisation, which means that we do have to very closely monitor what is happening in the market and make sure we remain competitive.

270. Sainsbury's denied that low prices were used to increase the number of customers going to stores:

> It is not to increase footfall. It is when the customer is there, the first thing they see of the store is that "this is a store which understands the sort of things I am going to be looking for", and that includes discounts.[274]

274 Q 1214

271. The supermarkets also denied that promotions led to 'increased excessive consumption. Sainsbury's told us:

> There is little or no recent research into off-trade alcohol promotion sales which substantiates a clear link between the two. We believe that the issue is much more complex and involves getting to the crux of why people misuse alcohol in the first place. As a food retailer, while our customers may buy alcohol on promotion, it is overwhelmingly part of their weekly shop. Customer transaction details show that just over 1 per cent of weekly transaction sales are alcohol-only.[275]

Sainsbury's pointed to a survey in 2007 by Ipsos Mori[276] of its customers about their attitudes towards promotions on beer which found that:

> 'One third said they would buy a little more than usual, with nearly half saying they would buy 'about the same'
>
> 48% said they would check to see if the brand of beer they like is on promotion and if not, they would still buy their preferred brand
>
> 91% of customers said they would drink about the same in a month when purchasing beer in bulk
>
> Only 23% said they tend to choose a beer based on its strength'[277]

Mr Beadles of the WSTA argued that 'the people who are most likely to buy into promotional activities are ABC1 consumers over the age of 45 and the people least likely to buy are DE consumers under the age of 28'.[278]

272. In answer to questions about new Scottish measures, we were told that

> the 10am threshold for alcohol purchases was most likely to inconvenience pensioners who prefer to shop when stores tend to be quieter and parents accustomed to shopping after completing the school run—restricting alcohol sales to one aisle would impose costs on supermarkets[279] but would increase sales (WSTA)

273. We were particularly interested in the effect of restricting alcohol promotion to one aisle as the following exchange indicate:

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275 AL 21A

276 AL 21A

277 AL 21A. Sainsbury's claimed that 'the vast majority of our customers take advantage of promotions to either trade up to higher cost brands (particularly in the case of wine), or to stock up for special occasions such as family birthdays and summer barbeques period of time or with a wider group of family and friends

278 Q 328

279 Sainsbury's is critical of the changes stating that "We trialled some of the measures, including locating all alcohol in one area, at our store in Cameron Toll [Edinburgh].The results suggest that we will incur significant costs in order to comply with the changes. It seems particularly unnecessary when it is at best questionable what impact the changes in legislation will have on public health;

Q1206 Moving to an aisle only location for alcohol has led to an increase, a burden, in terms of how you train staff, how you organise the store, how you organise the point of sale, how you mark off various areas. I did not want to overstate that burden, but I think that there is a financial cost to organising the store differently

> Mr Beadles: There is some quite interesting work on this. Morrisons has 11 stores in the UK that for historical reasons have got separate alcohol aisles and ASDA has provided some data from Northern Ireland where they have separate alcohol aisles. What we see within those sales is it increases the sale of alcohol. We think the reason for that overall is that people who have to go through a separate purchase experience stock up more. They are inconvenienced by having to go through a separate area and a separate till and, therefore, they stock up more as a result of it. What we see less of is people putting a single bottle of wine in the basket on the way through; what we see more of is bulk purchasing when they go into the separate area [280]
>
> Dr Stoate: That is completely at odds with the academic research we heard this morning that was told to us by Sheffield University which says if you have alcohol in a completely separate aisle you see reductions in consumption by up to 40%. I find it very difficult to see where you get your figures from.[281]

274. However, it was too early to see what the effects were in Scotland. Mr Grant told us:

> In the nature of these experiments, we do not know where it is going to end up with the results. The question was asked before about what the effect in Scotland has been from selling from the beer aisle, and so on, only. We will not know for a little while, and I do not think the Scottish Government knows either where it will end up.[282]

275. We also questioned the supermarkets about the use of large notices warning customers of the dangers of alcohol. Waitrose told us that it already had them. We asked whether they could be more powerful along the lines of "Alcohol can kill you if you are not careful".[283] Mr Fisher told us:

> We have spoken to customers in focus groups about this particular issue and asked them what they want and what they do not want. Frankly, I think if we come across as preaching like that it is just going to switch people off. What we are trying to do is a more subtle approach around education, thinking about units, getting people to understand how many units they can consume, what the hazardous levels are and where they are in relation to that and, hopefully, addressing their behaviour. I genuinely believe that if we put a sign up like that in store, it would not make a lot of difference and I do not think it would engage.[284]

276. We asked about the introduction of a voluntary code:

> Q324 Sandra Gidley: Why do the supermarkets not adopt a voluntary code on not piling them high and selling them cheap at the store entrances when it comes to alcohol? You can actually put the beer at the bottom of your trolley; it is not that difficult.

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280 Q326 and see Q 1256

281 Q327

282 Q 1256

283 Q 1233

284 Q 1234

> Mr Blood: The OFT has given us very clear guidance on what we can and cannot agree within a voluntary code. Where we can we have made those agreements. One of the issues that the OFT has advised us on that we have to be very careful about in a voluntary arrangement is the placing of promotional activities within stores. It is a discussion that we have had and the OFT has been very clear with us that there is a line and the placement of promotional activities in stores is a competitive and commercial issue and, therefore, a voluntary agreement on that at this moment in time is something that they advise us not to step over.

277. In view of this response we called in the OFT to give evidence, in particular the extent to which the OFT took into account article 152 of the EC Treaty that 'a high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities'? We were told that the OFT

> applies UK competition legislation which is derived from EC treaty provisions. Article 152 does not directly apply to implementation or the way in which competition legislation is enforced. It would however be relevant if, for example, you were looking at government measures taken on board at national level, but in terms of the specifics of competition enforcement article 152 is not directly relevant.[285]

Ms Branch of the OFT added:

> To a certain degree you could have trade association guidance in principle on product placement if it did not have an impact on the way in which they were competing. From our perspective we need to ensure that the commercial independence and uncertainty that need to be there to get efficient, competitive markets are not removed.[286]

Robert Madelin, the head of the Health and Consumers Directorate-General, European Commission, informed us that

> in terms of internal market provisions, the Treaty allows Member states to restrict free movement based on public health grounds, provided that these restrictions are non-discriminatory and proportional…
>
> as the issue of voluntary agreements to restrict the promotion of alcoholic products is concerned I tend to agree with the OFT analysis that agreements between economic operators, such as supermarkets and others, aimed at restricting the promotion of alcoholic beverages would need to be assessed in terms of the competition provisions of the EC Treaty, such as Article 81.[287]

Minimum pricing

278. 73% of those surveyed in the RCN/RCP Survey on Alcohol Treatment Services believed that the Government should take action on the sale of low priced alcohol.[288] The

285 Q 582

286 Q584

287 AL 71

288 Ev 106

main policy witnesses advocated to curtail the sale of cheap alcohol and prevent supermarkets from using discounts as a way of competing for custom was minimum pricing. Most of the big supermarkets were opposed, but Tesco is in favour:

> Our position for some time now has been that we are very prepared to play an active and constructive role in discussions on minimum pricing or, indeed, the whole issue of pricing. What we have said is two things really. One is that for that to be effective it has to be done across the industry rather than on a unilateral basis, but, second, for reasons of competition policy, competition law, those are not things, frustratingly, that the industry can lead by themselves: those discussions have to be led by government.[289]

Conclusions and recommendations

279. **Over recent decades an ever increasing percentage of alcohol has been bought in supermarkets and other off-licence premises. Such purchases exceed those made in pubs and clubs by a large margin. The increase in off-licence purchases has been associated with the increasing availability of, promotions of, and discounting of alcohol. Heavily discounted and readily available alcohol has fuelled underage drinking, led to the phenomenon of pre-loading where young people drink at home before they go out and encouraged harmful drinking by older people.**

280. **Some areas have very large numbers of off-licences open for long hours. There are also too many irresponsible off-licences. Addressing this problem will require both better enforcement and improvements to the licensing regime. A public health objective in the licensing legislation would apply to off-licences as well as pubs and clubs and could be used to place limits on the number of outlets in an area. This aspect of the Scottish licensing legislation should be closely monitored with a view to its implementation in England.**

281. **Although they acknowledged that alcohol was a dangerous commodity, supermarkets told us that they used discounts and alcohol promotions because they were engaged in fierce competition with each other. In some cases, it is possible to buy alcohol for as little as 10p per unit. At this price, the maximum weekly recommended 15 units for a woman can be bought for £1.50p. This is not a responsible approach to the sale of alcohol. Retail outlets should make greater efforts to inform the public of the dangers of alcohol at the point of sale.**

282. **The Scottish Government has introduced controls on promotions including restricting alcohol to one aisle. These measures should be instituted in England.**

283. However, the main proposal for addressing aggressive discounts was to introduce minimum pricing. We consider this in the next chapter.

289 Q 392

10 Prices: taxes and minimum prices

284. While improvements in NHS services, education and information campaigns and controls on marketing, licensing and supermarket promotions have a part to play in curbing alcohol consumption, the use of the price mechanism is seen by health professionals as the key issue. It is also very contentious.

285. We took oral evidence about prices from health professionals, including the CMO and the President of RCP, representatives of four major supermarkets, of the drinks industry companies, of the Wine and Spirits Trade Association and CAMRA. We also heard from HM Treasury and Dr Meier who undertook the study of minimum pricing for the DH and Ms Rabinovich of the RAND Corporation who has undertaken an international study. As part of our visit to Scotland, we discussed the Scottish Government's proposal for minimum pricing with officials, medical and health experts, including the Chief Medical Officer for Scotland, producers, representatives of the licensed trade and economists.

286. The protagonists for raising prices argued that:

- Higher prices would reduce consumption (they noted that the increasing affordability of alcohol had been the major cause of increased consumption over recent decades)
- Higher prices would have their biggest impact on heavier drinkers because they drink most (hazardous and harmful drinkers drink three-quarters of all the alcohol sold, of which harmful drinkers drink around a third)
- In any case, it is desirable to reduce overall consumption since this will reduce the number of heavy drinkers
- Higher prices would be particularly effective in reducing drinking among low income heavy drinkers who suffer most from alcohol-related disease.

287. These arguments are disputed. The main arguments of those who are against price rises are that

- Price increases would have little effect on heavier drinkers
- Price increases would be unfair, because they would also affect moderate drinkers
- Rises in the price of cheap alcohol would particularly affect lower income groups
- Price increases would have little effect on alcohol harm; alcohol consumption has fallen in recent years but alcohol-related harm has continued to rise; there is therefore no good reason to reduce average consumption.

Pricing

The laws of supply and demand

288. While it seems self-evident that alcohol obeys the laws of supply and demand like almost all other commodities, some witnesses came close to implying that it did not. Their argument runs as follows. In each country the relationship between price and consumption is different. In some countries there are relatively high prices and high levels of consumption and vice versa. Therefore putting up the price of alcohol will have little effect. We were told:

> It is too simplistic to apportion responsibility for problem drinking to the price of alcohol alone; if low-cost alcohol were the only factor then countries such as France and Spain, where prices are much lower than in the UK, would have similar problems and countries like Finland, where alcohol is expensive and its availability restricted, would not (Tesco)

289. To many this argument is economic illiteracy. All these contrasts reveal is that there is a different relationship between price and consumption in each country. Each individual, each group and each country responds differently to a change in price, but all respond. The extent of this change is known by economists as the elasticity of demand.[290]

290. We know a good deal about the elasticity of demand for alcohol in England and the UK. We were told of information from[291]:

> a study undertaken for HMRC in 2003 (which HMT uses to assess the effect of price changes on revenues), The Treasury figures were estimated using historic expenditure data from 1970 to 2002. Separate elasticities were estimated for each category of alcohol. They also take into account how the change in price of one product will affect another.
>
> the 'Sheffield University' Study commissioned by the DH in 2008 'to quantify the potential impact of policies targeting pricing and promotion of alcohol on alcohol related harm. ... The study used UK data on alcohol consumption of around 7,000 individuals between 2001/02 and 2005/06. Alcohol elasticies were estimated as part of this study.
>
> A study by Oxford Economics in 2008 for the British Beer and Pub Association estimated elasticities for beer and other products.

There was also a study by the RAND in 2008 which undertook *inter alia* an international examination of the relationship between prices and consumption

291. Table 7 below supplied by the Treasury compares the own-price elasticities (i.e. how consumption responds to changes in the price of that product) from these three sources. For example, HMRC estimate that a 1% increase in the price of on-trade beer reduces consumption of on-trade beer by 0.48%.

290 Q 271 (Rabinovich)

291 The studies are described in AL 72

Alcohol type	University of Sheffield (Commissioned by the Department of Health)[1]	HMRC[2]	Oxford Economics (Commissioned by the alcohol industry)[3]
Beer on trade	-0.50	-0.48	-1.50
Beer off trade	-0.52	-1.03	-1.00
RTDs on trade	-0.36	-0.30	N/A
RTDs off trade	-0.38		
Spirits on trade	-0.23	-1.31	-1.73
Spirits off trade	-0.62		
Wine on trade	-0.33	-0.75	-0.99
Wine off trade	-0.58		
Cider on trade	N/A		-2.00
Cider off trade			-1.50

1. 'Independent Review of the Effects of Alcohol Pricing and Promotion: Part B Modelling The Potential Impact Of Pricing And Promotion Policies For Alcohol In England: Results From The Sheffield Alcohol Policy Model Version 2008(1-1)'

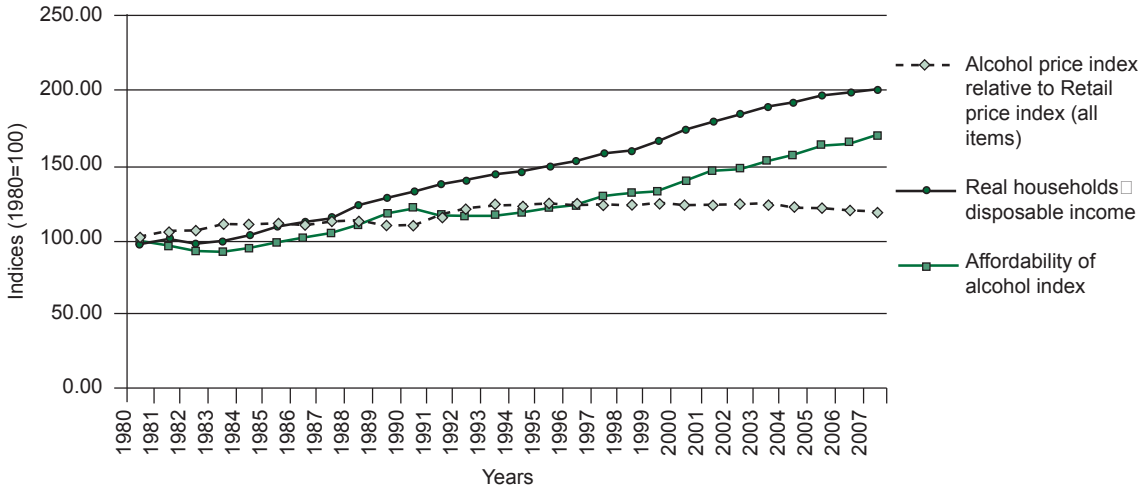
2. 'Econometric Models of Alcohol Demand in the United Kingdom', Government Economic Service Working Paper No. 140, May 2003

3. 'The economic outlook for the UK drinks sector and the impact of the changes to excise duty and VAT announced in the 2008 Budget and Pre-Budget Report', February 2009

Estimates of the elasticities vary considerably between the three studies; for example, the estimates of the effect of a 1% rise in the price of off-trade spirits vary from falls in the value of sales ranging from 1.73% to 0.62%. The Sheffield study figures are more conservative than the other two but are consistent with other studies based on survey data. The differences occur for a number of reasons. The Treasury figures estimates are based on changes in overall sales figures and prices. Larger estimates of alcohol price effects are consistent with models based on aggregate sales data..[292]

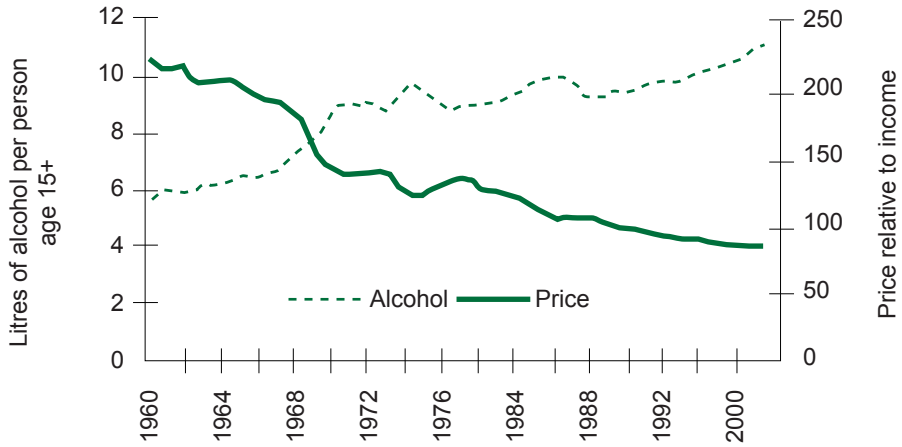
292. The relationship between price and consumption is strong, as is the correlation between the price of alcohol and affordability. The increase in consumption in recent decades is clearly related to reductions in real prices and increasing affordability, as the following figures show.

Figure 14: Indices of alcohol price relative to retail price index, real households' disposable income (RHDI) and affordability of alcohol, 1980 to 2007 United Kingdom



Source: Focus on Consumer Price Indices, Office for National Statistics and Economic Trends, Office for National Statistics, 2008

Figure 15: Price of Alcohol and consumption



Source: Academy of Medical Sciences. Calling time. The nation's drinking as a major health issue. London: Academy of Medical Sciences, 2004.

293. The RAND study came to similar conclusions:

> numerous international studies have generally concluded that increases in the prices of alcoholic beverages—for example through local or federal taxation—lead to reductions in drinking and heavy drinking as well as in the consequences of alcohol use and abuse

Effect of price rises on the heaviest drinkers

294. How are the heaviest drinkers affected by price rises? Some representatives of the drinks industry argue that the heaviest drinkers respond least to price rises and will switch to cheaper drinks to maintain their levels of drinking. The CEBR, in an analysis of the Sheffield and RAND reports commissioned by SAB Miller, the world's second largest brewer, argued that heavier drinkers were least responsive to price changes. Speaking of

minimum pricing (but the comments would apply to other price rises) CEBR claimed that it would be

> an incredibly blunt instrument which imposes significant costs across large sections of society, whilst having very limited benefits in terms of curbing the excesses of the minority

Mr Blood, the Chief Executive of Scottish and Newcastle, told us

> I have read the Sheffield report… Why do we, in principle, not support minimum pricing? We believe that where misuse is happening and where people are drinking more than is good for them or using alcohol in the wrong way, those are the people that will not change their behaviour if you apply minimum pricing, they will carry on misusing, and you will not address the proper concerns that society has got about the misuse of alcohol through that blanket approach.[293]

295. Specifically, the CEBR argued that the Sheffield study showed that heavier drinkers were more responsive to price changes for individual alcohol products, but omitted to mention that overall heavier drinkers were least responsive to price changes; ie it failed to take into account the 'substitution effect'. The CEBR claimed that the Sheffield study overestimated the impact of price changes on consumption levels of hazardous and harmful drinkers by a factor of two.[294]

296. The Sheffield study paid particular attention to underage drinkers, 18-24 year old binge-drinkers and harmful drinkers (over 50 units per week). Consistent evidence was found for an association between alcoholic price and patterns of drinking by these groups. It also found that most policy options affect moderate drinkers in a very minor way, simply because they consume only a small amount of alcohol.

297. Even if the elasticity of demand for heavier drinkers was exaggerated by the Sheffield study (and it is unclear it was and, if so, by how much), simply because the 10% of heaviest drinkers consume 44% of all the alcohol bought, the Sheffield study is able to claim that:

> Harmful drinkers are expected to reduce their absolute consumption most.

298. We asked our adviser, Professor Godfrey, to analyse the CEBR study, which had not been peer reviewed. She found that the CEBR claim about the elasticity estimates of the Sheffield study was based on a fundamental misunderstanding of the Sheffield study.

> The CEBR critique fails to recognise that the Sheffield model takes account of all the price effects across different types of consumers and is not artifically averaged as in the CEBR study. The models take account for each group not only of all the cross price effects of other alcoholic drinks but also the impact of a change in alcohol prices on the consumption of other non alcohol goods.[295]

293 Q 385

294 An Assessment of Minimum pricing of Alcohol; (WSTA)

295 AL 67

Price changes and harm

299. The Sheffield study also found evidence linking price increases to reductions in chronic and acute health harms and in crime: 'Significant health benefits are estimated for harmful drinkers (particularly deaths avoided)'. There would be less crime because young people would drink less: 'a much larger proportion of the crime-related harm is due to reduced drinking in the underage and 18-24 year old hazardous drinker groups'.

300. Opponents of price rises argued that higher prices could affect consumption but could not affect the misuse of alcohol because they did not affect harmful drinkers or binge drinkers who, it was claimed, did not reduce consumption when prices rose. The CEBR argued that the Sheffield study was wrong in linking alcohol consumption to harm done by alcohol: since 2004 alcohol consumption had fallen in the UK, but there had not been a reduction in hospital admissions. The question arises whether this short period is enough to establish a trend.

The effect of a decline in average consumption on heavy drinkers

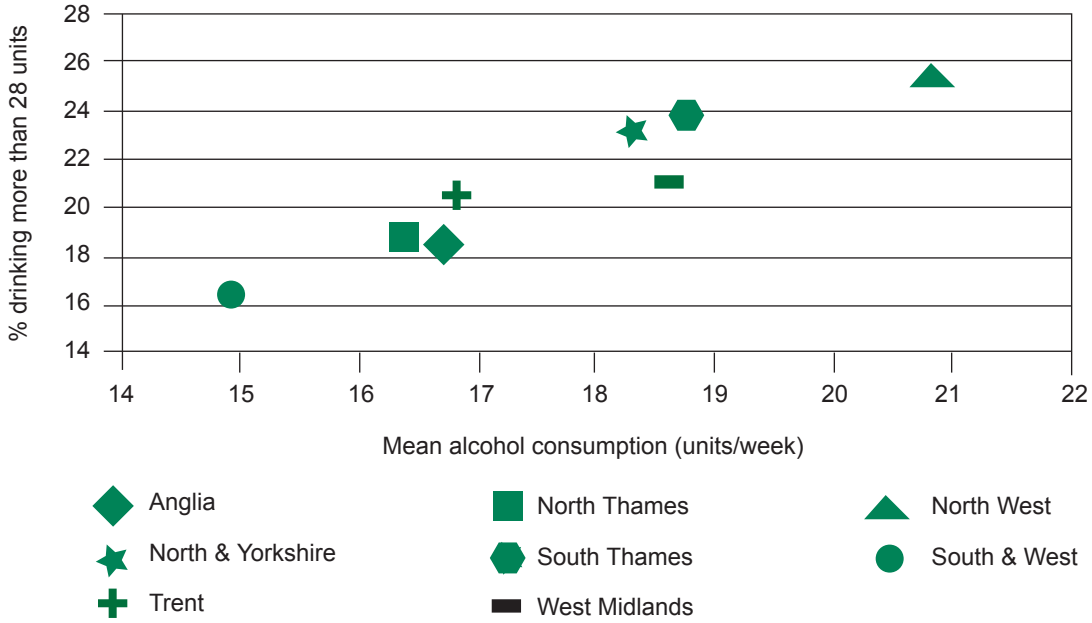
301. Linked to the previous argument is the dispute as to whether a decline in average consumption would affect heavy drinkers—ie if we all drank less, would there be fewer heavy drinkers? As we saw in chapter 4, Ledermann's 'whole population theory'[296] states that there is a fixed relationship between average per capita consumption of alcohol and the number of problem drinkers and alcohol-related problems. The alcohol industry believes that this not the case, arguing once again that the fall in alcohol consumption since 2004 has not been associated with a fall in hospital admissions.

302. On the other hand, it is pointed out that the figures for admissions are older than the consumption ones and the recent consumption fall is slight compared to the large historic rise. It is argued that the very modest fall from the 2004 peak is not yet large enough to significantly impact on the health harms from alcohol.

303. There are a number of studies which bear out Ledermann's theory. A study of English regions (see figure 16) found a strong relationship between average weekly consumption in the region and the percentage of the population drinking more than 28 units per week.

296 See chapter 4 above.

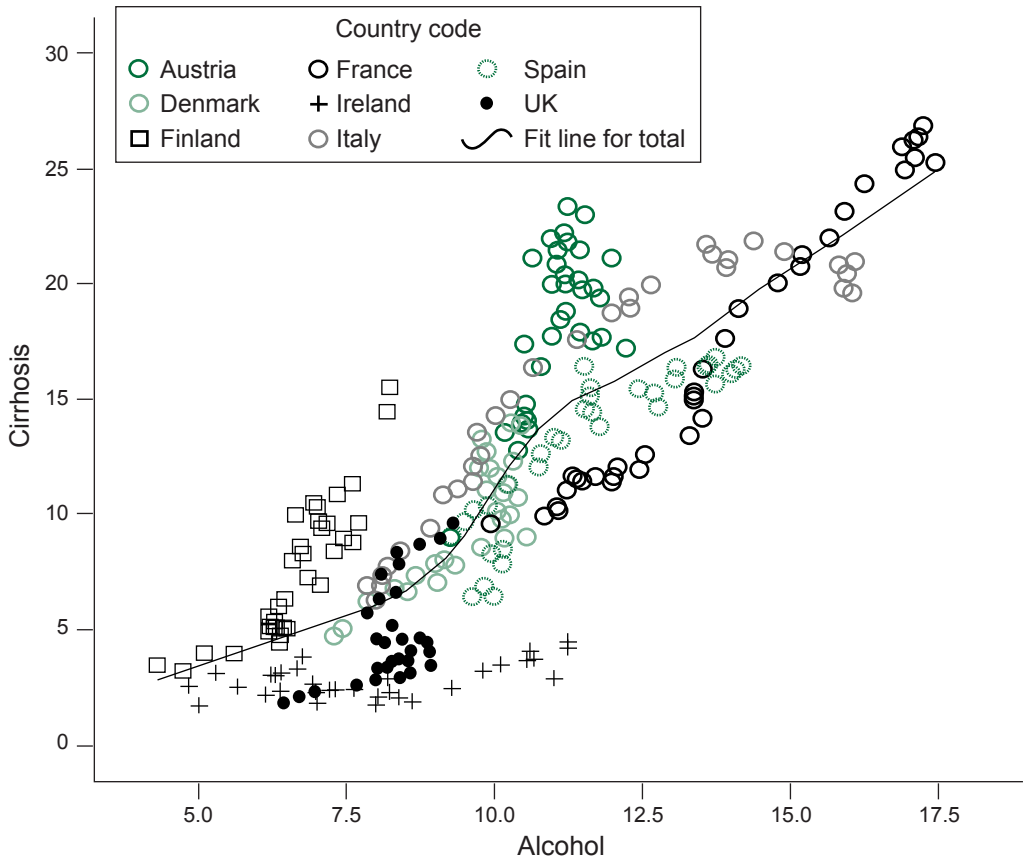
Figure 16: Relationship between mean alcohol consumption and prevalence of drinking more than 28 units (approx 224 grams) of alcohol per week: Men



Source: Primatesta et al., 2002.

304. The average intake of a patient with cirrhosis is around 100 units/week, and deaths from liver disease are a good indicator of the levels of regular heavy drinking within a population. Figure 17 shows that liver deaths in the EU countries with the biggest changes in either death rates or alcohol consumption are strongly linked to consumption at a population level, both within countries and overall. The different gradients between countries suggest that other factors, for example nutrition, also operate to influence this relationship change.

Figure 17: Liver death rates and overall alcohol consumption



Source: British Association for the Study of the Liver

Higher prices are unfair on moderate drinkers and lower income groups

305. It is argued that raising prices would be unfair on moderate or responsible drinkers. Why should such drinkers be punished because a minority drink too much? It is also claimed that higher prices would be unfair because lower income groups drink less than higher income groups.

306. On the other hand, as we have seen, others argue that a rise in prices would have little effect on moderate drinkers because they drink so little. As we have noted, 44% of all the alcohol purchased is consumed by 10% of the population. According to the Sheffield study a minimum price of 40p per unit would cost a moderate drinker (defined as someone who drinks about 6 units per week which is the average consumption of drinkers) about 11p per week; A the same minimum price, a woman consuming the recommended maximum of 15 units would have to pay £6 for her weekly intake of alcohol , which is scarcely going to be a massive rise.

307. In fact, those most affected by of price increases, especially on cheap alcohol, would be heavy low income drinkers, as we discuss in the next section.

Minimum pricing or rises in duty

308. If prices are to rise, is this best achieved by introducing a minimum price for a unit of alcohol or by raising the level of duty or a mixture of the two?

Minimum pricing

309. Minimum pricing has recently had a number of powerful supporters including the CMO. While much of the alcohol industry and most supermarkets were against, there was some support for minimum pricing from Tesco, Molson Coors (makers of Carling lager) and CAMRA.

310. The main arguments for preferring minimum pricing to rises in duty are:

> Supermarkets will not pass on the full rises in duty to customers; they will get the drinks industry to absorb them; in contrast, this could not happen with minimum prices. As a result, supermarket and other off-licence sales would be much more affected than pub sales; thus minimum pricing could help traditional pubs.
>
> Minimum prices would be particularly effective in raising the price of the cheap alcohol; this would be particularly effective in reducing consumption by heavy drinkers in low income groups and young binge drinkers
>
> Minimum pricing would encourage people to buy weaker alcohol.

311. We have seen that supermarkets aggressively promote alcohol to attract customers; supermarkets even sell alcohol below the cost of the duty; thus raising the duty would not necessarily lead to higher prices.

312. Traditional pubs have lost custom for years. Rises in duty hit them; minimum prices would not since most pubs sell alcohol at a higher price than the any minimum price which has been proposed. For this reason CAMRA supports minimum pricing. Mr Benner, the Chief Executive of the organisation, told us:

> I think the price ratio at the moment is about five to one (ie the ratio of the off-sale to the on-sale price). If a minimum price of around 40 pence was introduced, that would make the ratio about three to one. Therefore, I think that is enough for there to be a shift in consumption towards drinking in community pubs.[297]

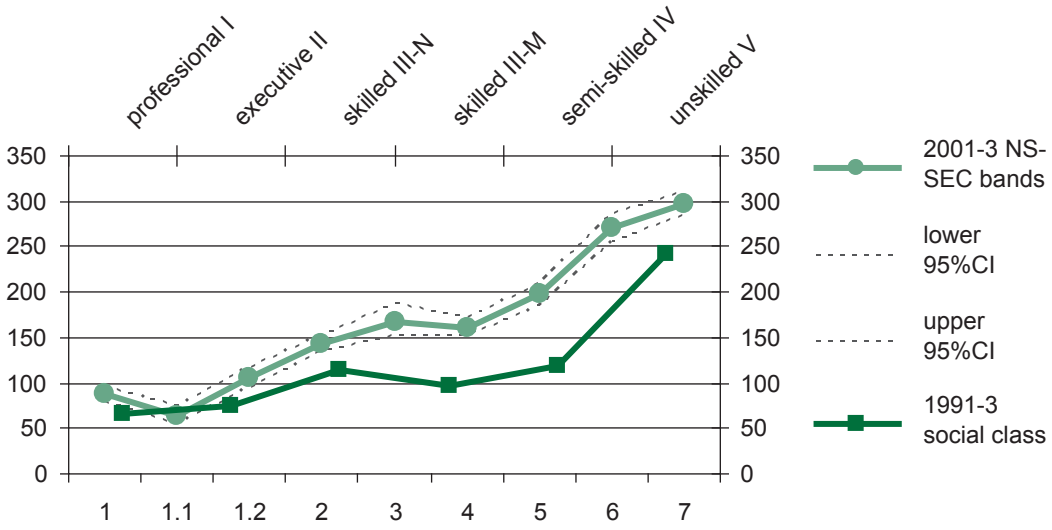
313. While most pubs would benefit, some pubs and clubs, such as those which offer 'Happy Hours' and special promotions, would be affected. The Sheffield study found that the greatest impact on crime and accident prevention would be achieved through reducing the consumption of 18-24 year old binge drinkers, by raising the cost of cheap drinks in pubs and clubs and by reducing off-licence sales which encourage pre-loading. Off-licence sales can be very cheap with alcohol being sold for as little as 15 p per unit in some outlets.

314. BASL pointed out that alcohol-related ill health and mortality was very strongly linked to socio-economic status, with the most deprived experiencing between a three and five fold increase in death rates (health statistics quarterly 33) compared to the most privileged. For any level of drinking, lower income groups suffer more. The organisation argued that given the strong link with socio-economic status, one would predict that changes in the affordability of alcohol over time would have had the most impact on death rates in the poorer sections of society, which is what happened to liver death rates between 1991 and

297 Q 395

2001. We know that professional groups drink more than lower income groups but, astonishingly, as the figure below shows, lower income groups suffer far more from liver disease. In the 1990s as price fell and consumption increased, liver disease increased among more deprived social groups but fell among the 'higher' social classes. Alcohol duty increases can therefore be predicted to reduce mortality in those lower socio-economic groups most at risk.

Figure 18: Changes in age standardised liver mortality rates (deaths / million) according to socio-economic status



Age standardised alcohol mortality rates according to social class for 1991 -3 (1) when socio-economic status was assessed by social class, and again for 2001–3 (Health Statistics Quarterly no 38) by which time socio-economic status was assessed by NS-SEC groupings—hence the different x axes in the graph.

315. According to the Sheffield study, a minimum price of 50p per unit would save over 3,000 lives per year,[298] a minimum price of 40p, 1,100 lives.

316. Minimum pricing would encourage people to buy weaker alcohol; for example, at a minimum price of 40p a 70cl bottle of 10% abv wine could sell for £2.80, of 12% wine for about. £3.40 (8.4 units), of 15% wine, about .£4.20p.

317. Opponents of minimum pricing argue that it would be illegal under EU competition law. The Scottish Government, which has examined this issue thoroughly, strongly disagrees and 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, winning a number of cases in the ECJ which were brought by the alcohol industry.

318. The DH memorandum to this inquiry stated that the Government had made no decision about minimum pricing. However, when the CMO's report which advocated minimum pricing was leaked, a Government representative rejected minimum pricing.

Rises in duty

319. The main case for higher sales duties rather than minimum prices is that minimum prices would lead to higher profits for producers and vendors of alcohol, assuming that any fall in sales would be more than offset by the increase in revenue from each unit. In contrast, a rise in duty would avoid this, producing not additional profits but extra money for the Exchequer. A rise in taxes can also be justified, as we found in Scotland, on the basis of recovering the costs imposed by alcohol—estimated at £20-55bn; the duty on alcohol currently raises far less. The duty on alcohol in the UK raised £14.7 bn (£8.3 bn excluding VAT) in 2007/8 and £14.7 bn (8.5bn excl VAT) in 2008/9

320. In addition, minimum pricing is likely to lead to a large increase in expenditure on marketing and other forms of non-price competition as price competition declined. This would not happen with a rise in prices since supermarkets and others could more readily compete on price.

321. Another potential advantage of increasing duty is that increases can be targeted on stronger drinks. Alcohol duty rates and structures in the UK must comply with European Directives on the structure and minimum rates of alcohol duty. Under this legislation, beer and spirits must be taxed in direct proportion to the alcohol they contain. For example, the duty on a pint of beer at 6% alcohol by volume is double that of a pint of 3% abv. Wine and cider must be taxed in strength bands; thus 10% abv wines can be taxed more heavily per unit of alcohol than 12 or 14% abv wines. However, it is possible to tax some different products at different rates; thus in the UK spirits are taxed more heavily per unit of alcohol than beer and wine. Member states can also charge lower rates on beer products below 2.8% abv (beer of this strength currently accounts for a tiny amount of beer sales—less than 0.5 %).[299] In addition, the main beer duty rates can be and have been reduced for small breweries.

322. We questioned the Treasury in oral evidence about two apparent anomalies in the present tax system: first, the low rate of duty on cider and secondly the fall in real terms in price as a result of the freeze on the duty on spirits from 1997 to 2007. It is little wonder that cheap cider and spirits are popular with many young people and heavy drinkers.

323. The Treasury's rationale for the low duty on cider was to protect small producers.[300] While this is a laudable aim, some 'white cider' is an industrial product which uses fermented corn syrup.[301]

324. The rationale for freezing the duty on spirits from 1997 to 2007 was that Government wanted to equalise rates of duty so that the duty on each product would be equivalent to its alcoholic strength; ie the tax on a unit of alcohol would be the same for all alcoholic products. In contrast, older policies taxed strong liquors such as spirits at a higher rate per unit of alcohol than weaker products such as beer. The decade long freeze on the duty on spirits was unusual but in line with a long trend that has seen a very significant decline in spirits duty as a percentage of average earnings. This has transformed drinking habits:

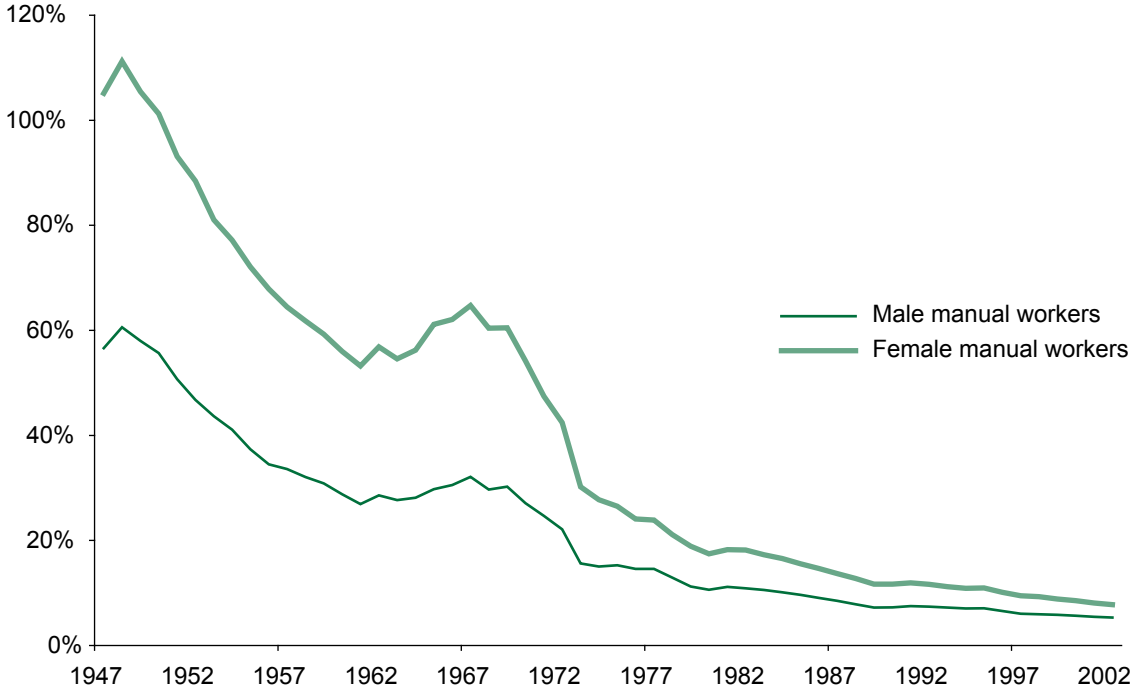
299 AL 72

300 Q 956

301 http://www.james-crowden.co.uk/index.php?option=com_content&task=view&id=102&Itemid=30

spirits were once an expensive occasional tipple; now they are a cheap way for teenagers to get drunk. The remarkable figure below shows the dramatic fall in affordability. The rate of duty on spirits per litre of pure alcohol in 1947 was almost 60% of a average male manual weekly earnings; in 1973 when VAT was introduced, it fell and since then it has declined consistently as the figure below shows.

Figure 18: Duty level per litre of spirits as a percentage of average weekly wages of manual workers (1948 to 2002)



Source: House of Commons Library, based on HM Treasury statistics on duty levels

Conclusions and recommendations

325. **The consumption of alcohol, like that of almost all other commodities, is sensitive to changes in price as all studies have shown. Because some countries with high alcohol prices have high levels of per capita consumption and vice versa some countries with low levels of consumption have low prices, it is sometimes implied that alcohol sales do not respond to price changes. This is economic illiteracy. Different countries, like different people and groups, respond differently to price, but they all respond. Studies have shown varying elasticities of demand. The increase in alcohol consumption over the last 50 years is very strongly correlated with its increasing affordability.**

326. **Increasing the price of alcohol is thus the most powerful tool at the disposal of a Government. The key argument made by the drinks industry and others opposed to a rise in price is that it would be unfair on moderate drinkers. We do not think this is a serious argument. The Sheffield study found that for the moderate drinker consuming 6 units per week a minimum price of 40p per unit would increase the cost by about 11p per week. At 40p per unit a woman drinking the recommended maximum of 15 units could buy her weekly total of alcohol for £6.**

327. **Opponents also claim that heavier drinkers are insensitive to price changes, but these drinkers will be most affected by price rises since they consume so much of the alcohol purchased in the country (10% of the population drink 44% of the alcohol consumed; 75% of alcohol is drunk by people who exceed the recommended limits).**

328. **We believe that the Government should introduce minimum pricing for the following reasons:**

- **It would affect most of all those who drink cheap alcohol, in particular young binge-drinkers and heavy low income drinkers who suffer most from liver disease**
- **It is estimated that a minimum price of 50p per unit would save over 3,000 lives per year, of 40p 1,100 lives per year.**
- **Unlike rises in duty (which could be absorbed by the supermarkets' suppliers and which affect all sellers of alcohol) it would benefit traditional pubs and discourage pre-loading. For this reason it is supported by CAMRA**
- **It would encourage a switch to weaker wines and beers.**

329. **However, without an increase in duty minimum pricing will lead to an increase in the profits of supermarkets and the drinks industry and an increase in marketing, promotions and non-price competition. The Treasury must take into account public health when determining levels of taxation on alcohol as it does with tobacco. Alcohol duty should continue to rise year on year above incomes, but unlike in recent years duty increases should predominantly be on stronger alcoholic drinks notably on spirits.**

330. **The duty on spirits per litre of pure alcohol was 60% of male average manual weekly earnings in 1947; in 1973 (when VAT was imposed in addition to duty) duty was 16% of earnings; by 1983 it was 11% and by 2002 it had fallen to 5%. We recommend that in stages the duty on spirits be returned in stages to the same percentage of average earnings as in the 1980s. Cider is an extraordinary anomaly; the duty on industrial cider should be increased. To protect small real cider producers, their product should be subject to a lower duty. Beer under 2.8% can be taxed at a different rate: we recommend that duty be reduced on these weak beers; although at present there a few producers of beers of this strength, the cut should encourage substitution.**

331. **In the longer run the Government should seek to change EU rules to allow higher and more logical levels of duty on stronger wines and beers; it should also seek to raise the strength of beer which can be subject to a lower duty rate from 2.8 to slightly higher levels.**

332. **The introduction of minimum pricing would encourage producers to intensify their marketing. This will make it all the more important to control marketing.**

11 Solutions: a new strategy

333. Is alcohol a problem in England? Is it just a problem for a small minority as the drinks industry states and as the Strategy Unit repeated in the 2004 Alcohol Strategy? During this inquiry we heard strikingly contrasting views from Diageo and the Royal College of Physicians

> While we believe that alcohol misuse is a problem, particularly for some specific groups (under-age drinkers, binge drinkers and harmful, private drinkers), it is wrong to paint Britain as a nation with an alcohol problem [302]

> In the UK the health harms caused by alcohol misuse are underestimated and continue to spiral:… 6.4 million people consume alcohol at moderate to heavy levels (between 14 and 35 units per week for women and 21 and 50 units per week for men… In the last 30 years of the 20th century deaths from liver cirrhosis steadily increased, in people aged 35 to 44 years the death rate went up 8-fold in men and almost 7-fold in women.

334. We believe that England has a drink problem. Three times as much alcohol per head is drunk as in the mid 20th century. It is not just a problem for a small minority, for the obvious alcoholics and heavy binge drinkers, but for a much larger section of the population. 10m people drink more than the recommended limits, 2.6m more than twice the limit. We take all kinds of risks and drinking a little more than the recommended alcohol limits is similar to other risks we often take in life. However, most medical opinion suggests that drinking twice the limits is unwise. While liver disease rates have declined in the EU, in the UK they have risen at an alarming rate. Other diseases caused by alcohol, such as cancer, have risen too. The President of the Royal College of Surgeons told us that 30-40,000 deaths per year could probably be attributed to alcohol. In addition, binge-drinking causes serious disorder, crime and injuries. 27% of young male and 15% of young female deaths were caused by alcohol. Our teenagers have an appalling drink problem; among Europeans only Bulgaria and the Isle of Man are worse. In 2003 the Strategy Unit estimated the total cost of alcohol to society to be £20 bn; another study in 2007 put the figure at £55 bn.

335. Faced by a mounting problem, the response of successive Governments has ranged from the non-existent to the ineffectual. In 2004 an Alcohol Strategy was published following an excellent study of the costs of alcohol by the Strategy Unit. Unfortunately, the Strategy failed to take account of the evidence which had been gathered.

336. The evidence showed that a rise in the price of alcohol was the most effective way of reducing consumption just as its increasing affordability since the 1960s had been the major cause of the rise in consumption. We note that minimum pricing is supported by many prominent health experts, economists and ACPO. We recommend that the Government introduce minimum pricing.

302 (Diageo AL 18)

337. There is a myth widely propagated by parts of the drinks industry and politicians that a rise in prices would unfairly affect the majority of moderate drinkers. But precisely because they are moderate drinkers a minimum price of for example 40p per unit would have little effect. It would cost a moderate drinker who drinks 6 units per week 11p per week, as we have seen, a woman drinking the recommended maximum of 15 units could buy her weekly total of alcohol for £6.

338. Opponents also claim that heavier drinkers are insensitive to price changes, but as a group their consumption will be most affected by price rises since they drink so much of the alcohol purchased in the country. Minimum pricing would most affect those who drink cheap alcohol, in particular young binge-drinkers and heavy low income drinkers who suffer most from liver disease. It is estimated that a minimum price of 50p per unit would save over 3,000 lives per year, of 40p, 1,100 lives.

339. Minimum pricing would have benefits. Unlike rises in duty minimum pricing would benefit traditional pubs which sell alcohol at more than 40p or 50p per unit; unsurprisingly it is supported by CAMRA. Minimum pricing would also encourage a switch to weaker wines and beers. With a minimum price of 40p per unit, a 10% abv wine would cost a minimum of £2.80p, a 13% abv. wine about £3.60p.

340. However, without an increase in duty minimum pricing will lead to an increase in the profits of supermarkets and the drinks industry Alcohol duty should continue to rise year on year, but unlike in recent years duty increases should predominantly be on stronger alcoholic drinks, notably on spirits. The duty on spirits per litre of pure alcohol was 60% of male average manual weekly earnings in 1947; in 1973 (when VAT was imposed in addition to duty) duty was 16% of earnings; by 1983 it was 11% and by 2002 it had fallen to 5%. We recommend that the duty on spirits be returned in stages to the same percentage of average earnings as in the 1980s. The duty on industrial white cider should also be increased. Beer under 2.8% can be taxed at a different rate and we recommend that the duty on this category of beer be reduced.

341. An increase in prices must be part of a wider policy aimed at changing our attitude to alcohol. The policy must be aimed at the millions who are damaging their heath by harmful drinking, but it is also time to recognise that problem drinkers reflect society's attitude to alcohol. There is a good deal of evidence to show that the number of heavy drinkers in a society is directly related to average consumption. Living in a culture which encourages drinking leads more people to drink to excess. Changing this culture will require a raft of policies.

342. Education, information campaigns and labelling will not change behaviour, but they can change attitudes and make more potent policies more acceptable. Moreover, people have a right to know the risks they are running. Unfortunately, these campaigns are poorly funded and ineffective at conveying key messages; people need to know the health risks they are running, the number of units in the drink they are buying and the recommended weekly limits, including the desirability of having two days drink-free each week. The information should be provided on the labels of alcohol containers and we recommend that all alcohol drinks containers should have labels containing this information. We doubt whether a voluntary agreement, even if it is possible to come to one, would be adequate. The Government should introduce a mandatory labelling scheme.

343. Expenditure on marketing by the drinks industry was estimated to be c. £600-800m in 2003. The current system of controls on alcohol advertising and promotion is failing the young people it is intended to protect. Both the procedures and the scope need to be strengthened. The regulation of alcohol promotion should be completely independent of the alcohol and advertising industries; this would match best practice in other fields such as financial services and professional conduct. In addition young people should themselves be formally involved in the process of regulation: the best people to judge what a particular communication is saying are those in the target audience.

344. The current controls do not adequately cover sponsorship or new media which are becoming increasingly important in alcohol promotion. The codes must be extended to address better sponsorship. The new media present particular regulatory challenges, including the inadequacy of age controls and the problems presented by user generated content. Expert guidance should be sought on how to improve the protection offered to young people in this area. Finally, there is a pressing need to restrict alcohol advertising and promotion in places where children are likely to be affected by it.

345. Alcohol-related crime and anti-social behaviour have increased over the last 20 years, partly as a result of the development of the night time economy with large concentrations of vertical drinking pubs in town centres. The DCMS has shown extraordinary naivety in believing the Licensing Act 2003 would bring about 'civilised cafe culture' and has failed to enable the local population to exercise adequate control of a licensing and enforcement regime which has been too feeble to deal with the problems it has faced. Some improvements have been made through the Policing and Crime Act 2009, in particular the introduction of mandatory conditions on the sale of alcohol. We urge the Government to implement them as a matter of urgency, but problems remain. It is of concern that section 141 of the Licensing Act 2003 is not enforced and we call on the police to enforce s.141 of the Licensing Act 2003.

346. The 2009 Act has made it easier to review licences, giving local authorities the right to instigate a review. We support this. However, we are concerned that local people will continue to have too little control over the granting of licences and it will remain too difficult to revoke the licences of premises associated with heavy drinking. The Government should examine why the licences of such premises are not more regularly revoked.

347. In Scotland legislation gives licensing authorities the objective of promoting public health. Unfortunately, public health has not been a priority for DCMS. We recommend that the Government closely monitor the operation of the Scottish licensing act with a view to amending the Licensing Act 2003 to include a public health objective.

348. The most effective way to deal with alcohol related ill-health will be to reduce overall consumption, but existing patients deserve good treatment and a service as good as that delivered to users of illegal drugs, with similar levels of access and waiting times. As alcohol consumption and alcohol related ill health have increased, the services needed to deal which these problems have not increased; indeed, in many cases they have decreased, partly as a result of the shift in resources to dependency on illegal drugs.

349. Early detection and intervention is both effective and cost effective, and could be easily be built into existing healthcare screening initiatives and incentives for doing this should be provided in the QOF. However the dire state of alcohol treatment services is a significant disincentive for primary care services to detect alcohol related issues at an early stage before the serious and expensive health consequences of regular heavy drinking have developed. These services must be improved.

350. The alcohol problem in this country reflects a failure of will and competence on the part of government Departments and quangos. Although the CMO has struggled to get Government to introduce effective policies, the Strategy Unit produced an excellent analysis of the problem in 2003 and the Department of Health has commissioned important pieces of research, most Departments have failed adequately to engage with the problem. DCMS has been particularly close to the drinks industry. The interests of the large pub chains and the promotion of the 'night-time' economy have taken priority; Ofcom, the ASA and the Portman Group preside over an advertising and marketing regime which is failing to adequately protect young people. OFT shows a blinkered obsession with competition heedless of concerns about public health. The Treasury for many years pursued a policy of making spirits cheaper in real terms. Collectively Government has failed to address the alcohol problem.

351. It is not inevitable that per capita alcohol consumption should be almost three times higher than it was in the middle of the twentieth century or that liver disease should continue to rise. Nor is it inevitable that at night town centres should be awash with drunks, vomit and disorder. These changes have been fuelled by cheap booze, a liberal licensing regime and massive marketing budgets. In the past Governments have had a large influence on alcohol consumption, be it from the liberalisation which encouraged the eighteenth century 'Gin Craze' and to the restrictions on licensing in the First World War. Alcohol is no ordinary commodity and its regulation is an ancient function of Government.

352. 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 would lose 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.

Conclusions and recommendations

History

1. The history of the consumption of alcohol over the last 500 years has been one of fluctuations, of peaks and troughs. From the late 17th century to the mid-19th the trend was for consumption per head to decline despite brief periods of increased consumption such as the gin craze. From the mid- to the late 19th century there was a sharp increase in consumption which was followed by a long and steep decline in consumption until the mid 20th century. (Paragraph 29)

2. The variations in consumption are associated both with changes in affordability and availability, but also changes in taste. Alternative drinks such as tea and alternative pastimes affected consumption. Different groups drank very different amounts. Government has played a significant role both positive and negative, for example in reducing consumption in the First World War as well as in stimulating the 18th century gin craze by encouraging the consumption of cheap gin instead of French brandy. (Paragraph 30)

3. From the 1960s consumption rose again. At its lowest levels in the 1930s and -40s annual per capita consumption was about 3 litres of pure alcohol; by 2005 it was over 9 litres. These changes are, as in past centuries, associated with changing fashion and an increase in affordability, availability and expenditure on marketing. Just as Government policy played a part in encouraging the gin craze, successive Government policies have played a part in encouraging the increase in alcohol consumption over the last 50 years. Currently over 10 million adults drink more than the recommended limits. These people drink 75% of all the alcohol consumed. 2.6 million adults drink more than twice the recommended limits. The alcohol industry emphasises that these figures represent a minority of the population; health professionals stress that they are a very large number of people who are putting themselves at risk. We share these concerns. (Paragraph 31)

4. One of the biggest changes over the last 60 years has been in the drinking habits of young people, including students. While individual cases of student drunkenness are regrettable and cannot be condoned, we consider that their actions are quite clearly a product of the society and culture to which they belong. The National Union of Students and the universities themselves appear to recognise the existence of a student binge drinking culture, but all too often their approach appears much too passive and tolerant. We recommend that universities take a much more active role in discouraging irresponsible drinking amongst students. They should ensure that students are not subjected to marketing activity that promotes dangerous binge drinking. The first step must be for universities to acknowledge that they do indeed have a most important moral "duty of care" to their students, and for them to take this duty far more seriously than they do at present (Paragraph 32)

5. Since 2004 there has been a slight fall in total consumption but it is unclear whether this represents a watershed or a temporary blip as in the early 1990s. (Paragraph 33)

The impact of alcohol on health, the NHS and Society

6. The fact that alcohol has been enjoyed by humans since the dawn of civilization has tended to obscure the fact that it is also a toxic, dependence inducing teratogenic and carcinogenic drug to which more than one million people in the UK are addicted. The ill effects of alcohol misuse affect the young and middle aged. For men aged between 16 and 55 between 10% and 27% of deaths are alcohol related, for women the figures are 6% and 15%. (Paragraph 64)

7. Alcohol has a massive impact on the families and children of heavy drinkers, and on innocent bystanders caught up in the damage inflicted by binge drinking. Nearly half of all violent offences are alcohol related and more than 1.3 million children suffer alcohol related abuse or neglect. (Paragraph 65)

8. The costs to the NHS are huge, but the costs to society as a whole are even higher, all of these harms are increasing and all are directly related to the overall levels of alcohol consumption within society. (Paragraph 66)

The Government's strategy

9. We congratulate the Government on the impressive research it has undertaken and commissioned and its analysis of the effects and costs of alcohol. It has analysed the health risks and shown them to be significant and found the costs of alcohol to society to be about £20 bn each year. It has also commissioned research into the effectiveness of a range of policies for reducing consumption. (Paragraph 88)

10. Unfortunately, the Government's Alcohol Strategy failed to take account of this research. Despite all the evidence to the contrary, in its 2004 Strategy the Government stated that alcohol was a problem for a small minority; we assume it meant that a small minority committed alcohol-related crime and were chronic alcoholics. We are pleased that it has subsequently recognised that the problem affects a significant minority as medical opinion indicates. (Paragraph 89)

11. Unfortunately, too, the Government has given greatest emphasis to the least effective policies (education and information) and too little emphasis to the most effective policies (pricing, availability and marketing controls); in fact, by freezing the duty on spirits from 1997 to 2007 the Government encouraged consumption. (Paragraph 90)

12. We are concerned that Government policies are much closer to, and too influenced by, that of the drinks industry and the supermarkets than those of expert health professionals such as the Royal College of Physicians or the CMO. The alcohol industry should not carry more weight in determining health policy than the CMO. Alcohol consumption has increased to the stage where the drinks industry has become dependent on hazardous drinkers for almost half its sales. (Paragraph 91)

13. In view of the scale and nature of the problem, we agree with the health professionals that a more comprehensive alcohol policy is required, which makes use of all the mechanisms available to policy makers: the price mechanism, controls on availability and marketing and improvements in NHS services as well education and

information. There is a relationship which needs to be addressed between how much we drink as a society and the number of people who drink too much. (Paragraph 92)

NHS policies to address alcohol-related problems

14. Alcohol related-ill health has increased as alcohol consumption has increased, but there are no more services to deal with these problems. Indeed in many cases there are fewer, partly as a result of the shift in resources to addressing dependency on illegal drugs. The most effective way to deal with alcohol related ill-health will be to reduce overall consumption, but existing patients deserve at least as good a service as that provided to users of illegal drugs, with similar levels of access and waiting times. (Paragraph 142)

15. Early detection and intervention is both effective and cost effective, and could be easily built into existing healthcare screening initiatives. However, the dire state of alcohol treatment services is a significant disincentive for primary care services to detect alcohol-related problems at an early stage before the serious and expensive health consequences of regular heavy drinking have developed. (Paragraph 143)

16. The solution is to link alcohol interventions in primary and secondary care with improved treatment services for patients developing alcohol dependency. In time we believe such a strategy will result in significant savings for the NHS but will require pump priming and intelligent commissioning of services. Specifically, the NHS needs to improve treatment and prevention services as follows

treatment services:

Each PCT should have an alcohol strategy with robust needs assessment, and accurate data collection.

Targets for reducing alcohol related admissions should be mandatory.

Acute hospital services should be linked to specialist alcohol treatment services and community services via teams of specialist nurses.

There should be more alcohol nurse hospital specialists.

Treatment budgets should be pooled to allow the cost savings from reduced admissions to be fed back into treatment and prevention, with centrally provided 'bridge' funding to enable service development.

Access to community based alcohol treatment must be improved to be at least comparable to treatment for illegal drug addiction.

These improved alcohol treatment services must be more proactive in seeking and retaining subjects in treatment with detailed long term treatment outcome profiling.

Funding should be provided for the National Liver Plan.

prevention services:

Improved access to treatment for alcohol dependency is a key step in the development of early detection and intervention in primary care.

Clinical staff in all parts of the NHS need better training in alcohol interventions.

Early detection and brief advice should be undertaken in primary care and appropriate secondary care and other settings. Detection and advice should become part of the QOF.

Once detected patients with alcohol issues should progress through a stepped program of care; seven out of eight people do not respond to an early intervention and it is these people who go on to develop significant health issues.

Research should be commissioned into developing early detection and intervention in young people. (Paragraph 143)

Education and information policies

17. Better education and information are the main planks of the Government's alcohol strategy. Unfortunately, the evidence is that they are not very effective. Moreover, the low level of Government spending on alcohol information and education campaigns, which amounts to £17.6m in 2009/10 makes it even more unlikely they will have much effect. In contrast, the drinks industry is estimated to spend £600-800m per annum on promoting alcohol. (Paragraph 154)

18. However, information and education policies do have a role as part of a comprehensive strategy to reduce alcohol consumption. They do not change behaviour immediately, but can justify and make people more responsive to more effective policies such as raising prices. Moreover, people have a right to know the risks they are running. We recommend that information and education policies be improved by giving more emphasis to the number of units in drinks and the desirability of having a couple of days per week without alcohol. We also recommend that all containers of alcoholic drinks should have labels, which should warn about the health risks, indicate the number of units in the drink (eg 9 units in a bottle of wine), and the recommended weekly limits, including the desirability of having two days drink-free each week. We doubt whether a voluntary agreement would be adequate. The Government should introduce a mandatory labelling scheme. (Paragraph 155)

Marketing

19. 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. (Paragraph 204)

20. The regulation of alcohol promotion should be completely independent of the alcohol and advertising industries; this would match best practice in other fields such as financial services and professional conduct. In addition young people should themselves be formally involved in the process of regulation: the best people to judge what a particular communication is saying are those in the target audience. (Paragraph 205)

21. The current controls do not adequately cover sponsorship, a key platform for alcohol promotion; the codes must be extended to fill this gap. The enquiry also heard how dominant new media are becoming in alcohol promotion and the particular regulatory challenges they present, including the inadequacy of age controls and the problems presented by user generated content. Expert guidance should therefore be sought on how to improve the protection offered to young people in this area. (Paragraph 206)

22. Finally, there is a pressing need to restrict alcohol advertising and promotion in places where children are likely to be affected by it. Specifically:

—Billboards and posters should not be located within 100 metres of any school (there used to be a similar rule for tobacco).

—A nine o'clock watershed should be introduced for television advertising. (The current restrictions which limit advertising around children's programming fail to protect the relatively larger proportions of children who watch popular programmes such as soaps).

—Cinema advertising for alcohol should be restricted to films classified as 18.

—No medium should be used to advertise alcoholic drinks if more than 10% of its audience/readership is under 18 years of age (the current figure is 25%).

—No event should be sponsored if more than 10% of those attending are under 18 years of age

—There must be more effective ways of restricting young people's access to new media which promote alcohol

—Alcohol promotion should not be permitted on social networking sites.

—Notwithstanding the inadequacies of age restrictions on websites, they should be required on any site which includes alcohol promotion—this would cover the sites of those receiving alcohol sponsorship. This rule should also be extended to corporate alcohol websites. Expert guidance should be sought on how to make these age controls much more effective.

—Alcohol advertising should be balanced by public health messaging. Even a small adjustment would help: for example, for every five television ads an advertiser should be required to fund one public health advertisement. (Paragraph 207)

Licensing, binge-drinking, crime and disorder

23. Alcohol-related crime and anti-social behaviour have increased over the last 20 years as a result of the development of the night time economy with large concentrations of vertical drinking pubs in town centres; under-age drinkers in the streets have also caused problems. The Alcohol Strategy 2004 recognised these problems and claimed that they were being addressed by a number of measures including the Licensing Act 2003. In addition, the alcohol industry established voluntary standards to govern the promotion and sale of alcohol. (Paragraph 248)

24. The worst fears of the Act's critics were not realised, but neither was the DCMS's naive aspiration of establishing cafe society: violence and disorder have remained at similar levels, although they have tended to take place later at night. The principle of establishing democratic control of licensing was not realised: the regulations governing licensing gave the licensing authorities and local communities too little control over either issuing or revoking licences, as ACPO indicated. KPMG examined the alcohol industry's voluntary code and found it had failed. (Paragraph 249)

25. Problems remained and the 2007 Strategy introduced new measures. Partnership schemes such as the St Neots Community Alcohol Partnership were established. The main changes are being introduced by the Policing and Crime Act 2009 which gives the police greater powers to confiscate alcohol from under 18s, introduces a mandatory code in place of the industry's voluntary code and has made it easier to review licences, giving local authorities the right to instigate a review. We support the introduction of mandatory conditions and urge the Government to implement them as a matter of urgency. (Paragraph 250)

26. Despite the recent improvements, much needs to be done given the scale of alcohol-related disorder. It is of concern that section 141 of the Licensing Act 2003, which creates the offence of selling alcohol to a person who is drunk, is effectively not enforced despite KPMG's finding that this behaviour is frequently observed. We note the police and Home Office's preference for partnerships and training, but do not consider these actions should be an excuse for not enforcing a law which could make a significant difference to alcohol-related crime and disorder. We call on the police enforce s.141 of the Licensing Act 2003 more effectively. (Paragraph 251)

27. We note the concerns of ACPO and other witnesses about the difficulties local authorities have in restricting and revoking licences. The Government has made some improvements in the Policing and Crime Act 2009, but must take additional measures. (Paragraph 252)

28. In Scotland legislation gives licensing authorities the objective of promoting public health. Unfortunately, public health has not been a priority for DCMS. We recommend that the Government closely monitor the operation of the Scottish licensing act with a view to amending the Licensing Act 2003 to include a public health objective. (Paragraph 253)

Supermarkets and off-licence sales

29. Over recent decades an ever increasing percentage of alcohol has been bought in supermarkets and other off-licence premises. Such purchases exceed those made in pubs and clubs by a large margin. The increase in off-licence purchases has been associated with the increasing availability of, promotions of, and discounting of alcohol. Heavily discounted and readily available alcohol has fuelled underage drinking, led to the phenomenon of pre-loading where young people drink at home before they go out and encouraged harmful drinking by older people. (Paragraph 279)

30. Some areas have very large numbers of off-licences open for long hours. There are also too many irresponsible off-licences. Addressing this problem will require both better enforcement and improvements to the licensing regime. A public health objective in the licensing legislation would apply to off-licences as well as pubs and clubs and could be used to place limits on the number of outlets in an area. This aspect of the Scottish licensing legislation should be closely monitored with a view to its implementation in England. (Paragraph 280)

31. Although they acknowledged that alcohol was a dangerous commodity, supermarkets told us that they used discounts and alcohol promotions because they were engaged in fierce competition with each other. In some cases, it is possible to buy alcohol for as little as 10p per unit. At this price, the maximum weekly recommended 15 units for a woman can be bought for £1.50p. This is not a responsible approach to the sale of alcohol. Retail outlets should make greater efforts to inform the public of the dangers of alcohol at the point of sale. (Paragraph 281)

32. The Scottish Government has introduced controls on promotions including restricting alcohol to one aisle. These measures should be instituted in England. (Paragraph 282)

Prices: taxes and minimum prices

33. The consumption of alcohol, like that of almost all other commodities, is sensitive to changes in price as all studies have shown. Because some countries with high alcohol prices have high levels of per capita consumption and vice versa some countries with low levels of consumption have low prices, it is sometimes implied that alcohol sales do not respond to price changes. This is economic illiteracy. Different countries, like different people and groups, respond differently to price, but they all respond. Studies have shown varying elasticities of demand. The increase in alcohol consumption over the last 50 years is very strongly correlated with its increasing affordability. (Paragraph 325)

34. Increasing the price of alcohol is thus the most powerful tool at the disposal of a Government. The key argument made by the drinks industry and others opposed to a rise in price is that it would be unfair on moderate drinkers. We do not think this is a serious argument. The Sheffield study found that for the moderate drinker consuming 6 units per week a minimum price of 40p per unit would increase the

cost by about 11p per week. At 40p per unit a woman drinking the recommended maximum of 15 units could buy her weekly total of alcohol for £6. (Paragraph 326)

35. Opponents also claim that heavier drinkers are insensitive to price changes, but these drinkers will be most affected by price rises since they consume so much of the alcohol purchased in the country (10% of the population drink 44% of the alcohol consumed; 75% of alcohol is drunk by people who exceed the recommended limits). (Paragraph 327)

36. We believe that the Government should introduce minimum pricing for the following reasons:

- It would affect most of all those who drink cheap alcohol, in particular young binge-drinkers and heavy low income drinkers who suffer most from liver disease.
- It is estimated that a minimum price of 50p per unit would save over 3,000 lives per year, of 40p 1,100 lives per year.
- Unlike rises in duty (which could be absorbed by the supermarkets' suppliers and which affect all sellers of alcohol) it would benefit traditional pubs and discourage pre-loading. For this reason it is supported by CAMRA.
- It would encourage a switch to weaker wines and beers. (Paragraph 328)

37. However, without an increase in duty minimum pricing will lead to an increase in the profits of supermarkets and the drinks industry and an increase in marketing, promotions and non-price competition. The Treasury must take into account public health when determining levels of taxation on alcohol as it does with tobacco. Alcohol duty should continue to rise year on year above incomes, but unlike in recent years duty increases should predominantly be on stronger alcoholic drinks notably on spirits. (Paragraph 329)

38. The duty on spirits per litre of pure alcohol was 60% of male average manual weekly earnings in 1947; in 1973 (when VAT was imposed in addition to duty) duty was 16% of earnings; by 1983 it was 11% and by 2002 it had fallen to 5%. We recommend that in stages the duty on spirits be returned in stages to the same percentage of average earnings as in the 1980s. Cider is an extraordinary anomaly; the duty on industrial cider should be increased. To protect small real cider producers, their product should be subject to a lower duty. Beer under 2.8% can be taxed at a different rate: we recommend that duty be reduced on these weak beers; although at present there a few producers of beers of this strength, the cut should encourage substitution. (Paragraph 330)

39. In the longer run the Government should seek to change EU rules to allow higher and more logical levels of duty on stronger wines and beers; it should also seek to raise the strength of beer which can be subject to a lower duty rate from 2.8 to slightly higher levels. (Paragraph 331)

40. The introduction of minimum pricing would encourage producers to intensify their marketing. This will make it all the more important to control marketing. (Paragraph 332)

Formal Minutes

Thursday 10 December 2009

Members present:

Mr Kevin Barron, in the Chair

Charlotte Atkins
Mr Peter Bone
Sandra Gidley
Stephen Hesford
Dr Doug Naysmith
Mr Lee Scott
Dr Howard Stoate
Mr Robert Syms
Dr Richard Taylor

Draft Report (Alcohol), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 327 read and agreed to.

Paragraphs 328 and 329 read as follows:

> "330. We believe that the Government should introduce minimum pricing for the following reasons:
>
> • It would affect most of all those who drink cheap alcohol, in particular young binge-drinkers and heavy low income drinkers who suffer most from liver disease
>
> • It is estimated that a minimum price of 50p per unit would save 3,000 lives per year, of 40p 1,100 lives per year.
>
> • Unlike rises in duty (which could be absorbed by the supermarkets' suppliers and which affect all sellers of alcohol) it would benefit traditional pubs and discourage pre-loading. For this reason it is supported by CAMRA
>
> • It would encourage a switch to weaker wines and beers
>
> 331. However, without an increase in duty minimum pricing will lead to an increase in the profits of supermarkets and the drinks industry and an increase in marketing, promotions and non-price competition. The Treasury must take into account public health when determining levels of taxation on alcohol as it does with tobacco. Alcohol duty should continue to rise year on year above incomes, but unlike in recent years duty increases should predominantly be on stronger alcoholic drinks notably on spirits."

Amendment proposed, to leave out from "We believe" in paragraph 328 to "non-price competition." in paragraph 329.— (Mr Lee Scott)

Question put, That the Amendment be made.

The Committee divided

Ayes, 2	Noes, 6
Mr Lee Scott	Charlotte Atkins
Mr Robert Syms	Sandra Gidley
	Stephen Hesford
	Dr Doug Naysmith
	Dr Howard Stoate
	Dr Richard Taylor

Question put, That Paragraphs 328 and 329 Stand Part of the Report.

The Committee divided

Ayes, 2	Noes, 6
Mr Lee Scott	Charlotte Atkins
Mr Robert Syms	Sandra Gidley
	Stephen Hesford
	Dr Doug Naysmith
	Dr Howard Stoate
	Dr Richard Taylor

Paragraphs 330 to 352 read and agreed to.

Summary agreed to.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Thursday 7 January 2010 at 9.30 am

Witnesses

Thursday 23 April 2009

Professor Ian Gilmore, President, Royal College of Physicians, and
Dr Peter Anderson, Public Health Consultant

Professor Martin Plant, Professor of Addiction Studies, University of the West of England, **Dr James Nicholls**, Senior Lecturer, Bath Spa University, and **Dr James Kneale**, Lecturer in Human Geography, University College London

Thursday 7 May 2009

Professor Mike Kelly, Director, Centre for Public Health Excellence, National Institute for Health and Clinical Excellence (NICE), **Dr Lynn Owens**, Nurse Consultant, Liverpool PCT, and **Dr Paul Cassidy GP**, Gateshead PCT

Professor Robin Touquet, Accident and Emergency Consultant, St Mary's Hospital London, **Ms Carole Binns**, Commissioner, Southampton PCT,
Mr Brian Hayes, Alcohol Bus Service, London Ambulance Service,
Dr Duncan Raistrick, Alcohol Treatment Specialist, Leeds Addiction Unit

Thursday 14 May 2009

Dr Petra Meier, University of Sheffield, and
Ms Lila Rabinovich, Analyst, RAND Europe

Mr David North, Community and Government Director, Tesco,
Mr Jeremy Blood, Chief Executive, Scottish and Newcastle, British Beer and Pub Association, **Mr Jeremy Beadles**, Chief Executive, Wine and Spirit Trade Association, **Mr Mike Benner**, Chief Executive, Campaign for Real Ale (CAMRA)

Mr Mike Craik, Chief Constable of Northumbria, Association of Chief Police Officers (ACPO) Lead for Licensing

Thursday 2 July 2009

Mr Guy Parker, Chief Executive, Advertising Standards Authority, and
Ms Kate Stross, Director of Content, Ofcom

Mr Derek Lewis, Chairman, The Drinkaware Trust, and
Mr David Poley, Chief Executive, Portman Group

Ms Sonya Branch, Senior Director, Markets and Projects – Goods, Office of Fair Trading, **Professor David Foxcroft**, Chair in Healthcare, Oxford Brookes University, and **Mr Alan Downey**, UK Head of Healthcare, KPMG

Thursday 9 July 2009

Mr Nick Gill, Account Planner, Five by Five, **Mr Nick Constantinou**, Managing Director, AKQA, and **Ms Roberta Fuke**, Head of Planning, Bray Leino

Ms Charlotte Thompson, Director, BJL, **Mr Joseph Petyan**, Joint Managing Director, JWT, **Mr Chris Morris**, Chairman, Big Communications Group, and **Mr Andrew McGuinness**, Chief Executive, BMB

Mr Andy Fennell, Chief Marketing Officer, Diageo, **Mr Simon Davies**, Marketing Director, Molson Coors, **Ms Deborah Carter**, Marketing Director, Beverage Brands, and **Mr Graham Oak**, Marketing Director, Halewood International Ltd

Thursday 16 July 2009

Mr Alan Campbell MP, Parliamentary Under-Secretary of State for Crime Reduction, and **Mr Mark Cooper**, Deputy Head, Alcohol Strategy Unit, Home Office, and **Mr Gerry Sutcliffe MP**, Minister for Sport, and **Mr Andrew Cunningham**, Deputy Director, Head of Leisure, Department for Culture, Media and Sport

Mr Edward Troup, Director of Business and Indirect Tax, HM Treasury

Gillian Merron MP, Minister of State for Public Health, **Sir Liam Donaldson**, Chief Medical Officer, and **Mr Will Cavendish**, Head of the Alcohol Team, Department of Health

Thursday 15 October 2009

Mr Paul Kelly, Corporate Affairs Director, ASDA, **Mr Nick Grant**, Head of Legal Services, Sainsbury's, and **Mr Giles Fisher**, Head of Alcohol Buying, Waitrose

Mr William Bush, Director of Communications & Public Policy, Barclays Premier League, and **Mr Stewart Thomson**, Commercial Director, Football League

List of written evidence

The following memoranda were published as *Alcohol: Written evidence*, HC 368–II, Session 2008–09

AL

1 Department of Health
2 Professor David Foxcroft
3 Royal Pharmaceutical Society of Great Britain
4 Alcohol Education and Research Council
5 Sovio Wines Ltd
6 British Medical Association
7 Professor Neil McIntosh
8 The College of Emergency Medicine
9 Royal College of Midwives
10 National Association for the Children of Alcoholics
11 British Liver Trust
12 Professor Sir John Marsh
13 Alcohol Concern
14 NSPCC
15 National Association of Cider Makers
16 Socialist Health Association
17 Royal College of General Practitioners
18 Diageo
19 Family Planning Association (fpa)
20 British Society of Gastroenterology and the British Association for the Study of the Liver
21 J Sainsbury plc
22 ASDA
23 Professor Forrester Cockburn, Dr John McClure, and Dr Margaret Watts
24 British Retail Consortium
25 Institute of Alcohol Studies (IAS)
26 Scottish Health Action on Alcohol Problems (SHAAP)
27 Professor Eileen Kaner
28 Royal College of Nursing
29 Breakthrough Breast Cancer
30 Children in Scotland
31 Scotch Whisky Association and Gin and Vodka Association
32 Children in Northern Ireland
33 Local Government Association
34 Our Life (North West)
35 Portman Group
36 Nuffield Council on Bioethics
37 Barnardo's UK
38 Scottish & Newcastle UK

39 Wm Morrison Supermarkets plc
40 Association of Convenience Stores (ACS)
41 The NHS Confederation
42 BII
43 Advertising Standards Authority (ASA)
44 National Organisation for Fetal Alcohol Syndrome - UK
45 Business in Sport and Leisure Limited (BISL)
46 Royal College of Physicians
47 The Wine and Spirit Trade Association
48 Alcohol Focus Scotland
49 Royal College of Psychiatrists
50 Dr Noel Olsen
51 Alcohol Health Alliance
52 SABMillar

List of further written evidence

The following written submissions were received after the publication of *Alcohol: Written evidence*, HC 368–II, Session 2008–09. They are reproduced with the Oral evidence in Volume II of this Report.

1 Department of Health (AL 01A)
2 Department of Health (AL 01B)
3 Department of Health (AL 01C)
4 Department of Health (AL 01D)
5 Diageo (AL 18A)
6 Diageo (AL 18B)
7 British Association for the Study of the Liver (AL 20A)
8 Sainsbury's (AL 21A)
9 ASDA (AL 22A)
10 The Portman Group (AL 35A)
11 Advertising Standards Authority (AL 43A)
12 The Wine and Spirit Trade Association (AL 47A)
13 The Wine and Spirit Trade Association (AL 47B)
14 Alcohol Focus Scotland (AL 48A)
15 Advertising Association (AL 53)
16 Constellation Europe Limited (AL 54)
17 Dr James Kneale (AL 55)
18 The Drinkaware Trust (AL 56)
19 The Drinkaware Trust (AL 56A)
20 Dr Phil Withington, University of Cambridge and Dr Angela McShane, V&A Museum (AL 57)
21 Dr Peter Anderson (AL 58)
22 Dr James Nicholls (AL 59)
23 The Royal College of Surgeons of England (AL 60)
24 Southampton City Council and Southampton Primary Care Trust (AL 61)
25 Dr Petra Meier, University of Sheffield (AL 62)
26 Dr Petra Meier, University of Sheffield (AL 62A)
27 Tesco (AL 63)
28 Tesco (AL 63A)
29 CAMRA (Campaign for Real Ale) (AL 64)
30 ACPO (AL 65)
31 Dr Duncan Raistrick (AL 66)
32 Professor Christine Godfrey (AL 67)
33 Office of Fair Trading (AL 68)
34 Office of Communications (AL 69)
35 Sue Otty (AL 70)
36 Health and Consumers Directorate-General, European Commission (AL 71)
37 HM Treasury (AL 72)
38 Department for Culture, Media and Sport (AL 73)

39 Home Office (AL 74)
40 Home Office (AL 74A)
41 Five by Five (AL 75)
42 Molson Coors Brewing Company (UK) Limited (AL 76)
43 Beverage Brands (UK) Ltd (AL 77)
44 The Football League (AL 78)
45 Waitrose (AL 79)
46 Premier League (AL 80)
47 National Union of Students (NUS) (AL 82)
48 Universities UK (AL 83)
49 Varsity Leisure Group Limited (AL 84)
50 Dr Nicholas Sheron and Kirsty Tull (AL 85)

List of unprinted evidence

The following memoranda have been reported to the House, but to save printing costs they have not been printed and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Parliamentary Archives, and are available to the public for inspection. Requests for inspection should be addressed to The Parliamentary Archives, Houses of Parliament, London SW1A 0PW (tel. 020 7219 3074). Opening hours are from 9.30 am to 5.00 pm on Mondays to Fridays.

List of meetings between Alcohol Concern and Government officials, 2007–2009 (AL 13A)
Professor Gerard Hastings (AL 81)
Alcohol Health Alliance (AL 51A)
Dr Julia Sinclair (AL 86)

Extracts from alcoholic drinks producers and advertising agencies' documents:
Beattie McGuinness Bungay
Big Communications
BJL Group
Cheethambell JWT
Diageo
Five by Five
Halewood International
JWT
Molson Coors

List of Reports from the Committee during the current Parliament

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2008–09

First Report	NHS Next Stage Review	HC 53 (Cm 7558)
Second Report	Work of the Committee 2007–08	HC 193
Third Report	Health Inequalities	HC 286 (Cm 7621)
Fourth Report	Top-up fees	HC 194 (Cm 7649)
Fifth Report	The use of management consultants by the NHS and the Department of Health	HC 28 (Cm 7683)
Sixth Report	Patient Safety	HC 151 (Cm 7709)
First Special Report	Patient Safety: Care Quality Commission, Monitor, and Professor Sir Ian Kennedy's Responses to the Committee's Sixth Report of Session 2008–09	HC 1019

Session 2007–08

First Report	National Institute for Health and Clinical Excellence	HC 27 (Cm 7331)
Second Report	Work of the Committee 2007	HC 337
Third Report	Modernising Medical Careers	HC 25 (Cm 7338)
Fourth Report	Appointment of the Chair of the Care Quality Commission	HC 545
Fifth Report	Dental Services	HC 289 (Cm 7470)
Sixth Report	Foundation trusts and Monitor	HC 833 (Cm 7528)
First Special Report	National Institute for Health and Clinical Excellence: NICE Response to the Committee's First Report	HC 550

Session 2006–07

First Report	NHS Deficits	HC 73 (Cm 7028)
Second Report	Work of the Committee 2005–06	HC 297
Third Report	Patient and Public Involvement in the NHS	HC 278 (Cm 7128)
Fourth Report	Workforce Planning	HC 171 (Cm 7085)
Fifth Report	Audiology Services	HC 392 (Cm 7140)
Sixth Report	The Electronic Patient Record	HC 422 (Cm 7264)

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)