House of Commons

Health Committee

Government's Alcohol Strategy

Third Report of Session 2012–13

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The Health Committee

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

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The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

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

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Summary

Alcohol misuse affects a large number of people. The current annual death rate from alcohol-related conditions is more than three times that for deaths in road accidents, and the cost to the NHS of treating such conditions is around 3% of its annual budget. The government's strategy is a welcome attempt to address some of these problems in a coherent way. The main focus of the strategy is the need to address public order issues. We agree that these are important, but we believe that the health impact of the misuse of alcohol is more insidious and pervasive.

Objectives and targets

The Committee believes it is important to ensure that the objectives of policy on alcohol are clearly stated and calibrated. The great majority of citizens enjoy alcohol without significant evidence of harm to their health. The Committee accepts that it is not possible to define a level of alcohol consumption which is, in any absolute sense, safe for all citizens at all times. We do not believe, however, that this conclusion should lead to disproportionate or heavy handed controls which are justified neither by public support nor evidence of proportionate health gain. The Committee also believes that healthy societies expect all citizens, both corporate and individual, to exercise their individual freedoms in ways which respect the rights and interests of their fellow citizens and observe shared standards of responsible behaviour. It is part of the function of Government to stimulate, lead and if necessary regulate, in order to encourage the development of this culture.

The Committee believes that an Alcohol Strategy should be seen as part of a wider public health strategy, and should contain some key quantified, alcohol-specific objectives which will provide both a framework for policy judgements and an accountability framework.

What is 'safe'?

Although we accept that it is a complicated issue, we regard a clearer, evidence-based definition of the health effects of alcohol consumption as fundamental to successful policy development in this area. The work of the Chief Medical Officer needs to be carried forward as a matter of urgency. Public Health England, acting independently of Government, then needs to use the outcome of the review as the basis for its promotion of public understanding of the issues, setting out the level at which harms are likely to result alongside sensible drinking guidelines.

Binge drinking

Despite some perceptions that binge drinking is largely a public order issue, the evidence presented to us suggests that it does contribute to some of the long-term health harms that have concerned us. We conclude that these health problems need to be addressed no less urgently than problems with public order and anti-social behaviour.

Minimum unit price

The Committee welcomes the Government's decision to introduce a minimum unit price for alcohol. It is, however, struck by how little evidence has been presented about the specific effects anticipated from different levels of minimum unit price. The proposition

that demand for alcohol is relatively price-elastic seems uncontroversial. Rather than relying on generalised statements about the effect of price on consumption, the Committee urges the Government to build its case for a minimum unit price by establishing direct links: between specific alcohol products and specific alcohol-related harms; between different levels of minimum unit price and the resulting selling prices for the products which are linked to alcohol-related harms; and the likely effect of different levels of selling prices for those products on demand for those products in the target range of households.

Given the Government's decision to introduce a minimum unit price, the debate has been about the level at which it should be set– whether it should be 40, 45 or 50 pence – but the setting of a minimum unit price will not be a one-off event. Once a minimum price is introduced, if it is judged to be successful, the level will need to be monitored and adjusted over time. A mechanism will need to be put in place in order to do this, but as yet there has been no indication from the Government of what it intends to do other than to consult on the price. One way of setting the level would be to establish an advisory body to analyse evidence and make recommendations to Government. Whatever mechanism is chosen should be used when setting the initial level of the minimum unit price to ensure that from the beginning the price is clearly evidence-based.

It has already been announced that the minimum unit price to be introduced in Scotland will be 50 pence per unit. There are practical arguments in favour of the same minimum price being set in England to avoid problems with cross-jurisdiction trading. Our main concern, however, is that the level of minimum price that is set should be evidence-based and designed to be effective. If the minimum unit price in England were to be fixed at a different level to that in Scotland, we would expect the evidence supporting that decision to be set out clearly. This is another argument in favour of establishing a transparent mechanism for setting the price.

Multibuys

The evidence we have seen does not convince us that a ban on multibuys is either desirable or workable. The proposed minimum unit price will provide a floor price for the sale of alcohol, including discounted sales. The Committee supports the principle of setting the minimum unit price at a level which is effective at reducing identified alcohol-related harm; it believes that an attempt to outlaw well-established and convenient retailing techniques for alcohol products, regardless of price level, would simply create opportunities for retailers to find innovative and newsworthy work-arounds which would invite ridicule and bring the wider policy objective into disrepute.

Challenging the industry to act responsibly

Messages contained in alcohol advertisements play an important part in forming social attitudes about alcohol consumption. The Committee believes that those involved in advertising alcoholic products should accept that their advertisements contain positive messages about their products and that these messages are supported by considerable economic power. If this were not the case it is not clear why shareholders should be content for their companies' resources to be spent in this way. Since it is true, however, it is important that the alcohol industry ensures that its advertisements comply in all respects with the principles of corporate social responsibility. Closer definition of these principles as they apply to alcohol advertising is a key objective of the Government's Responsibility

Deal.

The Committee does not believe that participation by the alcohol industry in the Responsibility Deal should be regarded by anyone as optional – we regard it as intrinsic to responsible corporate citizenship. We welcome the willingness of the industry to address the harms that alcohol can cause but we believe that it should be clear that the Responsibility Deal is not a substitute for Government policy.

It is for the Government, on behalf of society as a whole, to determine public policy and ensure that a proper independent evaluation of the performance of the industry against the requirements of the Responsibility Deal is undertaken. We recommend that such an evaluation is commissioned by Public Health England. We will be particularly interested to see the assessment of the effect of reducing the alcohol level in certain drinks. We do not believe that reducing the alcohol in some lagers from 5% to 4.8%, for example, will have any significant impact. If the industry does not being forward more substantial proposals than this it risks being seen as paying only lip service to the need to reduce the health harms caused by alcohol.

Expectations within the Responsibility Deal

The Committee is concerned that those speaking on behalf of the alcohol industry often appear to argue that advertising messages have no effect on public attitudes to alcohol or on consumption. We believe this argument is implausible. If the industry wishes to be regarded as a serious and committed partner in the Responsibility Deal it must acknowledge the power of its advertising messages and accept responsibility for their consequences. The industry will take a significant step down this road when it makes it clear that alcoholic products should not be marketed in ways which address audiences a significant proportion of whom are aged under 18, and cannot therefore legally purchase the product.

Advertising of alcoholic products on television is subject to rules which are relatively targeted and sophisticated. The Committee believes there is scope to apply these principles more widely and recommends that this principle be reviewed in the context of the Responsibility Deal. Serious consideration should be given to reducing to 10% the proportion of a film's audience that can be under 18 and still allow alcohol to be advertised, or to prohibiting alcohol advertising in cinemas altogether except when a film has an 18 certificate.

Loi Evin

The Committee believes that the approach adopted in the French *Loi Evin* merits serious examination in the English context. In particular the Committee recommends that Public Health England should commission a study of the public health effect which would be delivered in the UK by adopting the principles of *Loi Evin*; such a piece of work would provide a valuable reference point for the evaluation of the effectiveness of the Responsibility Deal which the Committee has recommended should also be undertaken by Public Health England.

Treatment services

We welcome the work which the Department is undertaking to provide an evidence base to allow commissioners to make informed decisions about which models of treatment

provision are most effective in addressing the health issues caused by alcohol abuse. In particular commissioners need evidence about the most effective form of early intervention in order to reduce the number of avoidable hospital admissions which currently represent avoidable illness for patients and avoidable costs for taxpayers. The evidence we received suggested that the establishment of Alcohol Specialist Nurse services throughout the country is one of those measures. The fact that over 70% of the costs to the NHS of alcohol-related services was spent on hospital treatment demonstrates the scale of the opportunity to restructure services to achieve better outcomes.

1 Introduction

1. The Government published its Alcohol Strategy on 23 March. In its introduction, the Strategy says:

> Fifty years ago, the United Kingdom had one of the lowest drinking levels in Europe but it is now one of the few European countries whose consumption has increased over that period. Over the last decade we have seen a culture grow where it has become acceptable to be excessively drunk in public and cause nuisance and harm to ourselves and others...
>
> A combination of irresponsibility, ignorance and poor habits – whether by individuals, parents or businesses – led to almost 1 million alcohol-related violent crimes and 1.2 million alcohol-related hospital admissions in 2010/11 alone. The levels of binge drinking among 15–16 year olds in the UK compare poorly with many other European countries[2] and alcohol is one of the three biggest lifestyle risk factors for disease and death in the United Kingdom after smoking and obesity. It has become acceptable to use alcohol for stress relief, putting many people at real risk of chronic diseases. Society is paying the costs – alcohol-related harm is now estimated to cost society £21 billion annually.[2]

2. It argues that the strategy puts forward a range of 'long-term and sustained' actions to be taken by 'local agencies, industry, communities and the Government' in order to 'turn the tide against irresponsible drinking'.[3] The Committee decided to examine the strategy to see whether the proposals are likely to have the effect the Government is seeking; whether the matters it is aiming to address are the most appropriate ones looking at the issue from a health perspective; and what further measures might be considered to counteract the harm that alcohol causes.

3. We took evidence from Anne Milton MP, Parliamentary Under-Secretary of State for Public Health, Chris Heffer, Deputy Director, Alcohol and Drugs, and Dr Mark Prunty, Senior Medical Officer, Alcohol and Drugs programme, Department of Health, Professor Sir Ian Gilmore, Royal College of Physicians special adviser on alcohol and Chair of the Alcohol Health Alliance, Eric Appleby, Chief Executive, Alcohol Concern, Professor Alan Brennan, and Dr John Holmes, Sheffield Alcohol Research Group, Chris Sorek, Chief Executive, Drinkaware, Brigid Simmonds OBE, Chief Executive, British Beer and Pub Association, Henry Ashworth, Chief Executive, The Portman Group, Barry Eveleigh, Lead Commissioner for Drug Treatment, Birmingham Drug & Alcohol Action Team, and Jacqui Kennedy, Director of Regulation and Enforcement, Birmingham City Council. We also received 67 written submissions. We are grateful to everyone who contributed to the inquiry.

2 The Government's Alcohol Strategy, March 2012, Cm 8336, paragraphs 1.1 and 1.3

3 Ibid, para 1.5.

2 Defining the problem

4. The strategy is mainly focused on social order and public binge drinking. The Prime Minister's introduction states:

> Binge drinking isn't some fringe issue, it accounts for half of all alcohol consumed in this country. The crime and violence it causes drains resources in our hospitals, generates mayhem on our streets and spreads fear in our communities.
>
> My message is simple. We can't go on like this. We have to tackle the scourge of violence caused by binge drinking. And we have to do it now.[4]

5. We asked Anne Milton MP, Parliamentary Under Secretary of State for Public Health if she felt that the Government's strategy took sufficient account of the health impact of high levels of alcohol consumption. She told us:

> ...the danger is that whenever you produce a strategy...somebody is going to count up the number of lines that are dedicated to issues A, B, C or D and say there has not been enough focus on X, Y or Z... The antisocial behaviour and crime associations of alcohol affect almost everybody's life in some way or another. The health harms affect probably fewer people's lives but they are still very relevant. There are huge financial costs, and we have concentrated on the financial costs, but I say that we should also concentrate on the human cost. I do not feel compromised. I do not think there is any diminution of the other harms that alcohol causes at all.[5]

6. **The Committee shares concerns about the social impact of binge drinking but we believe it is also important to ensure that the Government's strategy recognises and responds to the evidence of an increasing health impact of excessive alcohol consumption.**

Why is it a matter of concern?

7. Alcohol-related disease reflects the lifestyle choices and behaviours of individual citizens. This leads some to conclude that these behaviours are matters of individual choice which are of no concern to policy makers, and others to conclude that alcohol-related disease should be accorded a lower priority in public health policy than diseases and conditions which are in all respects involuntary.

8. **While it is sensitive to the need to avoid a moralising tone the Committee does not accept either of these positions. The establishment of Public Health England provides an important opportunity to analyse the true public health impact of alcohol consumption and adopt a package of policy responses which is evidence-based, as well as being carefully calibrated and targeted.**

4 Alcohol Strategy, page 2.

5 Q 348

9. It is the evidence of the growing scale of the health problems caused by alcohol consumption which makes it a significant public health issue. The latest Government figures, published at the end of May this year show that:

- There were 6,669 deaths directly related to alcohol in 2010, 1.3% more than in 2009 (6,584) and 22% more than in 2001 (5,476)
- In 2010/11, there were 198,000 hospital admissions where the primary diagnosis was attributable to alcohol, 2.1% more than 2009–10 (194,800) and 40% more than in 2002–03 (142,000)
- In addition, overall there were 1,163,300 hospital admissions which were to some degree attributable to alcohol, 11% more than 2009–10 (1,056,000) and more than twice as many as in 2002–03 (510,700).[6]

10. In what it describes as an evidence paper which it submitted with its memorandum to our inquiry, the Department of Health tells us that the cost to the NHS of alcohol misuse is £3.5 billion a year (2009–10 costs), and that lost productivity due to alcohol across the UK is estimated at £7.3 billion a year (2009–10 costs). It also says that:

> Disability adjusted life years (DALY) are a measure of combined ill health (adjusted for severity) and premature death. Alcohol is 10% of the UK burden of disease and death, as measured by DALYs lost – smoking is 15%. By this measure, alcohol is one of the three biggest lifestyle risk factors for disease and death in the UK, after smoking and obesity. This takes account of the net benefit from a reduced risk of heart disease for moderate consumption.
>
> It is important to note that DALYs take account of long term health damage and loss of life, short term accidents and injuries, which account for a high proportion of early deaths, and the burden of ill health linked to dependence. It is all of these together that account for alcohol's importance as a risk factor.[7]

11. The Royal College of Nursing made a similar point:

> Excessive alcohol consumption is a major source of morbidity and premature death in the UK. The World Health Organisation lists alcohol as the third leading risk factor for premature death in developed countries, with only tobacco and blood pressure causing more premature death and disability.[8]

The DH told us that "In England, the average years of life lost for men and women dying from alcohol-attributable conditions during 2003–2005 was 20 years and 15 years respectively."[9]

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6 Statistics on Alcohol: England, 2012, pages 11 and 12. NB, as is stated on page 11 of this report, "Comparisons over time in the broad measure are complicated by changes in recording practices over the period. In order to estimate the trend once changes in recording practices are accounted for, a method to adjust the national figures has been devised which is presented in Appendix G. Adjusted figures show a 49% increase from an estimated 783,300 in 2002/03 but a 3% decrease from 1,208,100 in 2009/10."

7 Ev 78–9

8 Ev w70

9 Ev 79

12. This chronic situation also links in to public order and other social problems. The NSPCC pointed out general harms alcohol causes to families:

> It is estimated that between 780,000 and 1.3 million children in England aged under 16 have parents whose drinking is classified as harmful or dependent. Around 79,000 babies under one year old in England have a parent who is a harmful drinker, which is equivalent to 93,500 babies in the UK. And around 26,000 babies under one year old in England have a parent who is a dependent drinker, which is equivalent to 31,000 across the UK. Furthermore, parental alcohol misuse is present in a number of cases of child abuse and neglect. Evidence shows that it was present in 22 per cent of Serious Case Reviews in England from 2007–2009.[10]

13. Alcohol harm is also connected with health inequalities. The Committee was told that people on lower incomes "suffer a greater risk of harm per unit of alcohol than those on higher incomes".[11] There is no clear understanding of why this is. Dr John Holmes of the Sheffield Alcohol Research Group said:

> Partly it is to do with other confounding factors, things to do with other aspects of their diet, other health behaviours, the environments in which they drink, their access to medical services and the quality of those services and, because of their other health behaviours, their body's ability to deal with the alcohol. There are lots of reasons which you could broadly consider as social exclusion arguments which mean that people on lower incomes are at greater risk of harm from alcohol than people on higher incomes.[12]

14. The Committee explored with several witnesses the paradox that these increases in alcohol-related harm have coincided with decreases in the proportion of the adult population who drink alcohol, and of the overall amount being drunk. Professor Alan Brennan, of the Sheffield Alcohol Research Group, said that:

> That is quite a complex thing to untie. There has been a recent reduction in reported alcohol consumption, but from quite a high level that has been going up over many years. Certainly in relation to these chronic health harms, where people drink substantially and over time that results in illnesses like cancers; a short-term downturn does not turn off that lagged effect around health harm.[13]

15. His colleague, Dr Holmes, added that:

> ...alcohol consumption peaked in 2005. In 2005 we were drinking more alcohol per person per year than we had been at any other time in the last hundred years. So, yes, we have seen a small fall from that peak, but in no way are we back down at what might be considered low levels in an historical context.[14]

10 Ev w39

11 Q 26

12 Q 27

13 Q 4

14 ibid

16. The Minister argued that part of the problem was that "a small number of people are drinking more and more alcohol. It should focus our attention on the fact that a message is getting through to some people, but not everybody."[15] Chris Heffer, Deputy Director, Alcohol and Drugs, at the Department of Health said that:

> consumption has risen over 30 years and quite dramatically peaked...in about 2004 and is down about 10%. But one needs, I think, to be cautious of over-interpreting year-on-year falls in that. There are a number of measures of alcohol harm. We can look at deaths, which fell the year before last but then did not fall last year...You may come back to hospital admissions as a measure...The primary coding has only grown about 2% or 3% over the period, not quite in line with falling consumption but certainly not growing rapidly while consumption falls. So I think the time-lag theory ...is very real. You might expect deaths to respond faster, which may be why you saw that in one year.[16]

17. The Committee discussed with witnesses whether the strategy correctly identified the main problems concerning alcohol, and whether it provided appropriate solutions. Eric Appleby of Alcohol Concern said:

> It is a significant step forward from anything we have had before...particularly because the strategy has looked at tackling consumption through price and availability—perhaps less so through marketing—which we know are some of the key triggers there. I think it could have gone further in terms of the issue of treatment... clearly the headlines are around binge drinking. It is a problem and an unsightly problem. In health terms, however, the bigger problem is not so much the binge drinking but the long-term, more hidden perhaps, middle-age and middle-class sort of drinking. In health terms, the most significant costs are hospital admissions, the vast majority of those being the chronic long-term impact of drinking.[17]

18. Sir Ian Gilmore of the Royal College of Physicians agreed with this last point, saying that

> For example...Liverpool Primary Care Trust data show that 90% of hospital admissions related to alcohol are for chronic conditions. They are not for people falling over in Lime Street when they are drunk, but for chronic conditions. In many areas the strategy does measure up to making an impact on those areas... it is stronger perhaps in areas that relate to crime and social disorder—licensing—than it is perhaps in some of its ambitions concerning health and, in particular, treatment...but we would have preferred it to have been framed more in terms of the health challenges and potential health benefits. None the less, there is a lot there that gives us something to work on.[18]

15 Q 307

16 Q 310

17 Q 2

18 ibid

19. Sir Ian also said that:

> We have to accept...that "alcohol is not an ordinary commodity". If it is left to personal choice as an entirely libertarian issue, we will run into problems. It is a drug. It is a drug of dependence. It is a psychoactive drug. It happens to be legal. We do not want to make it illegal, but it does require different handling from soap powder and other things that may be dealt with otherwise by the free market.[19]

20. **Alcohol misuse affects a large number of people. The current annual death rate from alcohol-related conditions is more than three times that for deaths in road accidents,**[20] **and the cost to the NHS of treating such conditions is around 3% of its annual budget. The Government's strategy is a welcome attempt to address some of these problems in a coherent way**.

21. **The main focus of the strategy is the need to address public order issues. We agree that these are important, but we believe that the health impact of the misuse of alcohol is more insidious and pervasive; the remainder of this report therefore focuses on ways in which those harms to health can be addressed.**

19 Q 6

20 1,850 people were killed in road accidents in 2010: http://assets.dft.gov.uk/statistics/releases/transport-statistics-great-britain-2011/transport-accidents-summary.pdf

3 Policy Response

Objectives and targets

22. **The Committee believes it is important to ensure that the objectives of policy on alcohol are clearly stated and calibrated. The great majority of citizens enjoy alcohol without significant evidence of harm to their health. The Committee accepts that it is not possible to define a level of alcohol consumption which is, in any absolute sense, safe for all citizens at all times. We do not believe, however, that this conclusion should lead to disproportionate or heavy handed controls which are justified neither by public support nor evidence of proportionate health gain.**

23. **The Committee also believes that healthy societies expect all citizens, both corporate and individual, to exercise their individual freedoms in ways which respect the rights and interests of their fellow citizens and observe shared standards of responsible behaviour. It is part of the function of Government to stimulate, lead and if necessary regulate, in order to encourage the development of this culture.**

24. Against this background the Committee believes it is important for policy to be guided by objectives which are clearly stated and defined. The Strategy outlines a series of outcomes that the Government wishes to bring about:

> Our ambition is clear – we will radically reshape the approach to alcohol and reduce the number of people drinking to excess. The outcomes we want to see are:
>
> - A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
> - A reduction in the amount of alcohol-fuelled violent crime;
> - A reduction in the number of adults drinking above the NHS guidelines[5];
> - A reduction in the number of people "binge drinking";
> - A reduction in the number of alcohol-related deaths; and
> - A sustained reduction in both the numbers of 11–15 year olds drinking alcohol and the amounts consumed.[21]

25. There are, however, no specific targets or measurements to say how the Government will judge the success of the strategy. The Alcohol Health Alliance noted its concern "about the absence of specific targets and timeframes for achieving changes in consumption, violent crime and incidence of alcohol-related chronic conditions"[22]. This contrasts with the example of Birmingham's local strategy that we looked at in evidence, which had some quite specific measures:

21 Alcohol strategy, paragraph 1.6

22 Ev 98

Key Outcomes

In order to achieve this overall vision we have set three key outcomes. These will direct all our work and activity will only be taken forward if it will impact upon them. The outcomes we will be seeking to achieve are:

- Increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities;
- Reduction in alcohol related crime and disorder and perception of crime and disorder;
- Reduction in the adverse impact of alcohol on families and the wider community

Key Performance Indicators

To measure our overall progress towards achieving these outcomes we have set three key performance indicators. These indicators are linked, as closely as available data allows, to the outcomes:

- Stabilisation of the rate of alcohol-related hospital admissions by reducing the rate of increase by 2% year-on-year;
- Reduction in alcohol related crime and disorder by 10% by end of strategy period;
- Reduction in the loss of months of life lost due to alcohol by 10% by end of strategy period.[23]

26. On the question of targets, the Minister told us:

> We have a public health outcomes framework out at the moment with two high-level objectives and looking at a number of public health issues in four domains. We will be developing that and are consulting on specific objectives and high-level outcomes as we go along. But, essentially, the money given to local areas on public health in the light of the strategy will be against the public health outcomes framework.[24]

27. We believe that in order for the alcohol strategy to be effective it needs to have quantified objectives. The Minister said that the public health outcomes framework would provide these objectives, but that framework is very broad and only one of the more than 60 indicators contained within it is entirely alcohol related (alcohol-related hospital admissions).[25] **The Committee believes that an Alcohol Strategy should be seen as part of a wider public health strategy, and should contain some key quantified, alcohol-**

23 Birmingham Alcohol Strategy 2012–16, page 2

24 Q 305

25 *Improving outcomes and supporting transparency Part 1: a public health outcomes framework for England, 2013–2016*, Department of Health, January 2012, p27.

specific objectives which will provide both a framework for policy judgements and an accountability framework.

28. **We address later in the report the issue of all local areas having an alcohol strategy, flowing from the national strategy but using local approaches to deal with local problems. It seems logical that Public Health England should oversee this process, given its overarching responsibility for public health matters. It also seems logical that Public Health England should devise the national measures against which the strategy can be tested.**

What is 'safe'?

29. If the objective is to allow consumers to make "informed choices", the question "what is safe?" is fundamental. Professor Sir Ian Gilmore, special adviser to the Royal College of Physicians on alcohol and Chair of the Alcohol Health Alliance, told us:

> There are great difficulties and this is the nub of the problem of the health messages to the general public. Everyone is different and probably responds differently to alcohol. If you take 100 very heavy drinkers the majority will never get cirrhosis of the liver, but we cannot yet tell you which group you fall into. There are those individual differences. Then there is the fact that for different diseases the threshold is very different. If you stick within so-called safe limits then there are certain diseases you are virtually guaranteed not to get, whereas there are other conditions, like some forms of cancer, where drinking well below safe recommended limits will significantly increase your risks. I am afraid that, at the moment, you cannot generalise and say you will be totally safe if you stick to such and such a level. But I do welcome the recommendation in the strategy that guideline advice is revisited. It should be possible to personalise that more than we have at present and to try to get round some of the understandable confusion in the general public.[26]

30. Eric Appleby, of Alcohol Concern, told us:

> It seems to me that one of the problems we have is that we are not very good at talking about alcohol. At one end it is a bit of a joke: going down the pub and getting drunk is comfortable and jokey. At the other end, talking about real problems is almost a taboo subject. In between we are not very good at having that conversation about the dichotomy, if you like, that alcohol is quite enjoyable and we like it but it also carries harms. Having this conversation about managing risk is something we just do not do, and people tend not to want to do. It is instigating that conversation which is to some extent what is needed.[27]

31. The Committee also heard that the message about sensible levels of drinking had been confused. Eric Appleby said:

> We have what were originally called "Sensible drinking guidelines", which, when they were framed, were relatively straightforward, but the world has changed since

26 Q 44

27 Q 45

> then—the strength of drinks, the size of servings, and all that. It is now very confusing for people. The strategy talks about reviewing those. The important thing is reviewing how we communicate them, because I think you will find that the science has not changed very much. It is about how you communicate that and how you can get the message across to people of the true nature of the issue. It is a very loaded subject. Nobody wants to be told that they should drink less than they are currently drinking. We have this spectrum between, at one end, a sort of fatalism about drinking, "You cannot do anything about it. People drink. It just happens" and a denial at the other end, "Yes, I have my bottle of wine with a meal every night. I do not get drunk. I do not cause anyone any problems. There is nothing wrong with that," except 20 years down the line when you end up in one of Ian's hospital beds.

32. As the Strategy notes, the Government launched a campaign earlier this year to communicate the health harms of drinking above the lower risk guidelines and provide a range of tips and tools to encourage people to drink responsibly.[28] It also says that "we will ask Dame Sally Davies, the UK Government's Chief Medical Officer, to oversee a review of the alcohol guidelines for adults. This will also take account of available science on how we can best communicate the risks from alcohol, improving the public's understanding of both personal risks and societal harms".[29]

33. There is clearly a need for such educational measures. The Royal Geographical Society (RGS) quoted evidence that showed

> very few people acknowledge the use of 'units' as a way of either measuring, and hence controlling, their own levels of drunkenness, or of monitoring the health impacts of alcohol consumption. In a survey of drinkers in urban Stoke-on-Trent and rural Eden, Cumbria, not one single person surveyed said that they used units in their day to day life and that measuring 'units' simply did not work. However what the study did find was that people tend to consider the impact of drinking on their health in terms of how they felt, with their level of drunkenness determined by a number of factors including their mood, food intake, level of tiredness, and their own personal (often changing) tolerance to alcohol.
>
> The conclusions is that a whole range of factors, including cultural norms and peer pressure, are what are important in determining what, and how much, people drink. This suggests the use of 'units' in alcohol policy may not resonate as a useful public health tool: first, 'units' do not always correlate to the actual negative health effects of alcohol on our bodies; second, under current government guidance, a majority of drinkers are being classified officially as 'bingers'. In practice, however, these same drinkers may experience little or no harmful (immediate) health issues because of their alcohol consumption.[30]

34. The RGS also noted "that in the UK people have tended not to worry about their consumption, even when reporting excess consumption... evidence shows that the amount

28 Alcohol Strategy, para 5.13.

29 ibid, para 5.14

30 Ev w133

of alcohol consumed reported in surveys is considerably (about one third) less than that sold".[31]

35. The Minister agreed that there were problems with the guidelines:

> I think that public understanding of units is quite poor. In fact, there has been quite a lot of voluntary work from some of the producers and supermarkets on units. Most people look at how much alcohol they drink by the number of glasses they drink and glasses are very large now. They can hold a lot more units than they used to when I was younger. The [Chief Medical Officer] is reviewing the guidelines across the piece and that will be important. It is a recognised thing. Scientists and Government can use units but what we have to do is get across messages that are easy for people to understand. It is about the messaging more than whether the unit itself is a useless thing.[32]

36. **Although we accept that it is a complicated issue, we regard a clearer, evidence-based definition of the health effects of alcohol consumption as fundamental to successful policy development in this area. The work of the Chief Medical Officer needs to be carried forward as a matter of urgency. Public Health England, acting independently of Government, then needs to use the outcome of the review as the basis for its promotion of public understanding of the issues, setting out the level at which harms are likely to result alongside sensible drinking guidelines.**

Binge drinking

37. The strategy highlights the public order and related issues concerning binge drinking, but there are clearly health issues which also need to be addressed. As the Department told us:

> Drunkenness, due to single, heavy drinking episodes ('binge drinking') has been shown to have a number of health and social consequences on the drinker and/or on other people, such as:
>
> - Injuries, for example from falls
> - Violence and aggression, including alcohol-related crime and disorder and domestic violence increase with drunkenness and with heavier drinking in general. If the heavy drinker is a parent, this can contribute to a variety of childhood mental and behavioural disorders. Systematic reviews have suggested that alcohol is a contributory factor in 16% of child abuse cases.
> - Increased risk of stroke, heart arrhythmias, and sudden coronary death, even in people with no evidence of pre-existing heart disease – any protective effect of regular, moderate consumption may be lost through binge drinking, even if this is infrequent.
> - Harming home life or marriage

31 Ev 134

32 Q 317

- Damaging work performance
- Limiting young people's educational attainment[33]

38. Chris Sorek of Drinkaware noted changes in attitudes to excessive drinking:

> during my first time in the United Kingdom in the late 1970s and early 1980s—when I was working here—going out and getting drunk, at that age, was seen as losing face. People would think less of you. That has changed and there has been a cultural shift.[34]

39. The London Health Improvement Board told us that:

> Heavy binge drinking by adolescents and young adults is associated with increased long-term risk for heart disease, high blood pressure, type 2 diabetes, and other metabolic disorders. A UK study found that binge drinking in adolescence was associated with increased risk of health, social, educational and economic adversity continuing into later adult life. The problems included increased risk of alcohol dependence and harmful drinking in adulthood, illicit drug use, poorer educational outcomes, criminal convictions and lower socioeconomic status.[35]

40. **Despite some perceptions that binge drinking is largely a public order issue, the evidence presented to us suggests that it does contribute to some of the long-term health harms that have concerned us. We conclude that these health problems need to be addressed no less urgently than problems with public order and anti-social behaviour.**

Minimum unit price

41. In the Strategy, the Government notes measures already taken on price to address what it calls the 'heavily discounted' price of alcohol:

- Raising alcohol duty by 2% above retail inflation (RPI) each year to 2014–15;
- Introducing a 'minimum juice' rule for cider, so that high strength white ciders can no longer qualify for the lower rates of duty that apply to cider; and
- Introducing a new higher rate of duty for high strength beer over 7.5% Alcohol By Volume (ABV) and a new lower rate of duty for beer at 2.8% ABV and below to align duty more closely to alcohol strength.[36]

42. The Government notes, however, that

> as there is such a strong link between price and consumption, we need to go further still to end the irresponsible promotion and discounting of alcohol.... We will

33 Ev 76

34 Q112

35 Ev w174

36 Alcohol Strategy, paragraph 2.5

> introduce a minimum unit price (MUP) for alcohol meaning that, for the first time ever in England and Wales, alcohol will not be allowed to be sold below a certain defined price. We will consult on the level in the coming months with a view to introducing legislation as soon as possible.[37]

No figure is suggested for the minimum price in the body of the Strategy, but the Prime Minister, in his introduction, says "if [the minimum price] is 40p that could mean 50,000 fewer crimes each year and 900 fewer alcohol-related deaths a year by the end of the decade."

43. Written evidence to the Committee reveals a clear divide on this issue between industry and health bodies. For example, the Wine and Spirit Trade Association is outspoken on price, saying that:

> The WSTA is opposed to a policy of minimum unit pricing both in principle and in practice. There is no evidence to prove that it will tackle alcohol misuse yet it will raise prices for consumers who do not have a problem with alcohol. A 40p minimum unit price will hit the poorest 30% of households in England and Wales the hardest... It is inconsistent with the operation of the free market for the state to intervene on price. Minimum pricing could therefore represent a barrier to trade and be illegal under EU law.[38]

44. The question of the legality under European law of a minimum unit price was also raised by the Office of Fair Trading:

> ... it is...important to distinguish between the current proposal for a statutory minimum price unilaterally imposed by Government, and the alternative of a voluntary agreement between retailers to agree prices (with or without Government encouragement). A voluntary agreement on price would almost certainly infringe [The Competition Act 1998] and European competition law.
>
> There may be constraints on minimum pricing legislation arising from wider European law. For example, minimum pricing legislation may raise issues of compatibility with European free movement rules. The OFT does not have jurisdiction over these areas of law – enforcement takes place at the European level. The OFT understands that this is currently a live issue in relation to proposals for minimum alcohol in Scotland, and it is possible that there may be legal action which would clarify the position.[39]

45. In its written evidence the Department told us:

> There are a number of issues to consider when implementing minimum unit pricing. The Government continues to take legal advice and will consider any potential legal

37 Alcohol Strategy, paragraphs 2.7 and 2.8.

38 Ev w101 and 102

39 Ev w16 and 17

> implications as we take forward this proposal and consult on a proposed level of minimum unit price.[40]

46. The British Beer and Pub Association (BBPA) in its memorandum notes that "The BBPA's membership has a range of views on the subject of minimum pricing", but overall expresses a cautious view:

> Whilst there is clearly a relationship between alcohol pricing and alcohol consumption, evidence of a link between pricing and harmful consumption is less well established. Are the heaviest drinkers affected by increased prices? The Sheffield study, in line with most international evidence, found that the heaviest drinkers are least responsive to changes in price.
>
> The BBPA believes that it is important that alcohol should be retailed in a manner that is socially responsible and supports a ban on below-cost selling...Whilst minimum pricing might cut the differential between the price of beer in a supermarket or pub, it must not be seen as the answer to pub closures which are clearly down to high taxation. Minimum pricing is, by definition, a blunt tool and clearly the higher the minimum price the greater the impact on the vast majority who enjoy alcohol responsibly; particularly those on the lowest incomes.[41]

Not all of the industry is opposed to minimum unit pricing, however. In evidence to us both Greene King[42] and Waitrose[43] strongly supported its introduction.

47. Professor Brennan's explanation of his research did not support the BBPA interpretation of his group's findings on the effects of price:

> The key advantage of minimum pricing, from a targeting perspective, is that it is, in the data, the harmful drinkers who tend to drink more of the cheaper alcohol. Compared to putting general prices or general taxes up, putting a minimum price means that it is the harmful drinkers who are disproportionately affected by the policy. Those are the kinds of analyses that we have done.[44]

48. Alcohol Health Alliance UK says that:

> The AHA strongly supports the Government's commitment to introduce a minimum price on alcohol in England and Wales. This step acknowledges the clear relationship between price and the consumption of alcohol and associated harms, which is supported by substantial and robust evidence and modelling...Minimum unit pricing is particularly important in helping to address alcohol consumption's contribution to chronic disease and will primarily target harmful and hazardous drinkers, with comparatively little impact on the spending of moderate drinkers[8] Evidence shows that it is the cheapest alcohol that is causing high levels of harm – in

40 Ev 67

41 Ev 91

42 Ev w160

43 Ev w92

44 Q 21

> the UK on average, harmful drinkers buy 15 times more alcohol than moderate drinkers, yet pay 40% less per unit.[45]

49. Canada already has a minimum price for alcohol, so we asked about the evidence of its effects there. Professor Brennan told us:

> Canada has had a minimum pricing policy for quite some time and its differential in different states has changed at different time points. It is quite clear that when they have changed their minimum price there has been a direct impact on consumption. Once they have had this policy for a while and they ratchet it up a little bit, or put it down, consumption follows quite quickly in terms of decreases and increases.[46]

50. Given the policy commitment to introduce a minimum price, it is the level at which it should be set that was the subject of greatest discussion in evidence. Most of those giving evidence to the Committee who commented on price argued in favour of a minimum unit price of more than the 40 pence[47] mentioned in the Prime Minister's forward to the strategy (although there is no statement of the anticipated level of the unit price in the document itself).

51. The Scottish Government announced on 14 May that it is proposing to introduce a minimum unit price of 50 pence. The Scottish Health Minister, Nicola Sturgeon MSP, said that

> We have a big package of measures that are addressing the problems Scotland has with alcohol misuse so minimum pricing is by no means the only part of the solution, it's not a magic bullet... But there is plenty of evidence that says unless you have a pricing mechanism at the heart of the package of measures, then that package of measures is not going to be as effective as it would otherwise be.[48]

52. The Scottish Parliament Bill which establishes a minimum price per unit provides that the power to set a minimum price will expire after six years unless the Scottish Ministers bring forward an order to continue it, which they may only do in the sixth year (the so-called "sunset clause").[49]

53. The Minister told us:

> I cannot tell you where we are heading [on unit price] because it would be premature to do so until we are at the end of [the consultation]... It is important to set it at a level at which it is effective. That is the thing. We know that alcohol is, to a greater or lesser extent, price sensitive, so it is important to have something that is effective. I go back to what I said earlier, that it has to be evidence based.[50]

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45 Ev 98–9

46 Q 33

47 For example, the Institute for Social Marketing, Stirling University Ev w7

48 *Minimum drink pricing 'more effective'*, BBC News, 14 May 2012. http://www.bbc.co.uk/news/uk-18062406

49 SP Bill 4B, Alcohol (Minimum Pricing) (Scotland) Bill [as passed] Session 4 (2012), section 1A.

50 Q 380

54. **The Committee welcomes the Government's decision to introduce a minimum unit price for alcohol.** It is, however, struck by how little evidence has been presented about the specific effects anticipated from different levels of minimum unit price. The proposition that demand for alcohol is relatively price-elastic seems uncontroversial. **Rather than relying on generalised statements about the effect of price on consumption, the Committee urges the Government to build its case for a minimum unit price by establishing direct links: between specific alcohol products and specific alcohol-related harms; between different levels of minimum unit price and the resulting selling prices for the products which are linked to alcohol-related harms; and the likely effect of different levels of selling prices for those products on demand for those products in the target range of households.**

55. **Given the Government's decision to introduce a minimum unit price, the debate has been about the level at which it should be set– whether it should be 40, 45 or 50 pence – but the setting of a minimum unit price will not be a one-off event. Once a minimum price is introduced, if it is judged to be successful, the level will need to be monitored and adjusted over time. A mechanism will need to be put in place in order to do this, but as yet there has been no indication from the Government of what it intends to do other than to consult on the price. One way of setting the level would be to establish an advisory body (there are a number of these already, dealing with a range of issues)[51] to analyse evidence and make recommendations to Government. Whatever mechanism is chosen should be used when setting the initial level of the minimum unit price to ensure that from the beginning the price is clearly evidence-based.**

56. It has already been announced that the minimum unit price to be introduced in Scotland will be 50 pence per unit. There are practical arguments in favour of the same minimum price being set in England to avoid the problems with cross-jurisdiction trading that we refer to later when we discuss the case for banning multi-buy promotions. Our main concern, however, is that the level of minimum price that is set should be evidence-based and designed to be effective. **If the minimum unit price in England were to be fixed at a different level to that in Scotland, we would expect the evidence supporting that decision to be set out clearly. This is another argument in favour of establishing a transparent mechanism for setting the price.**

57. **We recommend that there should be a "sunset clause" on any provisions for setting a minimum unit price for alcohol, and that a decision by Government to make a minimum price permanent should be taken following advice from the advisory body or other mechanism used to monitor and adjust the price during the initial period.**

58. **Throughout this section of the report we have emphasised the need for the decision on minimum price to be evidence-based. The debate so far is based almost entirely on the work of the Sheffield Alcohol Research Group, though research from Canada has become available more recently. It is not a criticism of the integrity of that research to say that, if there is to be a minimum unit price, a more substantial evidence base needs**

51 http://www.dh.gov.uk/health/about-us/public-bodies/advisory-bodies/

to be developed in the future to help in the assessment of whether the minimum unit price is achieving the anticipated benefits.

Multibuys

59. The Strategy says that:

> We will...consult on a ban on multi-buy promotions in the off-trade (shops) meaning that multiple bottles or cans could not be sold cheaper than the multiple of one bottle or can. This would put an end to any alcohol promotion or sale that offers customers a discount for buying multiple products in stores and therefore those that encourage and incentivise customers to buy larger quantities than they want.[52]

60. The Alcohol Health Alliance welcomed this move:

> The AHA strongly supports this ban. The University of Sheffield modelling shows that increasing restrictions in off-trade discounting (ie through multibuys) does have increasing effects in a similar way to minimum pricing. Restrictions to 40%, 30%, 20% and 10% discounting give estimated consumption changes of -0.1%, -0.3%, -1.6%, -2.8% respectively. A 2.8% reduction in consumption is similar to the change estimated for a 40p minimum price.[53]

61. The Advertising Association, representing the advertising industry, was not convinced. It said:

> We do not believe multi-buy alcohol promotions are inherently irresponsible; consumers are used to such multi-buy promotions in respect of many different goods and services. The focus should not be on banning a form of marketing, but rather on ensuring that all forms of marketing are undertaken in a responsible manner. We will respond to this consultation when launched by the Government but in the meantime we urge the Government to ensure that any proposals are proportionate and evidence-based.[54]

62. A ban on multi-buy promotions came into effect in Scotland in October 20911. Alcohol Focus Scotland told us that

> Experience in Scotland shows that to ensure maximum effectiveness, the ban on multi-buy discounts should be implemented alongside minimum pricing and across the UK. A ban on multi-buy discounts came into force in Scotland on 1st October 2011 with the implementation of the Alcohol etc. (Scotland) Act 2010. During the first weekend of the new legislation being implemented, a number of the major supermarkets sought to undermine the spirit of the Act by encouraging online purchasing of alcohol from distribution centres in England.
>
> Moreover, many of the major supermarkets slashed their prices when the ban came into effect in Scotland. The Grocer magazine published figures which showed that

52 Government's alcohol strategy, paras 2.9 .

53 Ev 99

54 Ev w147

> whilst supermarket multi-buys had disappeared, the number of products on price reduction promotions in the first four weeks following the ban period rocketed from 753 to 1,178. Whilst legal, these practices call into question the large supermarkets' claims to be responsible retailers and reinforce the case for a ban on multi-buy discounts to be introduced in conjunction with minimum unit pricing.[55]

63. The Minister told us that the consultation on multi-buy promotions would be on the principle of whether they should be banned.[56] When asked if it would cover selling wine by the case. as an example, she told us: "That is the one representation that I have already had, whether the newspaper offers, for instance, would be affected...".[57]

64. **This evidence does not convince us that a ban on multibuys is either desirable or workable. The proposed minimum unit price will provide a floor price for the sale of alcohol, including discounted sales. The Committee supports the principle of setting the minimum unit price at a level which is effective at reducing identified alcohol-related harm; it believes that an attempt to outlaw well-established and convenient retailing techniques for alcohol products, regardless of price level, would simply create opportunities for retailers to find innovative and newsworthy work-arounds which would invite ridicule and bring the wider policy objective into disrepute.**

Challenging the industry to act responsibly

65. It is an old truth that with freedom comes responsibility. That is true of freedom of speech as it is of all other forms of freedom, and it is true of advertisers, as it is of all other forms of speech.

66. **Messages contained in alcohol advertisements play an important part in forming social attitudes about alcohol consumption. The Committee believes that those involved in advertising alcoholic products should accept that their advertisements contain positive messages about their products and that these messages are supported by considerable economic power. If this were not the case it is not clear why shareholders should be content for their companies' resources to be spent in this way. Since it is true, however, it is important that the alcohol industry ensures that its advertisements comply in all respects with the principles of corporate social responsibility. Closer definition of these principles as they apply to alcohol advertising is a key objective of the Government's Responsibility Deal.**

67. The Strategy argues that:

> We are clear that it is not just the responsibility of Government or local agencies to tackle the issue of alcohol-related harm. It is the ethical responsibility of the entire industry – alcohol retailers, alcohol producers and both the on-trade and off-trade – to promote, market, advertise and sell their products in a responsible way. This is recognised by the major alcohol producers, who have established the Portman Group as a self-regulator. We are working with the industry in collaboration with

55 Ev w19

56 Q 401

57 Q 402

Non-Governmental Organisations (NGOs) through the Responsibility Deal, which does not cover pricing issues or other measures that only Government can take.[58]

68. The Department of Health memorandum says that:

> Both the Alcohol Strategy and *Healthy Lives, Healthy People* make clear that everyone has a part to play in improving public health, including Government, business, the third sector and individuals themselves. We have made clear from the start that the Responsibility Deal is just one strand of the Government's wide public health policy. It is part of our wider strategy to achieve responsible growth where economic development and businesses' role in improving health and wellbeing go hand in hand.
>
> Priorities for action to improve public health are defined by Government; and informed by research, advice from scientists, health professionals and others. But this does not mean that Government is necessarily best placed to deliver them. **The Public Health Responsibility Deal** is a new mechanism to deliver on these priorities.
>
> The Responsibility Deal taps into the potential for businesses to improve public health through their influence over food, physical activity, alcohol, and health in the workplace. These are areas where 'doing nothing' simply isn't an option, but the 'something' to be done is not necessarily best done by Government. However, that is not to say that Government does not have a role. The role of Government in this case is to facilitate action and to build the partnerships that will enable genuine advances to be made in a way that is consistent with the public health needs of the country.[59]

69. The Portman Group says that:

> The Responsibility Deal is the right approach. It enables industry to deliver practical measures quickly to effect positive behaviour change. It encourages local partnerships to reduce anti-social activity and uses innovative consumer marketing and education programmes (eg the industry-funded Drinkaware) to communicate the Government's sensible drinking guidelines and promote responsible behaviour.

70. The BBPA also supports this approach:

> BBPA believes the industry has a key role in addressing alcohol-related harms. Our members have an inherent interest in the responsible consumption of their products and believe that beer is there to be enjoyed and pubs are the home of sociable and responsible drinking. Industry expertise can be harnessed, as is being demonstrated through the [Public Health Responsibility Deal] and campaigns such as "Why Let The Good Times Go Bad?", to ensure the right consumer reach to raise awareness, encourage a responsible attitude to alcohol and provide the information to make informed decisions.

58 Alcohol Strategy, paragraph 4.3

59 Ev 63–4

71. Brigid Simmonds from the BBPA and Henry Ashworth from The Portman Group both noted that there is evaluation group as part of the Responsibility Deal to assess the effectiveness of the work it is doing.[60]

72. The Government notes in the strategy a recent pledge by the industry through the Responsibility Deal to take one billion units out of the market by 2015.[61] Brigid Simmonds told the Committee:

> That is being done in a number of ways. I have one major member of the BBPA who is reducing the strength of its three main premium lagers from 5% to 4.8%. That will take a million units from the market. We are obviously introducing newer, lower-strength beers—you will be aware that the Government reduced taxation for 2.8% beers—and we have over 30 brands out there which will be creating that change over a period of time.[62]

73. Henry Ashworth added that:

> We are also going to be looking at some behavioural trials to see what happens when you change, for example, the alcohol strength of a bottle of wine from 14% to 12%, or if a beer product, for example, came down from 5% to 4.5%. The behavioural assumptions are that people will continue to drink the products that they enjoy because they enjoy the drink and are loyal to the brand. Brand marketing is going to be crucial in the delivery of this unit reduction pledge. It will take a significant number of units out of the market and enable the growth of a lower-alcohol market. We may well be looking back in five years time and saying that this was a paradigm shift.[63]

74. Professor Gilmore expressed reservations about the drinks industry having a role in policy development:

> It is very difficult to get away from the conflict of interest of industry. There are areas where they can make a contribution, making sure that existing regulations as to serving underage drinkers and people that are drunk and so on are adhered to, but I have always had concerns about industry getting round the table to discuss how you produce a public health strategy for alcohol because you cannot get away from the conflict of interest. The same applies to supermarkets.[64]

75. The Minister told us:

> ...it is not the role of the industry to develop or dictate policy. It never has been and it will not be. Priorities and policy should be informed by research, advice and evidence. However, we would be crazy to ignore the reach that business has. I think 17 million families use the supermarkets every week, so the opportunities to

60 Q 214

61 Alcohol Strategy, para 4.8.

62 Q 214

63 ibid

64 Q 39

> influence are very great. The Responsibility Deal, which is where industry, NGOs and we come together, is an opportunity to persuade industry to be responsible, if you like, to recast responsibility for the industry as doing something that is seen to be in the public good. It is an opportunity to add something. It is not a substitute for and it is not a forum for developing policy. Anything that we can do without legislation is quick and easy. What will be quite interesting is that with any of the pledges made by the Responsibility Deal...there could be evaluation of the Responsibility Deal. We could test how effective it has been, and it will be independent.[65]

76. **The Committee does not believe that participation by the alcohol industry in the Responsibility Deal should be regarded by anyone as optional – we regard it as intrinsic to responsible corporate citizenship. We welcome the willingness of the industry to address the harms that alcohol can cause – for example by tackling issues with licensed premises through the formation of a business improvement district – but we believe that it should be clear that the Responsibility Deal is not a substitute for Government policy.**

77. **It is for the Government, on behalf of society as a whole, to determine public policy and ensure that a proper independent evaluation of the performance of the industry against the requirements of the Responsibility Deal is undertaken. We recommend that such an evaluation is commissioned by Public Health England. We will be particularly interested to see the assessment of the effect of reducing the alcohol level in certain drinks. We do not believe that reducing the alcohol in some lagers from 5% to 4.8%, for example, will have any significant impact. If the industry does not bring forward more substantial proposals than this it risks being seen as paying only lip service to the need to reduce the health harms caused by alcohol.**

Expectations within the Responsibility Deal

78. It is important to be clear about expectations of the industry within the Responsibility Deal. The Strategy says that:

> There is known to be a link between advertising and people's alcohol consumption, particularly those under the age of 18. Some countries have introduced a complete ban on alcohol advertising (Norway) or a ban on TV advertising with other controls (France) to tackle this. So far we have not seen evidence demonstrating that a ban is a proportionate response but we are determined to minimise the harmful effects of alcohol advertising.[66]

The Government proposes a number of initiatives, including:

- Work with the Portman Group to ensure that where unacceptable marketing does occur, it results in the removal of offending brands from retailers.

65 Q 423

66 Alcohol Strategy, paragraph 2.12

- Work with the ASA and Ofcom to examine ways to ensure that adverts promoting alcohol are not shown during programmes of high appeal to young people.
- Work with the ASA to ensure the full and vigorous application of ASA powers to online and social media and work with industry to develop a scheme to verify people's actual ages which will apply to alcohol company websites and associated social media.
- Work with the ASA and other relevant bodies to look at the rules and incentives that might inhibit the promotion of lower strength alcohol products.[67]

79. Alcohol Concern in its briefing comments that "[Alcohol Concern] knows from our own work with our Youth Advertising Advisory Council on alcohol that marketing has a strong impact on young people. We will be seeking to work with the Government on these issues to ensure we have robust policing in place that protect young people from the pressures of £800m of yearly advertising spend on alcohol."

80. The Institute for Social Marketing at the University of Stirling told us:

> The promotion of alcohol is extremely widespread and young people in particular are inundated by pro-drinking messages. This advertising has been shown to have a direct effect on both the age at which drinking starts and the amount consumed – reducing the former and increasing the latter. Despite this evidence, there are no proposals in the strategy to reduce the amount of alcohol advertising, or even to introduce a degree on independence into the regulatory process. Instead it is business as usual, with an industry driven focus on content regulation – and approach which lacks any evidence base and has been shown to fail. Nowhere is this complacency more apparent than with online advertising, which the strategy treats as a mere extension of current promotion. In reality it completely changes the landscape, with young people not just being marketed to, but being recruited as a peer to peer brand advocates, unwittingly feeding marketing campaigns with their personal details and generating their own promotional content. How, for example, can the current regime of content controls deal with this last phenomenon? And the talk in the strategy of better age restrictions on digital marketing is simply fanciful. Digital marketing has to be treated much more seriously.[68]

81. The Portman Group says that:

> Critics believe alcohol marketing encourages people, particularly under 18s, to start drinking earlier or to drink more. However, official statistics show fewer young people (16–24) and children (11–15) are drinking...
>
> The influence of marketing on alcohol consumption is subject to various studies. Whilst there is longitudinal research showing a modest relationship between marketing exposure and drinking among young people, the strength of association varies between studies...

67 Alcohol Strategy, page 9.

68 Ev w8

> Furthermore, the marketing impact on young peoples' drinking behaviours is likely to be outweighed by other factors (such as family environment, peer behaviour, socioeconomic status, and personal attitudes.[69]

82. It also says that it is reviewing these issues:

> The Strategy has asked us to look at other ways to tighten self-regulation around retail, sponsorship and marketing. These are being addressed in our Code review.
>
> The Strategy has also given a clear mandate to ASA and Portman Group to review any advertising rules which currently inhibit the promotion of lower strength alcohol products; this is being addressed by our Code review.

83. The BBPA argues along similar lines:

> The UK has some of the tightest restrictions on the marketing of alcohol in the world, particularly designed to avoid exposing children and young people to alcohol advertising. The large decline in youth consumption over the period that self-regulation has been in place serves as proof that alcohol advertising is not encouraging children to consume alcohol.
>
> Research into the link between advertising and alcohol consumption remains inconclusive, and many studies have found no correlation. For example, a study by Gerard Hastings at the University of Stirling found no association between awareness of alcohol marketing at age 13 and either the onset of drinking, or the volume of alcohol consumed two years later.[70]

84. This issue of interpretation of the findings of the Institute for Social Marketing's research came up in the Committee's inquiry into public health in the previous session of Parliament. It was stated in evidence that the research

> found no association between awareness of alcohol marketing, the onset of drinking or how much the youngsters drank between the ages of 13 and 15. The study was designed to prove that alcohol marketing increases or has an effect on youngsters drinking; in fact, it proved the opposite.[71]

85. We asked Professor Hastings to comment on that statement. He told us:

> The peer-reviewed journal article published by my research team clearly demonstrates an association between response to alcohol advertising and marketing at age 13 and initiation of drinking and increased frequency of drinking by age 15. The interpretation given...appears to rest on a misunderstanding of the research methodology.[72]

69 Ev 105

70 Ev 91

71 Q 256, Health Committee, 21 June 2011, Public Health, HC 1048-II

72 Footnote to Q 257, ibid

86. **The Committee is concerned that those speaking on behalf of the alcohol industry often appear to argue that advertising messages have no effect on public attitudes to alcohol or on consumption. We believe this argument is implausible. If the industry wishes to be regarded as a serious and committed partner in the Responsibility Deal it must acknowledge the power of its advertising messages and accept responsibility for their consequences.**

87. **The industry will take a significant step down this road when it makes it clear that alcoholic products should not be marketed in ways which address audiences a significant proportion of whom are aged under 18, and cannot therefore legally purchase the product.**

Existing precedents

88. There are already regimes in place in some sectors which the Committee thinks could be implemented more widely. Ofcom described the way in which television advertisements for alcohol are regulated:

> Scheduling rules already limit where alcohol advertisements may appear in the schedules. Alcohol may not be advertised in or adjacent to children's programmes or programmes commissioned for, principally directed at or likely to appeal particularly to audiences below the age of 18.
>
> Since 1999 a system of "indexing" has helped to prevent adverts being directed at children. A programme of "particular appeal" to children is deemed to be one that attracts an audience index of 120 for this age group. If a programme attracts an under-16 audience in a proportion similar to that group's presence in the viewing audience as a whole, it is said to index at 100. So an index of 120 is an over-representation of that group by 20 percent. For example, the proportion of 10–15 year olds in the viewing population is 8.24 percent, so any programme where more than 9.84 percent (8.24 x 1.2) of the audience is made up of 10–15 year olds would not be allowed to carry alcohol advertising in or around it.
>
> In other words, if the audience for a programme is expected to contain a disproportionately large number of young people, the broadcaster cannot place alcohol adverts in or around it. This is a more targeted approach than a pre-watershed ban as it hones in on specific programmes appealing to young people regardless of what time they appear in the schedule. For example *Glee* is broadcast after 9pm on Sky One, but alcohol advertisements cannot be placed in or around it because of the disproportionately high number of young people watching the show.[73]

89. It is useful to contrast this with the so-called CAP code,[74] the industry's own regulations on advertising in non-broadcast media. Specifically on the issue of alcohol and young people under 18, it says:

73 Ev w154

74 The UK Code of Non-Broadcast Advertising, Sales Promotion and Direct Marketing, produced by the Committee of Advertising Practice

> Marketing communications must not be directed at people under 18 through the selection of media or the context in which they appear. No medium should be used to advertise alcoholic drinks if more than 25% of its audience is under 18 years of age.[75]

90. The Advertising Association told us:

> Further to these exposure rules based on percentages, the [Cinema Advertising Association] also takes other steps to reduce the incidence of youth exposure to alcohol advertising. For example, unless the film is '18' certificate, the CAA takes the view that all releases featuring comic book characters in a central role are not permitted to carry alcohol advertising, given the potential appeal of those characters to younger audiences. This has meant that a number of highly successful films – including *Marvel Avengers Assemble*, which is currently making box office records, cannot carry alcohol [advertising]. Similar data analysis has meant that "gross out" comedies receiving '15' certificates rarely carry alcohol advertising.
>
> It is also essential to also note that many films that are popular with adults are lower certificate films, for example *The Best Exotic Marigold Hotel.* This film received a 12a certificate but, as the majority of its viewership was middle-aged or older, it would be wholly disproportionate to have banned alcohol advertising around this film.[76]

The CAP code therefore does provide protection against the marketing of alcohol to those under the age of 18, but to a lesser extent than the Ofcom broadcast code and on an entirely voluntary basis.

91. **Advertising of alcoholic products on television is subject to rules which are relatively targeted and sophisticated. The Committee believes there is scope to apply these principles more widely – for example in cinemas – and recommends that this principle be reviewed in the context of the Responsibility Deal. Serious consideration should be given to reducing to 10% the proportion of a film's audience that can be under 18 and still allow alcohol to be advertised, or to prohibiting alcohol advertising in cinemas altogether except when a film has an 18 certificate.**

Drinkaware

92. Education and public awareness campaigns clearly have a part to play in attempts to change people's behaviour and drinking habits. Drinkaware, established in 2007, exists to provide "consumers with information to make informed decisions about the effects of alcohol on their lives and lifestyles. Our public education programmes, grants, expert information, and resources help create awareness and effect positive change."[77] It also told us that:

> Drinkaware is entirely funded by voluntary donations from across the drinks industry, but operates completely independently from it. Our board is made up of

75 CAP code, paragraph 18.15

76 Ev w148

77 Ev 93

> five members of the health community, five members of the drinks industry and three independents. This structure enables the organisation to act independently whilst being fully funded through voluntary donations from industry.
>
> Our behaviour change campaigns are designed using an evidence-based approach. Drinkaware provides consumers with best evidenced information and facts about alcohol. Our independent medical advisory panel checks all information, web, and printed materials to ensure their accuracy and that it reflects the most current evidence.[78]

93. Chris Sorek, Chief Executive of Drinkaware, said that the organisation was

> looking at the demand side...changing people's demand for alcohol—changing their behaviour as to why they want to drink and what they are drinking—is something that we are focusing our attention on. What we are trying to do is reduce the amount of alcohol that parents give to their children. If they followed [Chief Medical Officer's] guidance you would not see the average age of first drink at 13.8 years. You would see it at 15, which is what CMO guidance says. That says that there are quite a few parents who are giving alcohol to children at a much earlier age. If you take a look at what we are doing with adults, we are trying to talk to them about units and unit guidelines. What they will then do is reduce the amount of alcohol they are drinking on a daily basis.[79]

94. Chris Sorek stressed that Drinkaware is an independent charity[80], but its role is seen by some as compromised because of its links with the alcohol industry. The British Medical Association told us that

> The involvement of the Drinkaware Trust in providing public health communications is a significant area of concern. This form of industry social marketing is counterproductive because industry responsibility campaigns are less effective than ones from other sources, keep messages in a commercial comfort zone, and distract attention away from more effective measures to regulate alcohol use. Industry-related messages about alcohol have been found to subtly enhance sales and company reputations. This is despite the fact that the public is cynical about the motives of corporate sponsors, and that non-governmental organisations make a more effective and credible source.[81]

95. In the Alcohol Strategy, the Government says that through the Responsibility Deal it expects to see progress on

> A long-term commitment (through to 2020) to an increased scope and funding for Drinkaware, including how it can best direct interventions to the target groups.

78 ibid

79 Q 101

80 Q 70

81 Ev w81

> There is a strategic review this year of Drinkaware and the Government will participate to seek to maximise its effectiveness and accountability.[82]

96. **The Committee believes that it is right that the industry should support education and awareness campaigns about the harms that alcohol can cause, and doing so through a separate organisation such as Drinkaware seems appropriate in principle, but the independence of the organisation is vital. The value of this contribution is likely to be very limited if the campaigns it promotes are considered to be constrained by industry links.**

97. **We acknowledge that the Board as presently constituted has a majority of non-industry Members, and we welcome that fact. Nevertheless, if Drinkaware is to make a significant contribution to education and awareness over the coming years its perceived lack of independence needs to be tackled, and as part of the review that is to be held this year the Committee recommends that further steps are taken to entrench that independence.**

Loi Evin

98. A number of submissions drew our attention to the French *Loi Evin* as an example of an effective way of regulating alcohol marketing. For example, the National Heart Forum said:

> The NHF recommend a UK adapted version of *Loi Evin* – a French regulatory framework that allows alcohol marketing and promotion only in media where adults are at least 90% of the audience. The Loi Evin model...provides a simple framework that can offer clarity on what marketing practices are and are not allowed. Under this model, the promotion of alcohol would be explicitly restricted to: media that adults use; at point of sale in licensed premises; and at local producer events.[83]

99. The *Loi Evin* was introduced in 1991. Its provisions are that:

- all drinks over 1.2 per cent alcohol by volume are considered as alcoholic beverages. Places and media where advertising is authorised are defined:
- no advertising should be targeted at young people;
- 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. When advertising is permitted, its content is controlled:
- messages and images should refer only to the qualities of the products such as degree, origin, composition, means of production, patterns of consumption;

82 Alcohol Strategy, para 4.10

83 Ev w63

- a health message must be included on each advertisement to the effect that "l'abus d'alcool est dangereux pour la santé": alcohol abuse is dangerous for health.[84]

100. In its evidence the Institute for Social Marketing at the University of Stirling told us that the Government's Strategy:

> misrepresents the *Loi Evin* as a ban on advertising. It is nothing of the kind. Rather it is exactly the type of imaginative response to a major public health problem that the UK lacks, and it simply ensures that alcohol advertisers behave responsibly by a) restricting their messages to verifiable statements of fact b) making sure these messages only reach adults. If the Government could not bring themselves to learn from this excellent cross-channel experience, there were a number of intermediate steps they could and should have taken, including: prohibiting alcohol advertising on television before the watershed; limiting or prohibiting sponsorship of sport; and requiring health promotion messages to be screened before programmes or films promoting drinking.[85]

101. **Although the precise terms of the *Loi Evin* reflect the circumstances of a different society at a different time, the Committee believes that the approach adopted in the French legislation merits serious examination in the English context. In particular the Committee recommends that Public Health England should commission a study of the public health effect which would be delivered in the UK by adopting the principles of *Loi Evin*; such a piece of work would provide a valuable reference point for the evaluation of the effectiveness of the Responsibility Deal which the Committee has recommended should also be undertaken by Public Health England.**

Local responses

102. The Strategy encourages local agencies to take responsibility for tackling alcohol-related problems in their areas. As it says in chapter 3:

> Local communities, services and businesses are best placed to tackle alcohol-related issues in their area and enforce the behaviour and develop the cultures that they want.

103. We took evidence from people involved in developing and implementing the strategy in Birmingham to see how one locality is dealing with the problems alcohol causes Jacqui Kennedy, Director of Regulation and enforcement at Birmingham City Council told us:

> Our strategy is very much an holistic approach to alcohol harm in Birmingham. We have based it on the framework that was the national strategy because we felt that that gave us the golden thread from neighbourhoods through to the national strategy. We have tried to consider the implications around health, crime and disorder, young people and antisocial behaviour. The strategy has tried

84 The *Loi Evin*: a French exception: Dr Alain Regaud, Dr Michel Craplet http://www.ias.org.uk/resources/publications/theglobe/globe200401-02/gl200401-02_p33.html

85 Ev w8

> systematically to structure a response to alcohol harm, and there are benefits associated with that.
>
> The new strategy has very strict and strong governance around it. It is responsible and accountable through the Health and Wellbeing Board; it is accountable through the community safety partnership board; and it is also responsible through a corporate management team of the local authority. The city council is the sort of guardian for it, but all those partnerships are absolutely key to govern how we deliver because the strategy has been developed, again, with another strong delivery plan underpinning it and each of the partners is called to account as part of a scrutiny approach to make sure that we deliver against the plan. It is very much business as usual.[86]

104. The Birmingham team reported some significant successes in the development of their services. We were told, for example, that there are no waiting lists in Birmingham for NHS patients referred to specialist alcohol services and that the establishment of business improvement districts in the two main night time economy areas had helped address issues of crime and antisocial behaviour. The costs are also contained within 'normal' activity. As Jacqui Kennedy said:

> ...this is our day job. It is linked into licensing, trading standards and environmental health. It is the day job. It is not a specially-funded activity.[87]

105. We were told that, having set specific targets for the strategy, there is also a structured monitoring plan in place in Birmingham to assess how well the aims of the strategy are being implemented. Barry Everleigh, of the Birmingham Drug and alcohol Action Team said "We are looking at six monthly reviews from creation of the strategy, and then a lower level with the providers, on a monthly and quarterly basis."[88]

106. **Birmingham is one example of local action that has been drawn to our attention during the inquiry, and it does demonstrate how local agencies can put together an effective action programme without the need for a substantial additional bureaucratic support structure. This model of local action, linking in with national priorities, makes sense as a pragmatic, practical way of addressing serious problems. As we recommended earlier in this report, Public Health England should use this model as the template for all local areas to address the various problems that alcohol causes in their communities, and to link local objectives to those at the national level. Central Government cannot direct a local area to address alcohol problems in a particular way, but the new public health structures, in which local authorities have a key role, should provide the opportunity to establish a national framework of local initiatives.**

Treatment Services

107. The NHS Confederation told the Committee:

86 Qq 229 and 230

87 Q 273

88 Q 276

> The increase in alcohol abuse in the UK has resulted in an increased demand for NHS services. It was already costing the NHS £2.7 billion a year in 2006/07 (the most recent year for which figures are available) and demand has increased significantly since then. For example, alcohol related admissions to hospital more than doubled between 2002–03 and 2009–10, from 510,200 to 1,057,000. Difficulties in recording alcohol-related harm mean that the impact is likely to be even higher. The burden on the NHS will be unsustainable if demand continues to grow.
>
> With the pressure to react to a growing number of urgent needs, preventative and specialist services have struggled to keep pace with alcohol driven demand and hospitals have been bearing the brunt of the burden. In 2008 over 70% of the cost of alcohol to the NHS was spent on hospital treatment. Inpatient costs were almost 45% of the total NHS expenditure in alcohol related services that year compared to around 12% in 2001.

108. There are difficulties with treatment of people with alcohol-related problems. The Department of Health told us in its memorandum:

> While there has been some improvement in provision for treatment of people dependent on alcohol, it is very likely that there is still significant under-provision overall. We estimate that numbers of people in England mildly or severely dependent on alcohol rose by 24% between 2000 and 2007. Without the decisive steps we are taking through our strategy to end the availability of cheap alcohol and to strengthen local powers to prevent the growth of alcohol misuse, it is likely that needs for treatment would grow in the future.
>
> Levels of need vary greatly from place to place. It is right that plans for investment in alcohol treatment and prevention are for decision at local level. Our reforms to the NHS and Public Health will ensure a greater focus on commissioning of alcohol services to meet local needs.[89]

109. St Mungo's told the Committee that

> The Government appears to have recognised that services are not available for tens of thousands of people who are alcohol dependent and need support to recover. Although investment is needed urgently, we are yet to see any solid proposals around how this problem will be addressed. We are concerned that central Government's ability to deliver this investment will be curtailed as the assessment of need and decisions on commissioning are all taken locally.
>
> It is right that there is a focus on integrated services. People who are dependent on alcohol often have a range of complex needs that require holistic support, not a disparate collection of needs that can be treated sequentially. This is especially true for our clients, our latest client needs survey shows that 42 per cent of our clients with an alcohol problem also have a mental health problem and 50 per cent have a significant medical condition.

89 Ev 68

> NICE guidance makes clear that there should be services tailored to maximise engagement with the homeless population due to the extra complications that working with this group can bring. However, our clients often have to wait for weeks or months to access rehab services and our staff report that it is becoming more difficult for them to secure access to services.[90]

110. One of the main ways the Strategy suggests that health problems associated with alcohol could be reduced is through a process known as Identification and Brief Advice:

> Identification and Brief Advice (IBA) is a simple intervention aimed at individuals who are at risk through drinking above the guidelines, but not typically seeking help for an alcohol problem. IBA has been proven to reduce drinking, leading to improved health and reduced calls on hospital services. At least one in eight at risk drinkers reduce their drinking as a result of IBA. The National Institute for Health and Clinical Excellence (NICE) recommends that NHS health professionals routinely carry out alcohol screening as an integral part of their practice, focusing on groups at increased risk.[91]

111. In oral evidence, Eric Appleby and Professor Gilmore both supported the use of Brief Advice. Mr Appleby also supported the NICE guidelines as a model for treatment. Professor Gilmore emphasised that there is a role for treatment right through to the most serious cases:

> Right at the far end, with the heavily-dependent patients that unfortunately are often considered "no hopers", treatment is still effective and cost-effective. We only remember the ones that come back and not the ones that do well. It is very good that the strategy acknowledges that treatment works but it perhaps has not identified fully the levers that people can use locally to implement good care.[92]

112. The Medical Research Council and the Economic and Social Research Council, in a joint submission, told us;

> With three sets of NICE guidance on alcohol published in the last five years as well as a series of systematic reviews, there is now a body of evidence on the effectiveness of existing behavioural and cognitive approaches (such as intensive case management, motivational enhancement therapy and social network based therapies) as well as certain pharmacological interventions (e.g. acamprosate and disulfiram). Nevertheless, many of our advisors highlighted the lack of joined-up effective delivery and available appropriate expert services for drinkers, especially in 'real-world' settings. This is a key element of support that they felt was not fully addressed in the Government's alcohol strategy.[93]

113. The need to implement what are known to be effective alcohol care services was referred to in a number of submissions. The Royal College of Physicians called for

90 Ev w66–7

91 Alcohol strategy, paragraph 5.16

92 Q 58

93 Ev w113

> the full implementation of the NICE guidelines relating to alcohol dependence, which provide an excellent, evidenced-based guide to effective intervention, treatment and referral systems that involve a wide range of health professionals.
>
> The RCP recommends that there should be a multidisciplinary 'alcohol care team', a seven day alcohol specialist nurse service and an 'assertive outreach alcohol service' in every district hospital. Transitions between teams and services should be quick and seamless in order to increase the efficiency and cost effectiveness of the service.[94]

114. The Alcohol Health Alliance said that

> Healthcare modelling methodology suggests that if each district general hospital established a 7 day Alcohol Specialist Nurse Service to care for patients admitted for less than one day and an Assertive Outreach Alcohol Service to care for frequent hospital attendees and long-stay patients, it could result in a 5% reduction in alcohol-related hospital admissions, with potential cost savings to its locality of £1.6 million per annum. This would equate to savings of £393 million per annum if rolled out nationally.[95]

115. The British Society of Gastroenterology told us

> The dramatic impact of Alcohol Specialist Nurses (ASNs) during a 5-day working week highlights the need for them to work routinely on a 7-day basis in hospitals, especially since such a large proportion of alcohol-related problems present out-of-hours, particularly at weekends. Alcohol specialist nurses pay for themselves many times over, in terms of improved detection of alcohol misuse, accessibility, waiting times, [did not attend] rates, reduced inpatient detoxifications and length of stay, thus achieving 4-hour trolley waits, relieving bed pressures and reducing A&E attendances, admissions and readmissions...
>
> Implementation of an ASN service in Nottingham improved the health outcomes and quality of care of patients admitted to hospital for detoxification, and also of those admitted for the complications of alcohol-related cirrhosis (S.D.Ryder et al, 2010). Hospital admissions were reduced by two thirds, resulting in a saving of 36.4 bed days per month in patients admitted for detoxification. Clinical incidents were reduced by 75%. Liver enzyme abnormalities were halved and there was also a reduction in bed days used in the cirrhotic group from 6.3 to 3.2 days per month.[96]

116. When we asked about the under-provision of treatment services, Dr Mark Prunty, Senior Medical Officer, Alcohol and Drugs Programme, told us:

> At the moment, in treatment services, demand is relatively well met: 82% of people seen are starting treatment within three weeks, 54% of those successfully complete treatment and the numbers of new entrants into treatment are increasing. As I say, there is success. The experience within the services in general is that there has been

94 Ev w38

95 Ev 101

96 Ev w94–95

> improvement and there is continuing improved access. The difficulty, to some extent, is knowing the need and how you make that decision at a local level... In some areas there are much higher rates of hazardous and risky drinking—people who do not need treatment but would be very likely to benefit from interventions and brief advice—other areas which have higher levels of dependence and other areas which have higher levels of social deprivation and, therefore, more harm. So each area has to look at that information.
>
> How do local commissioners make that decision [about the level of service on offer] taking all those other factors into account? What is the evidence now for what is the balance? We have said we have a 1.6 million dependent population. In any one year you would not expect more than a minority of those to need treatment places because a large number of them are not ready to change yet. They need support, encouragement, assessment, access to services, IBA and all those things. So local commissioners have to balance all these different pieces of evidence to try to determine how best to focus resources in order to reduce their hospital admissions to meet their other local priorities on alcohol-related harm. Work will be published in 2014 which looks at a research-driven, evidence-based capacity model to try and help local commissioners to bridge that gap. The information is there. The question is how we help commissioners to make those decisions and invest in the areas that require that investment locally.[97]

117. **We welcome the work which the Department is undertaking to provide an evidence base to allow commissioners to make informed decisions about which models of treatment provision are most effective in addressing the health issues caused by alcohol abuse. In particular commissioners need evidence about the most effective form of early intervention in order to reduce the number of avoidable hospital admissions which currently represent avoidable illness for patients and avoidable costs for taxpayers. The evidence we received suggested that the establishment of Alcohol Specialist Nurse services throughout the country is one of those measures. The fact that over 70% of the costs to the NHS of alcohol-related services was spent on hospital treatment demonstrates the scale of the opportunity to restructure services to achieve better outcomes.**

97 Q 323

4 Conclusion

118. In the course of this Inquiry the Committee has been mindful of several, considerations, some of which are sometimes in conflict with each other:

a) The great majority of citizens enjoy alcoholic products without significant evidence of harm to their health;

b) Against that background, the business of supplying alcoholic products is an entirely legitimate business;

c) Alcohol is, however, a product which has the capacity directly to cause serious damage to individual health, and indirectly to cause to significant social problems primarily though law-breaking and family breakdown;

d) Proper understanding of the rights and responsibilities which underpin a free society therefore require a particular framework of responsibility around the supply and consumption of alcohol;

e) This framework of responsibility should be the subject of constant review in the light of changing evidence and attitudes;

f) The Committee welcomes the Government's Alcohol Strategy as a timely attempt to provide such a review and development of the framework;

g) The Committee offers this Report as a contribution to that process.

Conclusions and recommendations

Defining the problem

1. The Committee shares concerns about the social impact of binge drinking but we believe it is also important to ensure that the Government's strategy recognises and responds to the evidence of an increasing health impact of excessive alcohol consumption (Paragraph 6)

Why is it a matter of concern?

2. The establishment of Public Health England provides an important opportunity to analyse the true public health impact of alcohol consumption and adopt a package of policy responses which is evidence-based, as well as being carefully calibrated and targeted. (Paragraph 8)

3. Alcohol misuse affects a large number of people. The current annual death rate from alcohol-related conditions is more than three times that for deaths in road accidents, and the cost to the NHS of treating such conditions is around 3% of its annual budget. The Government's strategy is a welcome attempt to address some of these problems in a coherent way (Paragraph 20)

4. The main focus of the strategy is the need to address public order issues. We agree that these are important, but we believe that the health impact of the misuse of alcohol is more insidious and pervasive; the remainder of this report therefore focuses on ways in which those harms to health can be addressed. (Paragraph 21)

Objectives and targets

5. The Committee believes it is important to ensure that the objectives of policy on alcohol are clearly stated and calibrated. The great majority of citizens enjoy alcohol without significant evidence of harm to their health. The Committee accepts that it is not possible to define a level of alcohol consumption which is, in any absolute sense, safe for all citizens at all times. We do not believe, however, that this conclusion should lead to disproportionate or heavy handed controls which are justified neither by public support nor evidence of proportionate health gain. (Paragraph 22)

6. The Committee also believes that healthy societies expect all citizens, both corporate and individual, to exercise their individual freedoms in ways which respect the rights and interests of their fellow citizens and observe shared standards of responsible behaviour. It is part of the function of Government to stimulate, lead and if necessary regulate, in order to encourage the development of this culture. (Paragraph 23)

7. The Committee believes that an Alcohol Strategy should be seen as part of a wider public health strategy, and should contain some key quantified, alcohol-specific objectives which will provide both a framework for policy judgements and an accountability framework. (Paragraph 27)

8. We address in the report the issue of all local areas having an alcohol strategy, flowing from the national strategy but using local approaches to deal with local problems. It seems logical that Public Health England should oversee this process, given its overarching responsibility for public health matters. It also seems logical that Public Health England should devise the national measures against which the strategy can be tested. (Paragraph 28)

What is 'safe'?

9. Although we accept that it is a complicated issue, we regard a clearer, evidence-based definition of the health effects of alcohol consumption as fundamental to successful policy development in this area. The work of the Chief Medical Officer needs to be carried forward as a matter of urgency. Public Health England, acting independently of Government, then needs to use the outcome of the review as the basis for its promotion of public understanding of the issues, setting out the level at which harms are likely to result alongside sensible drinking guidelines. (Paragraph 36)

Binge drinking

10. Despite some perceptions that binge drinking is largely a public order issue, the evidence presented to us suggests that it does contribute to some of the long-term health harms that have concerned us. We conclude that these health problems need to be addressed no less urgently than problems with public order and anti-social behaviour. (Paragraph 40)

Minimum unit price

11. The Committee welcomes the Government's decision to introduce a minimum unit price for alcohol. Rather than relying on generalised statements about the effect of price on consumption, the Committee urges the Government to build its case for a minimum unit price by establishing direct links: between specific alcohol products and specific alcohol-related harms; between different levels of minimum unit price and the resulting selling prices for the products which are linked to alcohol-related harms; and the likely effect of different levels of selling prices for those products on demand for those products in the target range of households. (Paragraph 54)

12. Given the Government's decision to introduce a minimum unit price, the debate has been about the level at which it should be set– whether it should be 40, 45 or 50 pence – but the setting of a minimum unit price will not be a one-off event. Once a minimum price is introduced, if it is judged to be successful, the level will need to be monitored and adjusted over time. A mechanism will need to be put in place in order to do this, but as yet there has been no indication from the Government of what it intends to do other than to consult on the price. One way of setting the level would be to establish an advisory body (there are a number of these already, dealing with a range of issues) to analyse evidence and make recommendations to Government. Whatever mechanism is chosen should be used when setting the initial level of the minimum unit price to ensure that from the beginning the price is clearly evidence-based. (Paragraph 55)

13. If the minimum unit price in England were to be fixed at a different level to that in Scotland, we would expect the evidence supporting that decision to be set out clearly. This is another argument in favour of establishing a transparent mechanism for setting the price. (Paragraph 56)

14. We recommend that there should be a "sunset clause" on any provisions for setting a minimum unit price for alcohol, and that a decision by Government to make a minimum price permanent should be taken following advice from the advisory body or other mechanism used to monitor and adjust the price during the initial period. (Paragraph 57)

15. We have emphasised the need for the decision on minimum price to be evidence-based. The debate so far is based almost entirely on the work of the Sheffield Alcohol Research Group, though research from Canada has become available more recently. It is not a criticism of the integrity of that research to say that, if there is to be a minimum unit price, a more substantial evidence base needs to be developed in the future to help in the assessment of whether the minimum unit price is achieving the anticipated benefits. (Paragraph 58)

Multibuys

16. The evidence does not convince us that a ban on multibuys is either desirable or workable. The proposed minimum unit price will provide a floor price for the sale of alcohol, including discounted sales. The Committee supports the principle of setting the minimum unit price at a level which is effective at reducing identified alcohol-related harm; it believes that an attempt to outlaw well-established and convenient retailing techniques for alcohol products, regardless of price level, would simply create opportunities for retailers to find innovative and newsworthy work-arounds which would invite ridicule and bring the wider policy objective into disrepute. (Paragraph 64)

Challenging the industry to act responsibly

17. Messages contained in alcohol advertisements play an important part in forming social attitudes about alcohol consumption. The Committee believes that those involved in advertising alcoholic products should accept that their advertisements contain positive messages about their products and that these messages are supported by considerable economic power. If this were not the case it is not clear why shareholders should be content for their companies' resources to be spent in this way. Since it is true, however, it is important that the alcohol industry ensures that its advertisements comply in all respects with the principles of corporate social responsibility. Closer definition of these principles as they apply to alcohol advertising is a key objective of the Government's Responsibility Deal. (Paragraph 66)

18. The Committee does not believe that participation by the alcohol industry in the Responsibility Deal should be regarded by anyone as optional – we regard it as intrinsic to responsible corporate citizenship. We welcome the willingness of the industry to address the harms that alcohol can cause – for example by tackling issues

with licensed premises through the formation of a business improvement district – but we believe that it should be clear that the Responsibility Deal is not a substitute for Government policy. (Paragraph 76)

19. It is for the Government, on behalf of society as a whole, to determine public policy and ensure that a proper independent evaluation of the performance of the industry against the requirements of the Responsibility Deal is undertaken. We recommend that such an evaluation is commissioned by Public Health England. We will be particularly interested to see the assessment of the effect of reducing the alcohol level in certain drinks. We do not believe that reducing the alcohol in some lagers from 5% to 4.8%, for example, will have any significant impact. If the industry does not bring forward more substantial proposals than this it risks being seen as paying only lip service to the need to reduce the health harms caused by alcohol. (Paragraph 77)

Expectations within the Responsibility Deal

20. The Committee is concerned that those speaking on behalf of the alcohol industry often appear to argue that advertising messages have no effect on public attitudes to alcohol or on consumption. We believe this argument is implausible. If the industry wishes to be regarded as a serious and committed partner in the Responsibility Deal it must acknowledge the power of its advertising messages and accept responsibility for their consequences. (Paragraph 86)

21. The industry will take a significant step down this road when it makes it clear that alcoholic products should not be marketed in ways which address audiences a significant proportion of whom are aged under 18, and cannot therefore legally purchase the product. (Paragraph 87)

Existing precedents

22. Advertising of alcoholic products on television is subject to rules which are relatively targeted and sophisticated. The Committee believes there is scope to apply these principles more widely – for example in cinemas – and recommends that this principle be reviewed in the context of the Responsibility Deal. Serious consideration should be given to reducing to 10% the proportion of a film's audience that can be under 18 and still allow alcohol to be advertised, or to prohibiting alcohol advertising in cinemas altogether except when a film has an 18 certificate. (Paragraph 91)

Drinkaware

23. The Committee believes that it is right that the industry should support education and awareness campaigns about the harms that alcohol can cause, and doing so through a separate organisation such as Drinkaware seems appropriate in principle, but the independence of the organisation is vital. The value of this contribution is likely to be very limited if the campaigns it promotes are considered to be constrained by industry links. (Paragraph 96)

24. We acknowledge that the Board of Drinkaware as presently constituted has a majority of non-industry Members, and we welcome that fact. Nevertheless, if

Drinkaware is to make a significant contribution to education and awareness over the coming years its perceived lack of independence needs to be tackled, and as part of the review that is to be held this year the Committee recommends that further steps are taken to entrench that independence. (Paragraph 97)

Loi Evin

25. Although the precise terms of the *Loi Evin* reflect the circumstances of a different society at a different time, the Committee believes that the approach adopted in the French legislation merits serious examination in the English context. In particular the Committee recommends that Public Health England should commission a study of the public health effect which would be delivered in the UK by adopting the principles of *Loi Evin*; such a piece of work would provide a valuable reference point for the evaluation of the effectiveness of the Responsibility Deal which the Committee has recommended should also be undertaken by Public Health England. (Paragraph 101)

Local responses

26. Birmingham is one example of local action that has been drawn to our attention during the inquiry, and it does demonstrate how local agencies can put together an effective action programme without the need for a substantial additional bureaucratic support structure. This model of local action, linking in with national priorities, makes sense as a pragmatic, practical way of addressing serious problems. As we recommended earlier in this report, Public Health England should use this model as the template for all local areas to address the various problems that alcohol causes in their communities, and to link local objectives to those at the national level. Central Government cannot direct a local area to address alcohol problems in a particular way, but the new public health structures, in which local authorities have a key role, should provide the opportunity to establish a national framework of local initiatives. (Paragraph 106)

Treatment Services

27. We welcome the work which the Department is undertaking to provide an evidence base to allow commissioners to make informed decisions about which models of treatment provision are most effective in addressing the health issues caused by alcohol abuse. In particular commissioners need evidence about the most effective form of early intervention in order to reduce the number of avoidable hospital admissions which currently represent avoidable illness for patients and avoidable costs for taxpayers. The evidence we received suggested that the establishment of Alcohol Specialist Nurse services throughout the country is one of those measures. The fact that over 70% of the costs to the NHS of alcohol-related services was spent on hospital treatment demonstrates the scale of the opportunity to restructure services to achieve better outcomes. (Paragraph 117)

Formal Minutes

Tuesday 10 July 2012

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper	Chris Skidmore
Andrew George	David Tredinnick
Grahame M. Morris	Dr Sarah Wollaston
Mr Virendra Sharma	

Draft Report (*Government's Alcohol Strategy*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 118 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair 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, reported to the House and ordered to be published on 12 June, was ordered to be printed with the Report.

Written evidence was ordered to be reported to the House for publishing on the Internet.

[Adjourned till Tuesday 17 July at 1.00 pm

Witnesses

Tuesday 17 April 2012

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Professor Sir Ian Gilmore, RCP special adviser on alcohol and Chair of the Alcohol Health Alliance, **Eric Appleby,** Chief Executive, Alcohol Concern, **Professor Alan Brennan,** Sheffield Alcohol Research Group, and **Dr John Holmes,** Sheffield Alcohol Research Group. Ev 1

Chris Sorek, Chief Executive, Drinkaware. Ev 13

Tuesday 22 May 2012

Brigid Simmonds OBE, Chief Executive, British Beer and Pub Association, and **Henry Ashworth,** Chief Executive, The Portman Group. Ev 22

Barry Eveleigh, Lead Commissioner for Drug Treatment, Birmingham Drug & Alcohol Action Team, and **Jacqui Kennedy,** Director of Regulation and Enforcement, Birmingham City Council. Ev 35

Tuesday 12 June 2012

Anne Milton MP, Parliamentary Under-Secretary of State for Public Health, **Chris Heffer,** Deputy Director, Alcohol and Drugs, and **Dr Mark Prunty,** Senior Medical Officer, Alcohol and Drugs programme, Department of Health. Ev 44

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26	Newcastle City Council and Newcastle Primary Care Trust	Ev w71
27	Pharmacy Voice	Ev w74
28	Northumberland Alcohol Strategy Implementation Group	Ev w76
29	British Medical Association	Ev w77
30	Diageo	Ev w88
31	Waitrose	Ev w91
32	British Society of Gastroenterology	Ev w93
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34	Wine and Spirit Trade Association	Ev w99
35	Business In Sport & Leisure	Ev w103
36	Mentor	Ev w105
37	Family Planning Association	Ev w108
38	Medical Research Council and the Economic and Social Research Council	Ev w109
39	Professor Keith Humphreys and Professor the Baroness Finlay of Llandaff	Ev w116

40	Royal College of Psychiatrists	Ev w117
41	Institute of Alcohol Studies	Ev w122
42	Drink Wise North West	Ev w128
43	Royal Geographical Society (with the Institute of British Geographers)	Ev w132
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52	Greene King	Ev w160
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Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132

Session 2010–12

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
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Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
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Sixth Report	Complaints and Litigation	HC 786 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)
Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and further issues	HC 1699
Sixteenth Report	PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)

Oral evidence

Taken before the Health Committee

on Tuesday 17 April 2012

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper	Chris Skidmore
Andrew George	David Tredinnick
Dr Daniel Poulter	Valerie Vaz
Mr Virendra Sharma	Dr Sarah Wollaston

Examination of Witnesses

Witnesses: **Professor Sir Ian Gilmore**, RCP special adviser on alcohol and Chair of the Alcohol Health Alliance, **Eric Appleby**, Chief Executive, Alcohol Concern, **Professor Alan Brennan**, Sheffield Alcohol Research Group, and **Dr John Holmes**, Sheffield Alcohol Research Group, gave evidence.

Q1 Chair: Good morning. Thank you for coming to join us. Could I open the session by asking each of our witnesses in turn to briefly introduce themselves, starting with Eric Appleby?

Eric Appleby: I am Eric Appleby. I am the Chief Executive of Alcohol Concern. I was from 1990 to 2004 and I have recently come back to the job in the last few months.

Chair: Congratulations.

Professor Gilmore: I am Ian Gilmore. I am a physician by background with an interest in liver disease. I chair the Alcohol Health Alliance, a coalition of more than 25 organisations who are concerned about the health implications of alcohol, and I still represent the Royal College of Physicians on alcohol issues.

Professor Brennan: I am Alan Brennan, Professor of Health Economics and Decision Modelling at the university of Sheffield with a team that have been looking at modelling minimum unit price and its effects.

Dr Holmes: I am John Holmes, a public health research fellow at the university of Sheffield, working on the Sheffield alcohol policy model.

Q2 Chair: Thank you very much. As you know, the Committee has announced that it is doing this review of alcohol policy—deliberately, as the Government announced their Alcohol Strategy a few weeks ago. It was notable that that document was a cross-Government document led by the Home Office but involving, obviously, the Department of Health. Would you open the session—perhaps each witness in turn—by telling us, first of all, how you reacted to the general principles set out in that strategy, and, secondly, whether you think it right that this is a policy that should be led from a Home Office perspective or from a health perspective. How would you deal with the emphasis in terms of the problem we are trying to solve? Is it a social problem or is it a health problem?

Eric Appleby: My initial reaction to the strategy was one of welcoming it. It is a significant step forward from anything we have had before. That was, overall, the response, and particularly because the strategy has looked at tackling consumption through price and availability—perhaps less so through marketing—which we know are some of the key triggers there. I think it could have gone further in terms of the issue of treatment. There is more that could be done and said on that.

As to the question about the location of the strategy, the key thing for us is that there is a strategy that has some teeth and that will have an impact. Health is clearly an important part of it. To go back in terms of the emphasis of it, clearly the headlines are around binge drinking. It is a problem and an unsightly problem. In health terms, however, the bigger problem is not so much the binge drinking but the long-term, more hidden perhaps, middle-age and middle-class sort of drinking. In health terms, the most significant costs are hospital admissions, the vast majority of those being the chronic long-term impact of drinking on things like strokes, cancers, hypertension and all that sort of stuff. As I say, I am reasonably relaxed about where it is located as long as it does the job that it sets out to do. We know that these things tend to get passed around Government Departments, so I would not want to make a big deal of it. As I say, the important thing is that it does the job it sets out to do.

Professor Gilmore: I would very much echo that. The overall impression is a positive one as far as the strategy is concerned. For the first time it really does accept the evidence as to the main drivers of the alcohol problems we are seeing in society, particularly price, availability and marketing. Clearly it is stronger in solutions in some of those areas than others. I think it does lack specific targets and ambition in some areas—the areas concerned with marketing are weaker. I would like to have seen a lot more said about treatment services, but we can come back to the detail of that.

I do not mind too much how it was framed. What I mind about is how it measures up to what I think it requires in order to reduce our per capita consumption and the concomitant harm. I very much agree with Eric Appleby that the emphasis is on binge drinking, but what we are more interested in is the impact on everyone's drinking. For example—and we may get on to talking about hospital admissions—Liverpool

Primary Care Trust data show that 90% of hospital admissions related to alcohol are for chronic conditions. They are not for people falling over in Lime Street when they are drunk, but for chronic conditions. In many areas the strategy does measure up to making an impact on those areas, and if it helps politically to have it framed in a particular way, then I have no specific objections.

Q3 Chair: But does it follow from what both you and Eric Appleby have said that the definition of the ambitions in the document, which focuses on alcohol-fuelled violent crime, binge drinking and alcohol-related deaths, is focused more on a social policy issue and you would want to see the emphasis shifted more in the direction of long-term morbidity caused by unnoticed alcohol consumption?

Professor Gilmore: That is fair. As I say, if it does the job then I do not mind quite in what terms it is couched, but it is stronger perhaps in areas that relate to crime and social disorder—licensing—than it is perhaps in some of its ambitions concerning health and, in particular, treatment. So, yes, I would accept that, but we would have preferred it to have been framed more in terms of the health challenges and potential health benefits. None the less, there is a lot there that gives us something to work on.

Professor Brennan: It is important to say that the economic effects of alcohol go across various different aspects. In our modelling efforts about the impact of minimum unit price, we have looked at the impact on health harms—hospital admissions and alcohol-related deaths. But crimes—and they are important, and I think it is important that that is acknowledged as part of the strategy—and also workplace-related harms, such as absence from work and unemployment caused by harmful drinking, are important economic aspects. The policies underlying the strategy, particularly as to pricing and licensing, are aligned well with the reviews of evidence nationally and internationally that we have undertaken about what works in terms of alcohol harm reductions.

Q4 Chair: Focusing on the question of policy objectives, though, it is odd, is it not, that against the background of declining overall alcohol consumption, there is perceived to be an increasing problem of alcohol-related morbidity?

Professor Brennan: That is quite a complex thing to untie. There has been a recent reduction in reported alcohol consumption, but from quite a high level that has been going up over many years. Certainly in relation to these chronic health harms, where people drink substantially and over time that results in illnesses like cancers; a short-term downturn does not turn off that lagged effect around health harm. So the damage that is being done to livers and other parts of the body is part of that complex picture.

Q5 Chair: Do you accept the evidence that there is now declining alcohol consumption or do you regard that as a blip related to the recession or some other factor?

Professor Brennan: I have not studied it in great detail so I would not like to say that I do not accept it, but certainly it has been short term compared to the very long-term trends.

Dr Holmes: To follow on that, alcohol consumption peaked in 2005. In 2005 we were drinking more alcohol per person per year than we had been at any other time in the last hundred years. So, yes, we have seen a small fall from that peak, but in no way are we back down at what might be considered low levels in an historical context.

Returning to the original questions, I think the strategy is a big step forward and I would echo what Ian and Eric have said. From a public health perspective, there is a lot in there which is evidence based and could be considered a good example of evidence-based policy making. In terms of whether it should be led by the Home Office or the Department of Health, a lot of the attention, obviously, went on minimum unit pricing. Minimum unit pricing will have some impact on binge drinking and it will have an impact on alcohol-related crime, according to our modelling, but there are other things in the policy which will also have an impact on the binge drinking. There is a lot in there about controlling the availability of alcohol, looking at the density of alcohol outlets in city centres and looking at the impact of introducing a public health consideration into the licensing objectives. While the focus has been on minimum pricing—and perhaps the biggest impact of that will be on health outcomes—there are plenty of things in there which, the evidence suggests, will have an impact on binge drinking.

Q6 Andrew George: Can we say that the liberalising of licensing hours has been a complete failure? In other words, are we coming to a conclusion now—and is this universally accepted by all four of you—that we need multiple Government interventions for the good of the individuals who are otherwise vulnerable to all the things that alcohol can do to them?

Professor Gilmore: We have to accept—to quote the bible on this topic—that "alcohol is not an ordinary commodity". If it is left to personal choice as an entirely libertarian issue, we will run into problems. It is a drug. It is a drug of dependence. It is a psychoactive drug. It happens to be legal. We do not want to make it illegal, but it does require different handling from soap powder and other things that may be dealt with otherwise by the free market. Yes, we certainly need to consider it differently and we do know that availability is a key factor. Availability was clearly increased in the last strategy of 2004 when licensing hours were relaxed. A lot of things changed around the same time, so it is very hard to blame one individual strand, but it has often been said that the vision of the Prime Minister of the time of turning England into a wine-sipping, continental cafe culture did not work.

If we look at the statistics, for example, of the admissions to St Thomas' hospital in the month of March before and the month of March after that change in policy, there was a huge increase in alcohol-related admissions and alcohol-related presentations. Overall, increasing availability is not in the interests of health, and regulation—admittedly the minimum regulation which then always has to be

balanced with individual freedoms—is not an area where we can sit back and leave it all up to individual personal choice, because we are dealing with a drug of dependence.

Q7 Andrew George: I wonder whether Professor Brennan or Mr Appleby want to comment on whether there were any beneficial outcomes from that experiment with the liberalisation of licensing hours. Can we draw a conclusion from it that there is something about the British psyche or culture that is different to the continental—that we are too immature in comparison with our continental counterparts, that we do not disperse at night, arm in arm, discussing Plato—

Chair: Unlike the Greeks.

Andrew George: Maybe some of us do—fairly incoherently probably—but in fact we go out and slug nine bells out of each other.

Valerie Vaz: They do that as well.

Andrew George: Is it that we, in Britain, are culturally different, incapable and too immature to cope with too much freedom and access to this particular drug?

Dr Holmes: There has been evidence over the years, looking at different drinking cultures in different countries. Traditionally, the Scandinavians had what we called the dry drinking culture where they did not drink as often but when they did they drank in quite an explosive fashion and got very, very drunk, whereas the Mediterranean countries had what we call a wet drinking culture, where they drank all the time but did not necessarily get particularly drunk, and Britain was somewhere in between. There is increasing evidence that that distinction is breaking down. Things like globalisation are changing it. You can obviously see how the different environments—which alcohol those countries were able to produce historically—determined those, but obviously that distinction has broken down. Increasingly, there is evidence that the continent is starting to drink in this British way, where young people increasingly drink to get drunk.

Q8 Andrew George: So we have exported our problem, have we?

Dr Holmes: You could argue that. Whether it is exported or someone else has exported it, I am not sure. The general point is that, as Ian said, there is no real evidence to suggest that increasing licensing hours will lead to a more relaxed drinking style. The evidence—and it is fairly limited on temporal availability—is that longer licensing hours and more days of sale lead to higher levels of consumption, more harmful consumption and more harms related to alcohol. There has not been a high-quality evaluation of the Licensing Act, but what there has been has certainly not suggested there have been beneficial effects.

Q9 Andrew George: Would you agree, Mr Appleby?

Eric Appleby: I would not disagree with anything that has been said. As to the first part of your question about the licensing changes, I do not think you could say they were an unqualified success. Things change, as Alan has been saying. The drinking culture changes over time and, as Ian has said, it is no ordinary commodity. We have a number of pressures on people with drinking—cultural and commercial—so it does need regulating, but things do change. I think one of the things we are learning is that—and what we have always had did not necessarily seem to work anyway—we have to keep a constant process of reviewing and changing the regulations that we put in place and the way we do this. Even if you look at it now, the major concern is about drink bought from supermarkets as opposed to pubs, whereas a while ago it was pubs we were worried about. This is a constant process of reviewing what we have and how we need to regulate it. I do not think leaving it either to a market or to a cultural assumption is enough.

Q10 Andrew George: Do you all think it is appropriate that the Home Office should be taking the lead on this policy area, or do you think it should be driven by a concern about health—in other words, the Department of Health driving this policy? Have the Government got it right, that in fact the primary concern is antisocial behaviour and that the policy must be driven by addressing those issues rather than the concern about the health of those who are drinking?

Professor Gilmore: From my point of view, what matters is outcomes. Clearly alcohol cuts across many areas of Government and it is not for me to tell Government how do its job. What I am interested in is the output and what impact that has on my primary concern, which is health. If I had turned left rather than right out of the school gates I might have been a police officer now and I would have been arguing from a crime and disorder point of view. It all depends on where we are coming from, but they are clearly all important. I cannot argue that health should have primacy, although I do think that the general public would put health very high up.

One of the striking features of alcohol is the damage it does to third parties, and we often do not make enough of that. There is hardly a family that has not been touched by some member having alcohol dependence or being a victim of violence or whatever. Health has to be up there, but how it is framed does not matter to me so much as what Government puts out in the end to help society to improve its health.

Q11 Chair: Does Professor Brennan want to comment on that?

Professor Brennan: Yes. I have two points on what you have been asking. I would come back on the licensing point to agree with what John said. I would have preferred it if some more substantial research had been done on the effects and evaluating the Licensing Act last time. In particular, there are quite a few data sets that do collect how many people are drinking what, but mostly they are cross-sectional data sets so they are different people each year who are surveyed. Having a longitudinal survey in which you could see how people change their patterns of drinking would be a very powerful tool for evaluation of alcohol policies. It would have been really powerful

in the licensing and will probably be even more powerful as a tool in the coming strategies.

Q12 Dr Poulter: Professor Gilmore, I have a question for you. You outlined earlier—I think quite rightly—that 90% of admissions to hospital were often linked with more chronic alcohol abuse. On that, in terms of connecting chronic conditions with alcohol abuse, traditionally the focus has been on liver disease, which is your specialty; but do you think there is a broad enough long-term evidence base—for example, with other conditions, certain types of cancer and the like—in terms of how the data is collected to say that alcohol is a part of this admission and a part of this illness, or do you think the evidence base at the moment is focused largely on illnesses that have almost a direct correlation purely with alcohol?
Professor Gilmore: The evidence base is quite strong for the impact of alcohol on conditions such as cancer, high blood pressure, heart disease, strokes and so on. The so-called alcohol-attributable fraction for different diseases has been very well worked out. What is less well worked out is how we code illnesses when patients come in and out of hospital. There has been an improvement in coding along with payment by results, and so on, but I think it is still not well done. I am concerned at the move to change the way that hospital admissions are measured so that only if alcohol is part of the primary diagnosis will it be captured. I think there is a real risk of losing the impact of alcohol on health if we do that. If it is done, it is very important that we continue to capture also the data on secondary diagnosis, because we know that coding is still poor. Yes, the impact of alcohol on other diseases—on cancer, breast cancer and the like—has been very well categorised, but we do not always put that evidence into practice.

Q13 Dr Poulter: So it is well documented. There is good medical evidence for it.
Professor Gilmore: Yes.

Q14 Dr Poulter: But in terms of linking that with hospital outcomes, admissions and policy, the coding that is used in hospitals may under-report the impact of alcohol on that particular admission.
Professor Gilmore: Absolutely. There are huge differences. If you look at deaths directly related to alcohol, you are talking of about 5,000 or 6,000. If you are looking at attributable fractions, you will be up to about 40,000 deaths a year. It can make a huge difference when you take into account the alcohol-attributable fraction of other major diseases.

Q15 Dr Poulter: I have one other quick question of clarification. You made the point earlier about 90% of admissions being alcohol-related, but you also talked about when licensing laws were extended and expanded. I presumed you were saying that the attendances at A and E at St Thomas' increased during that time to do with alcohol in that year—those March-to-March comparisons you gave earlier—and they would be not only the chronic disease picture that you painted but also the localised incidents of people on that particular night drinking too much and presenting at A and E but perhaps not being admitted to hospital later on.
Professor Gilmore: It was both. They looked at related attendances at A and E and hospital admissions, and there was a rise in both. So it is likely to affect both acute presentations and chronic conditions.

Q16 Valerie Vaz: How do you measure it? What is the timeline in relation to someone who has started drinking alcohol and it then becoming a chronic condition?
Professor Gilmore: How do we define "acute" and "chronic"?

Q17 Valerie Vaz: Yes. How do you define it?
Professor Gilmore: That is a difficult one. It tends to relate to the actual medical condition you have had. In other words, if you have cirrhosis of the liver from alcohol, even if you fall over and break your ankle that would be counted as an acute episode—if you had the chronic condition—and vice versa. It relates to whether the condition is one that requires long-term exposure to alcohol.

Q18 Valerie Vaz: Can you give a time estimate on that?
Professor Gilmore: No, I cannot. I do not think there is a time definition. It is related more to the episode. If it is a chest infection from lying in the gutter when drunk, it would be acute. Acute presentations tend to be related to the complications of being drunk, whereas the chronic ones tend to be those related to long-term consumption.

Q19 David Tredinnick: Sir Ian, you talked about codifying illnesses earlier on. Has any work been done on whether there is any different impact from the consumption of different alcoholic drinks? I put it to you that it has long been held that gin is a depressant, whereas people say that if you drink vodka you are less likely to get a hangover. I do not drink whisky, but I think that whisky is alleged to have certain characteristics too. Is there any evidence of relative harm from consuming particular spirits?
Professor Gilmore: There has been a lot of work looking at the supposed beneficial effects or less detrimental effects of different beverages—the health benefits of red wine as opposed to other colours of wine, and so on. You can find some research to suit whatever case you want to put on the day. The reason is that there is probably virtually no difference. What really matters to your body is the amount of alcohol you take in. Some people may find that they have a headache the next day after sherry and not after gin or vodka. We know that there are incredible innate differences between individuals in the way their bodies handle alcohol and there may well be individual differences in the way we handle different sorts of alcohol, but the bottom line, so far as your body is concerned, is how much alcohol you have taken in, both acutely in order to get drunk and chronically to sustain permanent damage. We know it is actually quite hard to get drunk on weak beer, whereas it is very easy to get drunk on shots of spirits.

That is because you can get in more spirits in a short time and there is a limit to the volume of beer you can drink, but if you find you get the beer in, the effect of the alcohol will be the same whichever way you have taken it.

Chair: It's "Bad luck, Bordeaux."

Q20 Rosie Cooper: There are difficult questions here and confused messages that the public hear. It can almost be seen as a circular argument, in the sense that we hear—there are various stories—it is better that you drink in a controlled environment, that is, in a public house where people can see that you get drunk and restrict your intake of alcohol, but earlier we were talking about the increased licensing hours. If you regulate that, then surely people are going to go back and drink more in an unsupervised place. How would you help policymakers and the general public understand and how would you help us help people to make the right choices?

Dr Holmes: The point is to retain the focus on the key driver of alcohol-related harm. It is not where you drink or who you drink with, but how much you drink. That is where the focus needs to remain. As I said already, we are drinking at historically very high levels. Yes, we can do other things as well, but fundamentally we need to bring that level of consumption down, particularly for those people who are drinking at the heaviest levels. That is unrelated to where they drink, accepting the fact that prices in the off trade are substantially lower and cheap alcohol is highly available to a greater degree than it is in the on trade. I am assuming we are going to be getting on to that shortly.

In terms of which place to drink is more or less risky, it depends who you are. If a 19-year-old man goes out drinking in a pub, he is probably at a higher risk of getting into a fight than a 50-year-old woman who goes out drinking in a pub, but that 50-year-old woman is probably at more risk of harm from drinking at home because she is at a time of life where she is at greater risk of the various chronic diseases you can get from drinking. So I do not think it is helpful, when you are giving out broad public health messages, to talk about where drinking is safe. The only point when it probably is relevant is ensuring that pubs are well run, that they abide by their licensing conditions and that they are not places that are conducive to violence.

Eric Appleby: The thing we have not been very good at has been the messages. We have what were originally called "Sensible drinking guidelines", which, when they were framed, were relatively straightforward, but the world has changed since then—the strength of drinks, the size of servings, and all that. It is now very confusing for people. The strategy talks about reviewing those. The important thing is reviewing how we communicate them, because I think you will find that the science has not changed very much. It is about how you communicate that and how you can get the message across to people of the true nature of the issue. It is a very loaded subject. Nobody wants to be told that they should drink less than they are currently drinking. We have this spectrum between, at one end, a sort of fatalism about drinking, "You cannot do anything about it. People drink. It just happens" and a denial at the other end, "Yes, I have my bottle of wine with a meal every night. I do not get drunk. I do not cause anyone any problems. There is nothing wrong with that," except 20 years down the line when you end up in one of Ian's hospital beds.

For policy makers, it is a difficult one. What we need to do is look at ways in which we can produce messages and produce medical evidence about what alcohol will do to your body over a period of time if you drink in this sort of way and get those messages across. We do love a bit of a headline, which is one of the reasons why we hear so much about the whole binge drinking thing. It is an important topic and a problem in certain areas, but we overdo the pictures of drunken youths and do not do quite enough on some of the more evidence-based underlying messages about the nature of alcohol and what it does.

Q21 Dr Wollaston: Can I move on to the question of minimum pricing and ask—perhaps starting with Dr Holmes—about how strong you feel the evidence is to support minimum pricing?

Dr Holmes: It is probably better if Alan talks about the strength of our evidence. He is the technical expert on our team.

Professor Brennan: Thanks, John. The key ingredient in a minimum price policy is obviously the price. From a public health evidence perspective, the evidence is absolutely completely overwhelming that if you increase prices people drink less alcohol. If you talk to the man in the street they are not convinced that that is the case. There are two recent systematic reviews, one of 132 studies and another one of 112 studies internationally, all showing that when prices increase people decrease their consumption, and not by as much as the price increases. If you put prices up 10%, consumption might fall by 5%, for example. That is really important.

The work that we have done modelling the effects of minimum price has had to look in detail at what people are drinking in England—or Scotland, when we have analysed Scotland—how much they are paying for it and what the different beverages are. All of that is taken into the account so that when we have done our analyses we have said, "We know exactly what market share is currently made up of things that are less than, for example, 40p per unit." If we assume that the prices for all those products were to increase to exactly that possible proposed minimum, then there would be price increases happening for all those products and all of the people that buy those products would face those price increases and reduce their consumption. So when we have done our modelling we have taken account of that kind of heterogeneous purchasing and consumption pattern across the population.

The key advantage of minimum pricing, from a targeting perspective, is that it is, in the data, the harmful drinkers who tend to drink more of the cheaper alcohol. Compared to putting general prices or general taxes up, putting a minimum price means that it is the harmful drinkers who are disproportionately affected by the policy. Those are the kinds of analyses that we have done.

Q22 Dr Wollaston: One of the criticisms sometimes made of minimum pricing is that it will not help with the wealthier long-term chronic home drinker. Is there any evidence that people on relatively higher incomes change their behaviour with a policy like minimum pricing?
Dr Holmes: There is no specific evidence looking at the impact of minimum pricing on those on high incomes but there is evidence looking at what people on high incomes spend their alcohol money on. It is very clear that, right across the income spectrum, people who are drinking at harmful levels are price responsive and that they drink cheap alcohol. For instance, we have had a look at the spending diary data from the Expenditure and Food Survey and found that in all income groups about 80% of alcohol units are purchased in the off trade and, of those units, in all income groups, more than half of the units bought by harmful drinkers were below 50p a unit. So even in the highest income group, half of harmful drinkers' alcohol spending is on cheap alcohol. That makes sense because, while we talk about high incomes, it is only those at the very, very top of the income spectrum who disregard price. The remaining 95% are price sensitive and still look at the price of their supermarket shopping.

Q23 Chris Skidmore: A bottle of wine is far cheaper now than it was, say, 20 years ago. You can pick up a bottle of wine in Tesco for a fiver. A minimum price is not going to affect that and it is the middle-class drinking—what Eric and Sir Ian said about the half a bottle a night for 20 years that then rebounds to end up in cirrhosis of the liver—that minimum pricing, surely, is not going to touch.
Dr Holmes: The evidence suggests that those who are drinking at harmful levels are buying that cheaper alcohol. No, a £5 or £6 bottle of wine is not going to be affected. But if you are buying your wine at Asda and you are buying three bottles for £10, it will be affected. If you are buying a £4 bottle of wine it will affected. Harmful drinkers do not only drink wine. They drink cheap own-brand spirits which are certainly affected. They drink super-strength ciders and beers. They buy the beers sold in packs of 24, which are almost exclusively sold below 50p or 40p per unit.
Professor Brennan: But you are right. It is not the case that a minimum unit price would stop everybody drinking alcohol or stop all alcohol-related harm.

Q24 Chris Skidmore: I was interested in the 90% of admissions in Liverpool that Sir Ian mentioned being affected by the long-term chronic conditions of cirrhosis that might not only affect those on low incomes, but those on the medium to higher incomes that this strategy will not touch. You will still have those admissions.

Q25 Dr Wollaston: That was the question, whether or not it will impact on that 90% as well as on the group that most people would accept it would have an effect on—or people would see that there could be an effect on—the young binge drinkers on a low income. Are you confident that the modelling is there to show that it will impact this 90% as well?
Dr Holmes: It is worth pointing out that, as I have said before, minimum pricing will have an impact on young binge drinkers. But young binge drinkers do not buy as much cheap alcohol as older people simply because they tend to drink more of their alcohol in the on trade, which is largely not sold at prices which will be affected by the policy. Some of it is, but largely it is not. The biggest impact from this policy is on those older people, not people necessarily with higher incomes but people of a higher age. This is not a policy which is targeted at young binge drinkers. This is a policy which is targeted at people of all ages who drink at harmful levels.

Q26 Dr Wollaston: Do you think there will an impact on health inequalities?
Dr Holmes: The evidence on this is a bit mixed. There is evidence that those on lower incomes suffer a greater risk of harm per unit of alcohol than those on higher incomes. A policy which reduces consumption in all income groups should have a bigger impact on the health outcomes of those on lower incomes because it will reduce their risk of harm by a greater amount.

Q27 Dr Wollaston: Can you clarify why they are at greater risk of harm if they are on a low income?
Chair: I do not understand that.
Dr Holmes: It is a bit unclear. Partly it is to do with other confounding factors, things to do with other aspects of their diet, other health behaviours, the environments in which they drink, their access to medical services and the quality of those services and, because of their other health behaviours, their body's ability to deal with the alcohol. There are lots of reasons which you could broadly consider as social exclusion arguments which mean that people on lower incomes are at greater risk of harm from alcohol than people on higher incomes.
Professor Gilmore: I would echo that. It is a big health inequalities issue. It is the poorest who do disproportionately suffer harm from alcohol. The reasons are complex, as we have heard, but I am sure that consumption coming down in general would have a disproportionately beneficial effect on the poorer.

Q28 Dr Wollaston: Coming back to the point that Chris touched on earlier about the level of the minimum price, if you want to impact on people who are buying a £4 or £3 bottle of wine, is there any evidence, in your view, about where the level should be set and whether or not we should co-ordinate that with Northern Ireland and Scotland?
Professor Brennan: It is clear that there is a kind of accelerating level of impact. If you were to set a minimum price at an extremely low level, like 20p—I think it is something like that—0.1% of the market is covered and you are basically doing nothing. As it rises up, the level of impact accelerates because you have two effects going on that multiply beneficially, which is more of the market being covered and people facing a higher relative price change for the alcohol that they were buying. For example, in our modelling

a 40p minimum price was reducing consumption by 2.4% nationally, but a 50p minimum price was something like 7.6%.
Dr Holmes: It was 6.7%.
Professor Brennan: Okay. So there is about two and a half to three times more impact on a range of different measures from 50p compared to 40p. There is a lot of coverage in that range across the market share. There are a lot of products sold at those levels.

Q29 Dr Wollaston: Can I ask you to clarify what it would be at 45p? That is the level that is being discussed for Scotland. What would be the reduction?
Dr Holmes: It would be 4.3%.

Q30 Dr Wollaston: Is that estimated to translate into reductions in alcohol-related deaths for each of those?
Professor Brennan: As to alcohol-related deaths, for 40p we estimated a reduction of 1,190; for 45p, 2,040; for 50p, 3,060.

Q31 Dr Wollaston: Over what time period is that?
Professor Brennan: That is the annual level of deaths, but that is once the policy has been in place for a considerable period of time, so accounting for the fact that there is this lag effect, those chronic diseases will not immediately disappear in year one.

Q32 Chair: What is the considerable period of time?
Professor Brennan: I think 10 years was how we were modelling things.
Professor Gilmore: If I could come in there, in countries that have increased the price and reduced consumption, you see a drop in deaths from liver cirrhosis within 12 months.
Professor Brennan: Yes, you will see that.
Professor Gilmore: We know it takes 10 years to get cirrhosis in most people, but the impact is seen much quicker. That is probably because there are quite a few people—hopefully not round this table—teetering on the brink and were they to suddenly reduce their consumption they would slip back into the safety zone. So although what Professor Brennan says is absolutely true, none the less you do get very real health benefits in the short term.
Professor Brennan: And they accumulate.
Professor Gilmore: Yes.

Q33 Valerie Vaz: I am quickly going to ask—you may not be able to answer this question—whether you have any comparisons with other EU countries and in particular what the EU Commissioner said, that EU rules will not apply if countries want to have a minimum pricing level. I am trying to get you, I suppose, to say that there is not any prohibition to doing it because other countries have done it, and if you have the evidence for that.
Professor Brennan: I have nothing to say as to the legal side of things. I do not think minimum price has been implemented in many European countries but it has in some of the Scandinavian ones. John might know.
Dr Holmes: I am not sure that is correct. I think it is only in Canada that they have had it properly implemented. Do you want to talk about the Canadian evidence?
Professor Brennan: Yes, I could. There is a recent paper by Professor Stockwell in the journal *Addiction.* Canada has had a minimum pricing policy for quite some time and its differential in different states has changed at different time points. It is quite clear that when they have changed their minimum price there has been a direct impact on consumption. Once they have had this policy for a while and they ratchet it up a little bit, or put it down, consumption follows quite quickly in terms of decreases and increases.

Q34 Andrew George: I want to follow up exactly on that point, the international comparisons—obviously you have real-life examples in Canada—and, therefore, where there have been problems in the north with the Inuit, whether the ratcheting up of prices had a clearer impact in that area. Also, you have adopted a modelling approach and clearly you have been advancing that and evangelising, if you like—if you do not mind me saying so—the potential benefits. To what extent has that been peer reviewed by colleagues in other academic institutions who have confirmed that your modelling appears to be robust?
Professor Brennan: I would not say I am a natural evangelist. A cautious and evidence-based approach is what I would say. Certainly the modelling work has been peer reviewed—the original work that we did for the Department of Health—and then the work that we did for the National Institute for Health and Clinical Excellence goes out to peer review in itself and is now published in peer-reviewed journals such as *The Lancet.* I am perfectly happy that it has had real detailed scrutiny by many people. There is a separate question which is "It is only modelling" and there are two ways to look at that. The way that I look at that is that modelling is not only modelling. Modelling is a synthesis of all of the available evidence in an integrated, sensible and coherent way. We pull it all together to answer the questions that policy makers have.

Q35 Andrew George: As to the example of Canada, you said that there were differential approaches—in different provinces, presumably. I wonder whether you could say anything about the northern territories, where there were particular problems with alcohol.
Professor Brennan: I do not have much to say on that in terms of health harms. I have been looking more at the price elasticities and the effects on consumption.

Q36 Chris Skidmore: In addition to a minimum pricing strategy, there are also the attempts to remove 1 billion units from the marketplace by 2015. I would be interested to get your views on—if you have done any modelling—how effective that might be. As a back-of-the-paper calculation, roughly £42 billion was spent on alcohol in 2010. If you take that as a 40p minimum pricing, I make that about 17 billion units. I know that is not accurate, but if you are trying to reduce by 1 billion, that is going to effectively reduce consumption by 6%, which is twice as effective as the minimum pricing. I do not know if you felt that was also the case, that, by taking units out, it would have

an even more dramatic effect than minimum pricing overall.

Professor Brennan: There are two separate things. We have not done any formal modelling yet of the reduced 1 billion. It would be very interesting to put it in. As John said earlier, it is the units of alcohol that cause the health harm, so there is no doubt in my mind that that approach will have benefits. As to the relative benefits against minimum price, in a way the two kind of relate to and counterbalance each other. If you have 40p per unit but there are fewer units in your beer or wine, then that interlinks.

Professor Gilmore: I think you are referring to the pledge in the Responsibility Deal. If 1 billion units are taken out over this time period, then we would expect to see some benefit. However, Eric and I were talking on the way down here—we have been around this field for a decade or more—and remember the pledges to get labels with unit information on them 10 years ago. If we get some extra added value from the pledges of the Responsibility Deal that will be a benefit, but we should not rely on that as an alternative to minimum unit price.

Q37 Chris Skidmore: In addition to the Responsibility Deal and the minimum unit price you have duty, which obviously—it was announced in November 2010—will be rising at 2% above inflation each year to 2015. I am interested in the concept of the ABV where you have the 2.8% for lower strength alcohol and then, for higher strength alcohol, 7.5%. I was interested in your views on whether you felt that was the right parameter to be set—that with a lower cost you could charge less duty on drinks under 2.8% and higher duty on 7.5%. To me, personally, 7.5% seems quite high and you could have had a far narrower parameter, but that itself is a lever that will surely help to change the marketplace and reduce units overall.

Professor Gilmore: Absolutely. We need every tool in the box. We have not been helped by the fact that you cannot charge more duty on 15% wine than 5% wine, for example. The regulations are through Europe, so we need to look at all these ways of influencing price. Minimum unit price, on the face of it, seems the fairest and most targeted way of doing it because it will impact on the heaviest drinkers and will also have a disproportionate effect probably on underage drinkers. We need to look at all ways of modulating price. It is a complex area and a lot of the other measures around marketing and licensing are particularly important. I am pleased that the strategy has acknowledged that treatment for people with alcohol problems—who have the problems now—does work. Also, it is fair to say that I do not think the strategy goes far enough in saying how to improve that treatment. There are lots of good things out there. There is QIPP evidence on alcohol care teams in hospitals that really save money and reduce hospital admissions that does not come through in the strategy. There are NICE tools for treatment of alcohol problems that do not come through, so I hope that the Committee will be looking at those aspects too.

Q38 Dr Wollaston: I have one final question about the evidence for ending multi-buys. How strong is the evidence from Scotland that that has an effect?

Dr Holmes: I am looking for a piece of paper which has some numbers on it. Because what we are interested in here is reducing consumption among harmful drinkers, we will not know the extent of the impact on those drinkers in Scotland until, maybe, 18 months after the policy was brought in because that is when the survey data, which looks at the impact on different groups, comes out. We have, however, seen some very early data from Nielsen on alcohol sales. I cannot find my piece of paper, but it does say—I think it was brought in at the start of November last year—that, compared to the previous November's sales, sales of wine and beer were substantially down. Wine and beer are heavily discounted and sold in multi-buys, so that is what you would expect. They also compared the change in sales in Scotland in that period with the change in sales in England in that period. Again, there was not the same change in England. It is very early evidence—we do not know who it is impacting on—but there is evidence that that policy did have an impact on consumption.

Q39 Dr Poulter: On the issue of corporate responsibility and corporate and consumer responsibility deals, which is quite an important area, there is evidence that this can work in some areas of policy—for example agriculture, supporting British farmers. However, what you have there is a tie-in with the consumer wanting to support the objective. This is a little bit difficult to achieve with alcohol where, as we have already heard, the consumer wants to drink a lot and often get drunk, for example. That is the objective, in many cases, of the consumer. So there is a behavioural change issue to tackle.

Looking at the history of the alcohol industry, despite these very laudable intentions on Government policy with extending the licensing hours—which was a laudable intention but did not achieve responsible drinking—and looking at the fact that supermarkets had been responsible for multi-buy deals and the cut-price alcohol deals and encouraging pre-loading, is it not the case that there is a risk that relying purely on corporate responsibility and consumer responsibility, unless substantial behavioural change is also indicated, is not going to be effective on its own? Also, in many respects, what minimum price alcohol pricing will help to do is encourage and engender that responsibility by forcing the supermarkets and the drinks industry to look at how much alcohol they have in their products because, thus far, they have not taken responsibility themselves.

Professor Gilmore: I will hand over to Eric in a second, but I would agree with that entirely. It is very difficult to get away from the conflict of interest of industry. There are areas where they can make a contribution, making sure that existing regulations as to serving underage drinkers and people that are drunk and so on are adhered to, but I have always had concerns about industry getting round the table to discuss how you produce a public health strategy for alcohol because you cannot get away from the conflict of interest. The same applies to supermarkets.

Eric Appleby: Absolutely. I echo that entirely. As Ian says, there are things the industry can do, but, at the end of the day, industry's first responsibility is to their shareholders and to making profits which, by and large, means selling more drink. Clearly, there are responsibilities the industry has and they should live up to them. Put crudely, they need to live up to them but I do not think there should be any deals involved. It is a responsibility that they have.

Professor Brennan: Can I add in one thing on that? It depends on how the policy is implemented, but when we first modelled minimum price we assumed that the Government were not taking any of the extra spending that consumers were putting in directly as an extra minimum unit tax in any way. So the off trade retailers are having their prices put up and they make more money. There is an incentive on the retailers for minimum unit price to exist.

Q40 David Tredinnick: I am listening to Dan and to you and making notes at the same time. I am going to ask you questions about advertising, but, following on from what Dan is saying here, and we are looking at the impact of pricing on reducing consumption, should there not be a much greater emphasis—and I speak as someone who has worked in the advertising industry—on tackling the fashion of over-consumption? We are starting to see this now with some advertisements showing the results of car smashes after a night out on the booze or girls being drunk in the street and they can either go home looking nice or they can go home in a complete state, bleeding and things like that. Do you think that as well as this pricing strategy we need to have a much more powerful driver changing behaviour through other methods?

Professor Gilmore: Clearly the answer to that is yes. As we have said before, we need to use every lever we have in the system. What we do know is that public health campaigns on their own tend not to produce much behaviour change but often do when combined with regulation. For instance, there was a big seat-belt campaign. Nobody actually changed their habits but when regulation came in people accepted it because they had been softened up. There are many opportunities for that. I will perhaps hand over to Eric, if he wants to add to that.

Eric Appleby: Yes. It is this business of needing both the carrot and the stick. Drink driving is a very good example of that. The breathalyser and the "Don't Drink and Drive" campaigns appear to have the effect. We do need more powerful advertising about the impact. It goes back to the messages, as I was saying before, but we need to look more at advertising—promotion—of drink as well. In particular, I am concerned about the issue of alcohol adverts getting out there and having a better pre-vetting system. What happens at the moment, often, is some quite unacceptable alcohol adverts get put out and the complaint process takes a while. It is some time before people can get the advert withdrawn, during which time some of the damage has been done. There are some very recent examples of that. Alcohol Concern did some work about young people and drinking and a particular product called Frosty Jack's, a very cheap white cider which was being sold in 3 litre bottles, which is what young people were drinking because it was the cheapest. Its advertising—its website—were frankly scandalous but it was out there. We complained and eventually the website got withdrawn, but not before a lot of people had seen it. A stronger pre-vetting of adverts would help.

Professor Gilmore: Could I come back? I had forgotten the other point I was going to make. Clearly we would like to change the culture. The drinks industry says again and again that it is not about price and that we need to change our culture, but price changes culture. It has been that differential between the on trade and the off trade that has driven us from a nation, 10 or 20 years ago, that drank in pubs to a nation that drinks at home because it is cheaper. So we can change culture by levers such as price, availability and marketing as well as by some nebulous trick that we have not yet discovered.

Q41 David Tredinnick: Could you not also argue that, socially, it is a very bad idea that people should be drinking at home? It would be much better if they were drinking in properly regulated pubs. There is a greater issue here, which perhaps we are not going to get on to, of the price differential between on premises and off premises. We are losing so many pubs. We have lost some in my constituency. They are closing all the time. It is a tragedy that people have to drink on their own or at home when they should be socialising in groups. Surely that has benefits too.

Professor Brennan: My take a little on the strategy is that it has not looked at the option of having a minimum unit price in pubs and bars, which is something which is plausible and feasible and we have also modelled. I have interpreted that in my own way to be saying that the Government are keen, in a sense, to redress the balance of affordability between the two sectors. That is helpful to me in my new year's resolution, which is to go to the pub more.

Q42 David Tredinnick: Moving on slightly, the Government, while acknowledging that there is a link between advertising and alcohol consumption, are not proposing to follow Norway's example and have a ban on alcohol advertising. It says it would not be a proportionate response. Do you think that is fair, and what evidence is there on the links between advertising and alcohol consumption? You touched on this earlier.

Professor Gilmore: I chair a science group that supports the European Commission Alcohol and Health Forum. They commissioned us to do a piece of work on marketing and young people and the conclusion, quite clearly from reviewing the literature internationally, was that children start drinking younger and, when they do start drinking, they drink more because of the influence of advertising. I have no doubt in my mind that it is important. I, personally, would like to have seen more in the strategy, tougher action on advertising. Dr Wollaston has given us a perfect example in her Bill on marketing. I find it remarkable still that they are showing advertisements for alcoholic beverages in films that are rated for 12-year-olds. If there is any situation where you know

you have to be 18—to get into an 18 film—yes, show them a product suitable for 18 plus, but to show it for people of 12 is beyond my capacity to understand. So there are still areas where we could beef up the strategy on advertising.

Q43 David Tredinnick: Are there any meaningful comparisons to be drawn between the alcohol industry and the tobacco industry, which has seen significant changes in advertising policy over the years?
Professor Gilmore: They are clearly, in many ways, different and the end point is different. We are not seeking eradication of alcohol, whereas we are seeking the eradication of tobacco products. None the less, there are very clear comparisons, often indeed in the way the industry promotes their products and the way the industry is moving into developing countries when developed countries start taking tougher action. Certainly I think we should be looking at following the examples, for instance, of health warnings on bottles. That is an obvious example. I would personally like to see a ban on broadcast advertising, as they have in France. I would personally like to see a ban on sponsorship at sports events, as they have in France.

Q44 Chair: Do you have a general view in your mind of the proportion of the alcohol consumption that causes no health problem?
Professor Gilmore: This is a—
Chair: I understand that this will not be evidence based. I am looking for an impression.
Professor Gilmore: You can come and see me afterwards, Chairman, if you want. There are great difficulties and this is the nub of the problem of the health messages to the general public. Everyone is different and probably responds differently to alcohol. If you take 100 very heavy drinkers the majority will never get cirrhosis of the liver, but we cannot yet tell you which group you fall into. There are those individual differences. Then there is the fact that for different diseases the threshold is very different. If you stick within so-called safe limits then there are certain diseases you are virtually guaranteed not to get, whereas there are other conditions, like some forms of cancer, where drinking well below safe recommended limits will significantly increase your risks. I am afraid that, at the moment, you cannot generalise and say you will be totally safe if you stick to such and such a level. But I do welcome the recommendation in the strategy that guideline advice is revisited. It should be possible to personalise that more than we have at present and to try to get round some of the understandable confusion in the general public.

Q45 Chair: The reason I ask the question—and then I will go to Virendra—is this. We started off this morning's evidence session by focusing on what the problem is. We acknowledged that there is binge drinking and the lawlessness problems associated with that. There is a defined group of people who definitely drink more than is healthy for them, and that has long-term consequences for their health. But there is a danger, in those two identifiable problems, that that discussion is moving on to a general theme that alcohol is bad, which for the majority of responsible users—in my perception at least—is not true.
Professor Gilmore: No, but you will get the maximum health gain by shifting the whole population consumption curve down. So we are looking for maximum public health gain, not only to get the very heavy drinker to drink a bit less. If everyone drinks a bit less, even those drinking within the current recommended upper limits will get a health gain too. An awful lot of hypertension, for example, is caused by alcohol and there is an impact within recommended limits. If someone has hypertension and they are drinking up to the upper limits, they will get health gains from reducing it. While we do not want to be killjoys, none the less there will be a bigger benefit than only targeting the very heaviest drinkers.
Eric Appleby: Can I add to that? We talked about messages and the guidelines and everything. It seems to me that one of the problems we have is that we are not very good at talking about alcohol. At one end it is a bit of a joke: going down the pub and getting drunk is comfortable and jokey. At the other end, talking about real problems is almost a taboo subject. In between we are not very good at having that conversation about the dichotomy, if you like, that alcohol is quite enjoyable and we like it but it also carries harms. Having this conversation about managing risk is something we just do not do, and people tend not to want to do. It is instigating that conversation which is to some extent what is needed.
Chair: That is a much broader issue in the whole discussion of health policy. David wants to follow through and then Virendra.

Q46 David Tredinnick: To what extent does exercise mitigate the impact of alcohol consumptions at different levels? If a person exercises regularly, is their body then able to process out the alcohol at a better rate? Has anything been done on this?
Professor Gilmore: I am not aware of any evidence on that. I would be surprised if exercise mitigated the adverse impact of alcohol. I do know that if you try and run off your hangover the following morning it is dangerous and people sometimes die of arrhythmias—
David Tredinnick: I will not be doing that.
Professor Gilmore:—of the heart, secondary to trying to clear their head the next day. I do not know of any evidence. What is interesting is that health messages relating to alcohol seem to be best wrapped up in general health and lifestyle messages. We reviewed this recently in another report from the European Commission on alcohol in the workplace. People seemed to take on the messages about alcohol better if they were part of general lifestyle advice—weight, exercise and alcohol—rather than preaching to them about alcohol. That is where I see the link between exercise and alcohol.

Q47 Mr Sharma: I am, I think, one of those very few individuals here who does not drink in the pub or at home. Do you not think that, with this trend of it being cheaper to drink at home, when you bring your drinks home—you drink and smoke in the presence of the young children—you also encourage the young

children to drink and that it is better to stick to the pub? Second, there is the community spirit—when you go and drink in the pub with friends and other community people, that brings the community spirit as well. Do you not think that this pricing trend of cheaper wine that you take home is also causing social damage to the local community and to society in general?

Eric Appleby: What is clear is that children learn and take messages from their parents and it depends what those messages are. It is not so long ago that we were told that drinking in pubs was bad news for children because it was forbidden and was something behind closed doors—it was forbidden fruit and they could not wait to get their hands on it—so we should be introducing our children to drinking at home as a gentle introduction, a glass of wine here or there. Now we are having the debate the other way round. Probably the answer has to be that it is what messages you give. If you drink at home socialising with some friends, one drink each and enjoying that, then children will see that, or they may see you going to the pub and coming home roaring drunk. It is very much about what parents show to the children. Clearly that is why a lot of what we are talking about here is important. It is not only about the health of middle-aged people, if you like, but also their drinking as parents and what the next generation is going to do.

Q48 Valerie Vaz: I want to follow up on the advertising industry. £800 million is spent on advertising. What are the targets you see in the Responsibility Deal that could possibly counter that? If there are not, clearly, say so, or if there are.

Eric Appleby: I am racking my brains. I do not recall anything in the Responsibility Deal so far which is going to make much of an impact on that. I have to say that in the strategy I was slightly disturbed to see talk about promoting advertising that promotes positive socialising—or something along those lines.

Q49 Chris Skidmore: It is page 23. It recommends the "Drinkaware's 'Why let good times go bad?' campaign and we expect to see more campaigns such as this in the future."

Eric Appleby: Sure. I have nothing against Drinkaware's "Why let good times go bad?" campaign.

Chris Skidmore: I was going to follow up to ask if you agreed with that particular statement.

Q50 Valerie Vaz: Can you answer the question?

Eric Appleby: There is a very fine line here. The advertising rules say that you should not advertise alcohol in such a way that suggests social success, either individually or as a group—positive socialising. It is dangerous. In my own view, again, I would prefer to see us go towards the French approach which is that you can advertise alcohol on a factual basis rather than in any other way. Unfortunately, I spent an evening on Sunday at Wembley watching a game sponsored by Budweiser and sitting opposite signs which said, "Great Times Are Waiting". I am not sure that I think that is the sort of advertising we want. Yes, of course, I enjoy drinking and everything but it feels to me that we still have a bit of a culture of advertising there which suggests that the more you drink the more you are going to enjoy yourself, I am afraid.

Professor Gilmore: I have some slight concerns about "Why let good times go bad?" because it is normalising going out and drinking to have a good time. One of the concerns is that people who do not drink are still considered odd—"What is wrong with them? Why do they not drink?" I think it is very regrettable that Heineken is the official beer of the Olympic Games.

Q51 Rosie Cooper: I have had constituents contact me about foetal alcohol syndrome, as I used to know it. I think it is called foetal alcohol spectrum disorder now. Do you have any estimates of the number of cases annually and why there is, essentially, a lack of good information out there about it—if and how we can improve that—and, I suppose, is the message very clear that if you are pregnant you should not drink at all?

Professor Gilmore: The message here is difficult because we do not have strong evidence on very light consumption during pregnancy. In the absence of evidence either way, the safest message—and this is what the Chief Medical Officer some years ago concluded—was to advise women not to drink at all. That is certainly the advice that the Alcohol Health Alliance would concur with. The problem is if you want to be evidence based, you have to be consistent. If somebody says, "Is there evidence that taking one glass of wine a week when I am pregnant is going to damage my baby?" then you have to say to be honest and say, "No, we do not have that evidence." But we do not have the evidence that it could not. By extrapolation from the fact that heavy drinking undoubtedly does damage the baby, the safest thing for women is not to drink at all.

Q52 Rosie Cooper: Do you know the number of cases a year?

Professor Gilmore: I cannot give you those data. The problem there is that we still do not fully understand what that spectrum is. We know babies that are obviously severely damaged, where their features are abnormal and they have brain damage. The numbers are, mercifully, fairly small, but there is clearly a tail and a lot of interest in whether inattention hyperactivity syndromes in children are linked to alcohol exposure in utero. We certainly know from animal work that the foetus is very sensitive to alcohol. At the moment, we have to work on a precautionary principle, but it is certainly an area where there is the need for more research. Until such time, the public health message is "Do not drink if you are pregnant". That would be an ideal starting message to have on labels.

Q53 Rosie Cooper: Absolutely. I used to be Chair of the Liverpool Women's hospital and pregnant ladies who come in are confused about those messages. But if you see the results when it goes dreadfully wrong, then—

Professor Gilmore: Absolutely.

Q54 Rosie Cooper: Can I move on almost into the public health field? The Government feel that Health and Wellbeing Boards will be instrumental in improving approaches to tackling alcohol problems. Do you agree with that? If you do, how do you think they will do it? Do you think alcohol will have a high enough priority in the huge amount of work that they are going to have to do?
Professor Gilmore: It is certainly a risk. With the major changes in the NHS, with public health going into local government, with clinical commissioning groups out there commissioning services from hospitals, there is bound to be a risk that alcohol will fall through the gap, both in preventive terms and in treatment. It should not, but we do not yet know how strong those connections are going to be. It will need a strong national steer, both from Public Health England and from the National Commissioning Board, to make sure that it does not get squeezed out. We know, historically, when money is tight, that the immediate or the urgent takes precedence over the important and public health has a tendency to be squeezed out.

Q55 Rosie Cooper: I am a person who totally believes in the idea of a Health and Wellbeing Board, but in the construct we have now I am not sure it has the powers and the tools to enable it to deliver. Is there any help and advice you could give them—or give us, even—about making sure that this does not fall through the net?
Professor Gilmore: I know the Royal College of Physicians have been looking very hard at the structure of Health and Wellbeing Boards, clinical senates and commissioning groups so we will submit evidence, I think, trying to encourage better links to make the system work.
Eric Appleby: I think the principle of Health and Wellbeing Boards is great and the potential to have a real impact is huge. I share Ian's concerns about whether it will actually happen. Looking at the strategy, this is an area where the strategy is, unfortunately, perhaps at its weakest. When it starts talking about treatment, it defers to the drug strategy. It says "We have a drug strategy". Payment by results refers to the drug strategy again, where in fact there are specific alcohol pilots going on. I think there are not the levers there to try and push the appropriate commissioning of alcohol services.
Earlier, Ian talked about admissions and the changing of the criteria. The one real alcohol-focused outcome target we have is alcohol-related hospital admissions. If that is going to dictate the future purchasing plans, if you change that so only primary diagnoses get picked up, then you are going to miss the 90% of hospital admissions because they are chronic, they are long term and what you do in the first year is not going to have a huge impact on that. So there are number of things. There are good things in the strategy. The introduction of health checks is great. I like the fact that it has highlighted the effectiveness of IBA—identification and brief advice—and particularly liaison nurses in hospitals. It has highlighted some good things, but I do not think it has done very much to push them further and encourage people to pick them up and do them.

Q56 Rosie Cooper: Can I ask a very quick question about the brief advice? Do you believe that that intervention is effective and there is enough of it?
Eric Appleby: I believe it is effective. There is not enough of it.

Q57 Chair: It is one or the other, presumably. It is either effective, in which case we want more, or ineffective, in which case it is not a sensible intervention.
Eric Appleby: It is effective and we want more.
Professor Gilmore: Effective and more—cheap, good value.
Professor Brennan: It is effective. In seven clinical trials and meta-analysis all the evidence shows that it is—surprisingly, to me—effective. People really reduce their consumption after the brief intervention. It is also, from a health economic perspective, clearly cost-effective. That was another part of the report that we did for NICE.
Rosie Cooper: That is a large circle to join up, is it not?

Q58 Chair: Can I stand back from it for a second? In your initial responses to the first question you did say that you felt that the strategy was weak on service delivery. You have come back to that point in response to Rosie's question. I wonder if you feel there is a clear view and, if so, where it is to be found, about what "good" looks like in terms of service delivery to people with alcohol problems.
Eric Appleby: Yes, there is. NICE have produced an excellent document—guidelines—and they have backed that up with an audit tool which is almost like a beginner's guide. It takes you through what—

Q59 Chair: Obviously it is a continuously evolving picture, but there is a clear view about what "good" looks like and what we should be looking for is effective rolling out of the strategy as defined by NICE.
Eric Appleby: Absolutely there is, yes. There is a spectrum and IBA—early identification—is one end of the spectrum. At the other end of the spectrum you have to do things because people are dying, but, again, it is the bit in between that sometimes we miss out.
Professor Gilmore: Right at the far end, with the heavily-dependent patients that unfortunately are often considered "no hopers", treatment is still effective and cost-effective. We only remember the ones that come back and not the ones that do well. It is very good that the strategy acknowledges that treatment works but it perhaps has not identified fully the levers that people can use locally to implement good care.

Q60 Chair: No doubt, along with all the other conditions—long-term chronic conditions—these services rely on greater integration of primary and secondary services with social care and so forth.

Professor Gilmore: Absolutely. I come back to the QIPP in NHS evidence where they can stop patients coming back into hospital and really save money. We could save nearly £400 million a year by implementing that.

Q61 Valerie Vaz: Is there anyone it is not effective on? Is it effective on young people, for instance?
Professor Gilmore: Funnily enough, the early studies suggested that brief interventions were less effective in women than in men, but I am not sure whether that has been substantiated. It is not my area of expertise. Now brief interventions have been looked at in A and E departments, general practice and criminal justice settings and it seems to have a significant impact in all the settings in which it has been looked at.

Q62 Valerie Vaz: And also on young people?
Professor Gilmore: I cannot answer that, I am afraid. We will send in some evidence.

Q63 Valerie Vaz: Does anyone know?
Eric Appleby: I am not sure.
Professor Brennan: I am not sure. It is clear that they are slightly less cost-effective in women than in men. That is because men are drinking slightly more at harmful levels and benefit more from the advice, marginally. But both are still very cost-effective compared to other interventions.

Q64 Dr Poulter: We have touched upon the need to ensure that interventions are effective, incentivised and prioritised. A traditional problem with the QOF payment for GPs is that it has been very much process focused and focused on data collection, which, of course, is important, but what we are interested in is outcomes and improving outcomes for patients. In relation to QOF payments and the issue the Chairman talked about of having a more integrated, community-focused care, is it important that GPs are incentivised to make sure that they focus on effective interventions rather than only on data collection, in order to make alcohol policy effective?
Professor Gilmore: I am not an expert in the GP contract or indeed how to incentivise GPs. We welcome the fact that alcohol has got into the health check, but it would be better embedded in the system if it was in QOF. As well as early identification, it has to be linked clearly to a mechanism where it goes on to provide the brief advice.
Eric Appleby: I would second that. It is very important. There is a perverse thing that goes on—you will know better than I probably—that GPs are one of the more resistant groups to implementing this, and I have never quite understood why that is, but to embed it, the more incentives there are the better.
Chair: Gentlemen, thank you very much. You have answered a wide range of questions and given us plenty of food for thought. Thank you for coming.

Examination of Witness

Witness: **Chris Sorek**, Chief Executive, Drinkaware, gave evidence.

Q65 Chair: Welcome. We shall try to make you feel at home, even if we ask you, hopefully, some piercing questions. Would you like to begin the session by introducing yourself and your organisation?
Chris Sorek: My name is Chris Sorek. I am the Chief Executive of Drinkaware. It is an independent charity that was formed in 2007 following an agreement between Government and the healthcare community, which Ian Gilmore was part of, as well as industry. We are fully funded by the drinks industry. We have a unique governance model that brings together five members of the alcohol industry, five members of the public health community and three independents—that includes the chair—so that everyone can sit around the table and have a discussion about information, education and what changes behaviour in the United Kingdom around alcohol.

Q66 Chair: Thank you very much. We would like to begin by probing a little, if we may, the nature of the Drinkaware organisation and then moving on to the substance of the issues. The Alcohol Strategy refers to the fact that there is a review going on—or a review planned—of the Drinkaware structure and I would like to start by understanding where that process is, how it came about and what factors need to be taken into account in that review.
Chris Sorek: In 2007, when Drinkaware was formed, it was said that by 2009, there would be a review of Drinkaware. At the time that review went through at the end of 2009, an addendum to the memorandum of understanding that originally set up Drinkaware was established and signed by the drinks industry and by the Government. Basically, what that said in 2009 was that Drinkaware would be funded at a higher rate than had been done in the past: more industry partners would be brought on board—stakeholders would be brought on board—and would raise the amount of money that Drinkaware would have made available to it to about £5 million per year. The addendum to the memorandum of understanding also recommended that in 2012 an audit be conducted again of Drinkaware and its activities and that would then move into a review of what Drinkaware's activity should be from 2013 onwards. It has all been part of a process that was established between Government, industry and the public healthcare community.

Q67 Dr Wollaston: Following on from that, it strikes me that having five industry representatives on your board is quite a heavy representation. I am interested that in 2009 the agreement was signed by the drinks industry and by Government but obviously not signed by the health representatives. Or is that not the case? Did they sign up to it as well?
Chris Sorek: My understanding—it was before my time—is that in 2007 the agreement was initially prepared and created with the input from the public healthcare community, Government and industry, but that the Drinkaware Trust, which was at that time part

of the Portman Group, was being spun out. That agreement—the memorandum of understanding—was to be signed between Government and industry to make Drinkaware an independent charity.

Q68 Dr Wollaston: Is there an argument that perhaps you need fewer industry representatives on this board? There is inherently a conflict of interest for the industry whose main obligation is to their shareholders.
Chris Sorek: The way it is currently set up is that there are five members from the public healthcare community as well as five members from industry, so there is an equal balance there, along with three independents.

Q69 Dr Wollaston: Should it be an equal balance, though?
Chris Sorek: All I am suggesting is that it currently stands that way. The review that we are going through is going to take a look at our governance structure, our organisational structure and what we need to be in the future as we go forward. I am saying that all these things are going to be considered in terms of the review process as we go forward.

Q70 Dr Wollaston: Can I ask perhaps for your personal opinion? Do you feel that there is inherently a conflict of interest for the industry to be involved?
Chris Sorek: As the chief executive and having worked for three and a half years with the board as it stands, there has never been any conflict of interest or anything where the board from the industry side has ever said, "You must do this or we will pull out," and there has never been anything saying, "You must do this because this is what we want." They have never said that. As a matter of fact, I have seen nothing but co-operation between the two. I can tell you, quite honestly, as I have said in the past, in public and in Parliament as well in previous evidence, that I would leave the organisation if I felt I was being told that I had to do something by industry—or, for that matter, by the public healthcare community—because I work for an independent charity.

Q71 Dr Wollaston: So you would not have had any discussions with the drinks industry prior to coming to this Select Committee meeting today?
Chris Sorek: None.

Q72 Chair: Can I ask about your personal background? Before you took this job, had you come from a drinks industry background or from a public health background or from neither?
Chris Sorek: Absolutely none of the above. My background is that I started off as a journalist. I went from being a journalist to working for Ogilvy in Asia-Pacific. I eventually went through that process and set up Ogilvy's operations in Asia-Pacific for about 11 and a half years. I then moved to New York where I handled work for one of Y&R's subsidiary companies, which is an advertising agency, on their global clients, working with consulting groups around the world. I then went to the Red Cross in Geneva where I headed up their communications and issues management programme for three and a half years. I established them on the internet as well as other things. I then moved from there to re-establish the SAP brand, came back to the United Kingdom to work on De Beers and the "Blood Diamond" movie and worked with people like Nelson Mandela and the presidents of Botswana and Namibia about blood diamonds and what was going on at that time because of my experience with the Red Cross. After that I eventually came over to Drinkaware to take over the chief executive job there.

Q73 Valerie Vaz: I want to drill deeper into this. It may be that you can correct this, but on Wikipedia you have your full members as Bacardi, Carlsberg, Diageo, Heineken, InBev UK, C&C Group, Molson Coors Brewing Company and Pernod Ricard. I do not see any healthcare people on there. Is that right, or do you want to correct that for us?
Chris Sorek: I would say that that has to be corrected because those people are not on the board. They are stakeholders.

Q74 Valerie Vaz: They are full members, yes.
Chris Sorek: There is no full membership. They are just stakeholders.

Q75 Valerie Vaz: Could you explain the governance structure? You mentioned £5 million. Where does that come from?
Chris Sorek: It comes from the drinks industry.

Q76 Valerie Vaz: Totally from the drinks industry?
Chris Sorek: Totally from the drinks industry. It is about £5.2 million.
In 2009 there was a new business plan put together for Drinkaware going forward because Drinkaware needed to be funded at probably a higher level, but also to get more people from the industry side involved within Drinkaware. At that time the business plan that was developed was based on income that is derived from the alcohol sales, for all intents and purposes, but it is delivered in three different categories. One is going to be the on trade, another the off trade and then you have producers. There is a banding structure that goes through that business plan, from A through, I believe, K, and it is based on how much money they make from alcohol. That determines how much money they give to Drinkaware. It was agreed that would be the most equitable way to go forward. The people that you mentioned there are some of the industry stakeholders. In terms of the public health community and their relationship with us, it varies based on whether or not we are dealing with local people in terms of local organisations, where we give out grants, or at regional level or, in some cases, within the devolved administration.

Q77 Valerie Vaz: Taking you back to the governance structure, who is actually sitting round the table? What do you do? What is your day like?
Chris Sorek: It is very busy.

Q78 Valerie Vaz: Yes, but I need to know who is making the decisions and how the decisions are coming out.
Chris Sorek: As it turns out, in terms of the strategy, the board—

Q79 Valerie Vaz: First, who is sitting on the board?
Chris Sorek: On the board sits Derek Lewis, who is the chair, an independent, Alex Hunter, an IT specialist, an independent, and Helen Humphreys, an independent from a communications industry background. You then have five members of the public health community, which include Dr Nick Sheron and Dr Michael Wilks. Does everybody know who—

Q80 Valerie Vaz: No. You need to tell us who they are.
Chris Sorek: Dr Nick Sheron is one of the top liver specialists in the country. Dr Michael Wilks is one of the top forensic specialists. We have Gill Valentine who is from the University of Leeds—and now University of Sheffield. She will be Pro-vice-chancellor for there but she is a human geographer. I cannot remember everyone on the board unless I mentally "look" around the table. Give me a second. There is Professor David Foxcroft from Oxford Brookes, who is a chartered psychologist, and we have one open position which was previously filled by Alan Maryon-Davis of the Royal Society for Public Health, who has retired and now moved on to our Chairman's role and, because of that, he has resigned from our board. On the industry side you have Benet Slay, who is from Carlsberg UK now—formerly from Diageo—Mark Hunter who is from Molson Coors, Ted Tuppen CBE from Enterprise Inns, Carolyn Bradley from Tesco and Nick Grant from Sainsbury's.

Q81 Valerie Vaz: You know what the debate has been raging about recently. How do you set your strategy and your policy? I know you said there is no interference from them, but surely not doing anything is just as bad as being interfered with. There is a huge debate raging about the effects of alcohol, is there not?
Chris Sorek: There is a huge debate.

Q82 Valerie Vaz: What do you do? I am confused about how you influence what is going on.
Chris Sorek: I appreciate that. We carry out campaigns that are aimed at consumers across the country, the entire United Kingdom. Our strategy is focused on three target audiences: parents and under 18s, young adults 18 to 24, and adults 25 to 44 years old.

Q83 Valerie Vaz: What were your campaigns?
Chris Sorek: The campaign that we are currently running now for parents and under 18s is a programme called "Talking to your kids about alcohol". That campaign, which was recently launched, is basically made up of two parts. One is a parents' brochure, but there is also a digital campaign that is aimed at parents of under-18s—basically 10 to 14-year-olds—to get them to have a conversation with their children about alcohol. A lot of parents think that they can have that conversation. When we first did the research about it, we found that 80% of all parents said, "Don't worry about it. I can talk to my kids about alcohol." Then they took a look at this interactive video—if you go on to our website you can see it—of a young child talking to their parent in the kitchen while they are having lunch or tea. They look and there is a wine bottle there, and they say, basically, "Can I have some of this?" That interactive video allows the parent to decide on what is said next, "Yes", "No" or "End of conversation," and then it trees down into number of other parts of it. This has all been approved by our independent medical panel. As it goes through that entire thing, it eventually gets down to a point where it gives parents advice.
The interesting thing about that campaign so far has been that, out of all the people that have seen it, which is well over 300,000, 40% of the parents, after they have seen it, feel, "I really cannot have that conversation with my children right now because I do not know enough." They stay on our website and they go to other parts for parents and the information that we give to them about how to talk to your children about alcohol. That is currently one programme that is going on. It is counterintuitive to see that people do not feel confident after seeing the video, but it tells us that parents who think they have a plan probably need to have more support and we provide that information to them. That is one area.
There are two other areas. One we have just mentioned, "Why let good times go bad?" which is aimed at 18 to 24-year-olds. That campaign was an agreement that was originally signed between the last Government and the drinks industry to conduct a campaign that we eventually took over, aimed at 18 to 24-year-olds, to bring down the level of binge drinking and nightlife issues that were out there. The bottom line is that in this last year's campaign we found that we were able to reach about 850,000 young people. Out of those 850,000, the total population that saw and recalled our campaign, which was about 27%—which is roughly double the industry average of people recalling any campaign—8 out of 10 young people took on our tips, which is great, because they said they would employ those tips to mitigate the issues regarding having a good night go bad, which, to your point, was what was the result of that. We also know that 56%, after they had seen the campaign, interacted with the campaign and were going to change their drinking behaviour. Granted, these are claimed behaviour changes, but that is still a fairly substantial number—a high number—for young people doing that.
The last area that we work on is with adults, which is the 25 to 44-year-olds, although it goes even higher than that, because we have about 350,000 people coming to our website on average per month. These are unique visitors. Most of those people come to our website and usually go round and get information from different places, but we have a specific campaign aimed at adults that is targeted to bring them to a website that is called MyDrinkaware. *[The witness showed illustrations of website pages to the Committee]* The MyDrinkaware part of the website is a tool and basically—you were talking about brief

interventions before—this is a brief intervention. People come in and sign up. Out of the 250,000 people that have come on to the MyDrinkaware part of the website, over 108,000 have already started using this. Out of that 108,000 only 30% are active users and I will tell you why only they are active in a few seconds, but—

Q84 Valerie Vaz: Do you know the demographics of the people who are using it?
Chris Sorek: We do have some demographics. We are restricted from going into too much detail because of data protection, but we do know that, out of those people that have come—the 30% of the 108,000 that are really on board with MyDrinkaware—that 30% stay with it and use the tool to reduce the amount of alcohol they are drinking. We know that, out of that, 30% have seen a reduction of between 5 to 3.9 units. But if I could just show you this for a second because you were talking about—

Q85 Chair: Can I interrupt a second, Mr Sorek? Purely at a practical level, in terms of evidence to the Committee, we have to publish the evidence and so if you could refer to it rather than point it out, that would be easier.
Chris Sorek: Sure.
Andrew George: We could have them sent to us.
Chair: Could we have them sent to us?
Chris Sorek: Yes.

Q86 Valerie Vaz: I appreciate all that, but I want to ask your view, or the group's view, on an advertising ban. Has that ever been discussed and would you ever consider it?
Chris Sorek: First of all, as an organisation, we are proscribed from talking about policy or lobbying. So we have no voice in issues about advertising, licensing, availability and things like that. There is a reason for that.

Q87 Valerie Vaz: How do you fit into the Department of Health then?
Chris Sorek: How do we fit into the Department of Health? We co-ordinate—

Q88 Valerie Vaz: Do you fit in at all?
Chris Sorek: We co-ordinate very closely with the Department of Health, the Home Office and the Department for Education.

Q89 Valerie Vaz: How do you do that without influencing policy? What are you doing when you are talking to them?
Chris Sorek: We provide information and education to consumers. We do not talk about policy. We provide them with research and information. I can only say that it resonates extremely well with consumers. When I started in 2008 we had maybe 40,000 or 50,000 people coming to our website every month. We are now having an average of about 340,000 to 350,000. Quite honestly, we have become more and more popular for people to come to and view the information on our website.

Q90 Valerie Vaz: So comparing with what is happening in Europe, like France and Norway, you do not consider that would be a route, a tool?
Chris Sorek: Not necessarily, no, because we are really focused on the United Kingdom and the consumers in the United Kingdom.

Q91 Dr Wollaston: Is it not a measure of the lack of genuine independence that you cannot actually say that the single best thing you could do would be to, say, remove the advertising? Even the WHO have commented that it becomes meaningless, given the disproportionate spend on advertising compared with the spend for Drinkaware. There is such a disproportion that the greatest effect would be for you to campaign to have a drop in advertising but you cannot do so because your terms are set partly by the board itself and because you need industry sign-up to it.
Chris Sorek: No. I am sorry, it is not disingenuous. It was an agreement made by the public health community, Government and industry to have this organisation set up that would only focus on providing information and education—just the facts—about alcohol to consumers. It has been that way since 2007.

Q92 Dr Wollaston: Do you feel that when you review what Drinkaware is all about that the fundamental change should be that you are allowed to lobby on reducing advertising?
Chris Sorek: That would be something that would be taken up—I am sure will be discussed—in the review potentially, but it would be also something that the board will have to take up and vote on.

Q93 Dr Wollaston: Would the board have to agree to it? In other words, would you have the drinks industry having to sign up to something that is fundamentally against their interests? In other words, that is a conflict of interest, surely.
Chris Sorek: We are speculating. All I can say is that whatever proposals the review brings up—

Q94 Dr Wollaston: But it is not speculating. It is a very serious point, is it not? The point is being made that there is such a huge disproportion in the spend on marketing and the spend on Drinkaware that levelling that playing field or significantly reducing advertising would have the single greatest effect.
Chris Sorek: The Alcohol Strategy suggests already—within the strategy it talks about this—that Drinkaware should be increased in scope and funding. How that happens is still something that needs to be proposed to the board and then the board has to take that decision. I cannot answer for the board.

Q95 Dr Wollaston: But are the turkeys going to vote for Christmas?
Chris Sorek: I am sorry?

Q96 Dr Wollaston: Are the drinks industry going to accept that one of the roles of Drinkaware could be to campaign against advertising?
Chris Sorek: It could be, but that is a decision that would have to be taken by the board.

Q97 Chris Skidmore: You mentioned that you could not make any decisions on policy, that you could not raise issues of policy.
Chris Sorek: We do not comment on it, yes.

Q98 Chris Skidmore: You do not comment on issues of policy, but the title of your press release on 23 March was, "Alcohol strategy must address Britain's hidden binge drinkers" and your own comments said, "We are concerned however that while young adults sprawled on pavements after a night out on the town grabs headlines, Britain's hidden binge drinkers present a worrying trend", and you go on quite convincingly. I do not disagree with your statement but that is clearly an attempt to influence policy. Therefore, you have a very grey area of which you are saying, on the one hand, "We cannot talk about policy. We cannot talk about banning advertising", but, on the other hand, you are very willing to talk about issues of policy in terms of hidden binge drinking which may or may not be convenient because then it deflects from young persons drinking, which, in terms of the alcohol industry, is far more valuable than hidden binge drinking. Do you not think that there is a grey area?
Chris Sorek: In fact, we provided the information that we felt needed to be placed in the public domain, which was a comment by Drinkaware about the Alcohol Strategy. That was that, for all intents and purposes, the Alcohol Strategy has a very high focus on binge drinking. What we wanted to do is to bring to the attention of the public, through the media, that most of the binge drinking, as you heard from the previous panel, happens at home and among adults and not among 18 to 24-year-olds. Clearly, that is an area that needs to be addressed because that is where chronic alcohol—and eventually acute alcohol—issues occur.

Q99 Chris Skidmore: I agree with you and I agree with the press statement, but my point is that the press statement there is a clear attempt to try and influence policy. Why not put out a press release saying, "The Government need to look at advertising in the run-up to the Olympics, and whatever European football cup there is, and the effect that advertising might have on young people's drinking habits in the future"? Why not put out a press release on that as well? That is simply asking for more information rather than policy.
Chris Sorek: I appreciate that. The reason why we took the position that we did in terms of the release we sent out was that if you focused only on the issues around binge drinking and 18 to 24-year-olds, in fact you missed the majority and the biggest issue that needed to be addressed, which is the people who are 25-plus who are over-drinking, at home usually. That is the only reason we put it out, so that it would not be forgotten within the discussion that was going to happen afterwards.

Q100 Chair: Mr Skidmore's point, surely, is that that is addressing a policy question. By putting out the press release you did, you are saying that the Government are right to focus on binge drinking and the social consequences of binge drinking but they should not forget in their policy the middle-class drinking issue that leads to long-term health consequences. That is a comment about the Government's objectives as defined in its policy paper, is it not?
Chris Sorek: It was as defined within the Alcohol Strategy. Re-reading the Alcohol Strategy, the initial parts of it are very much focused on the social harm that is caused by 18 to 24-year-olds who are binge drinking. In fact, all we were trying to do was to make sure that, within there, there was a balanced view that 18 to 24-year-olds are clearly an issue but so are people who are drinking and bingeing at home.
Chair: We have probably covered the point, have we not?
Valerie Vaz: Yes, fine. We can move on.

Q101 Chair: I think so. I wanted to come on to the attitude of Drinkaware to minimum pricing. You make the comment, "While price is one of many factors that influence drinking, at the source of behaviour change is tackling people's attitudes." Do you believe that price has an important impact on people's attitudes? Do you think those are alternatives, or are they the same thing?
Chris Sorek: As the previous panel said—and we fully agree with it—there are a number of tools in the toolkit. Pricing is one of those things. There are other issues as well. Those are things that the previous panel discussed in more detail and with a better understanding than we would. We are looking at the demand side. You may be able to raise the price and change availability but changing people's demand for alcohol—changing their behaviour as to why they want to drink and what they are drinking—is something that we are focusing our attention on. What we are trying to do is reduce the amount of alcohol that parents give to their children. If they followed CMO guidance you would not see the average age of first drink at 13.8 years. You would see it at 15, which is what CMO guidance says. That says that there are quite a few parents who are giving alcohol to children at a much earlier age. If you take a look at what we are doing with adults, we are trying to talk to them about units and unit guidelines. What they will then do is reduce the amount of alcohol they are drinking on a daily basis, which is one of the reasons why MyDrinkaware, I believe, has become so successful.

Q102 Dr Poulter: I am a doctor by background, as are other members of this Committee, and I was not aware that your organisation was in existence, I have to say, during my medical practice, which is interesting, in one way. You have a number of interesting initiatives and it is good that the number of hits on the website have gone up. But it is almost, it appears to me, that it requires people to recognise they have a problem with alcohol and to stumble upon or realise that they want to have a look at your website or find it in the first place. Many people with alcohol and drinking problems do not recognise the problem that they have in the first place.
One thing we have not talked about so far—and it would be interesting to hear your views—is how you interact as an organisation with local authorities who

are being given responsibility for public health, or at least 40% of the public health budget. It seems to me that if we want to engender behavioural change, working with schools and local authorities in their public health role is a key challenge and a way of getting into communities in a way that has perhaps been more difficult to do in the past.

Chris Sorek: If I can go back to your first question first, people, I would say, do not stumble on to Drinkaware. As a matter of fact, whenever they put in "alcohol", "alcohol-related illness", "health and alcohol" or any of those search items into Google we always come up number one in terms of we are the place where people come to. As a matter of fact, Eric Appleby's predecessor, Don Shenker, basically said to me, about 18 months ago, that we are the de facto consumer source for information about alcohol. I am simply saying that people come to us for a number of different reasons and on a regular basis.

Q103 Dr Poulter: Absolutely, but the point is that if I were an alcoholic it is very unlikely that I would recognise my own problem; I would not necessarily want to admit I had a problem or recognise it. My spouse, my family or my friends may recognise I had a problem, but it is unlikely that I, myself, would want to access or stumble across your website, which is the point I was getting at.

Chris Sorek: From that perspective, as an organisation, we focus on prevention. There are people like Addaction and others that focus on dependence issues. Our remit, again, is that it stops at the point of getting into dependence. That is something that we turn over to another organisation rather than ourselves. We do prevention and education work. We do not get into dependence.

Q104 Dr Poulter: But do you not think that is a difficult dividing line? For example, somebody who has an unhealthy relationship with alcohol—for example, the binge drinker—may not necessarily be a chronic alcoholic, yet that person may not recognise that going out and drinking far too much one night a week or two or three nights a month is a problem. So although we may recognise that here, they may not recognise that as a problem. It may well be it relies upon them to recognise the problem to access your website rather than dealing with the issue of engendering behavioural change. A general awareness of alcohol needs to be rather more nuanced than that, raising awareness in schools, working with local authorities and so on. I would be interested in teasing out how you do that.

Chris Sorek: To give you a bit of an idea—and I will not belabour you with a lot of different things—I have here unit measure cups. We are talking about local authorities and what we are giving out. We have given out approximately, I believe, somewhere in the neighbourhood of 500,000 or 600,000 of these unit measure cups over the last few years. Many of these go to the NHS—PCTs in the past—and to GP surgeries. We have given out more than 400,000 of these things in Scotland alone.[1] We also have free fact sheets that are being downloaded all the time, available to everybody across the country. Those are being used by local authorities. As a matter of fact, recently I was in Northern Ireland at the launch of "My Name is Katie". That is a programme aimed at parents where they have basically lifted our parents' brochure material, put it into a local environment and then renamed it as "My Name is Katie". They reprinted it almost verbatim. For all intents and purposes, what we are able to do is provide information free of charge to everybody across the country, including all local authorities. If you take a look at how our resources are being used, I can only say that our resources are being used across the entire United Kingdom on an ongoing basis and every year we spend probably close to about £300,000 or £400,000 doing nothing but supplying those types of resources to local authorities.

Q105 David Tredinnick: Can we see your glass? Would you mind passing it round?

Chris Sorek: Sure. *[The witness passed the item to the Committee]*

Chair: I am not sure how they record that in Hansard, but they are aware of that.

Q106 Rosie Cooper: You started off by telling us that Drinkaware provides information and education for consumers. But in the exchange, just then, with Daniel you said you deal with prevention and somebody else deals with addiction. Is that right?

Chris Sorek: Yes—dependence.

Q107 Rosie Cooper: My confusion is that you deal with prevention yet tell us you are not able to say, "Reduce alcohol advertising because that would help prevention." You then tell us you are not able to say, "Increase the unit price of alcohol because that will help prevention." So I do not get you at all.

Chris Sorek: The issue that you are talking about is that there are different people doing different things—different parts and different tools within the toolkit, as I mentioned. Our role is to provide information and education. Others are out there, including people like Alcohol Concern—I know Eric Appleby and what they are doing over there—and their job is to lobby and talk about policy around unit pricing and things like that. They would not be talking, necessarily, about prevention. They will talk about advertising and we will not. Addaction, who I know very well, will be talking about dependence issues and they take over from that perspective. We are trying to provide information and education to consumers and so hopefully, over a period of time, will prevent them from going into a dependence—

Q108 Rosie Cooper: The best information you could give them is not to drink excessively and not to watch adverts, and that the price should be increased, and you are telling us you cannot give it. I am genuinely confused, in the sense that I do not know what you are for beyond—and I am not trying to be difficult—being a fog, a means of confusing or jumbling up the messages and almost being a human shield where criticism can bounce off, saying "We are doing

[1] Note by witness: Supporting the Scottish Government's Alcohol Awareness Week activities in 2008, 2009 and 2010

something" when the big thing that you could be doing, you tell us, you are not able to do.
Chris Sorek: All I can say is that the campaigns we have been running over the last 18 to 24 months have been somewhat successful in terms of what they are doing. They are showing the green shoots of behaviour change, which is our intention. It is going to take time and many people working at it from a number of different directions. It is the same reason why you would not see, for example, to answer your point, Alcohol Concern running a campaign the same way we would be doing and talking to people about alcohol. It would not happen. You would not see Addaction doing the same thing. Everybody plays a role in this, so we are all part of the solution in terms of trying to change behaviour.

Q109 Rosie Cooper: You talk about green shoots. When I was a student we would apply gibberellic acid to increase the growth rate. All you have to do is turn the lights on and say, "These are two or three things you can do which will really help you not to get in this mess," and you are saying they are beyond you, but then you also include yourself in the prevention zone. It does not make sense.
Chris Sorek: We are in the prevention zone because we are talking to consumers directly about the facts relating to alcohol and alcohol misuse. When you talk about reducing advertising, availability or licensing, those are things that are all on the policy side and there are people talking about those things. We all work together to solve the problem. It is not just a supply-side issue. It is a demand issue. It takes more than simply changing the rules about availability or pricing. It also means changing people's attitudes towards the demand for alcohol.

Q110 Rosie Cooper: I think you should all join up together with a common message to reduce advertising and increase the unit price. Let us get on with it and start really saving lives and helping people.
Chris Sorek: It is something that, again, within the sphere of what we are doing—
Chair: It is a matter for the Committee.

Q111 David Tredinnick: Going back to Dr Wollaston's point earlier about the scale of the amount of money going into advertising versus the amount of money going into your organisation, I hear what you are saying and the way that your organisation has grown from small shoots to slightly larger shoots, but in terms of proportion of effect I would suggest to you that there is a massive difference in the resources that you have and the resources of the drinks industry. For that reason, your impact is disproportionately less.
Chris Sorek: I am not going to disagree with that. In some cases it would be great, and part of the review process is to take a look at what size we should be, what we should be doing and, as we go forward, how best to make behaviour change happen. It is definitely one of the questions that we are asking within the review.

Q112 David Tredinnick: Going to the point which was made just now about attitudes, there seems to have been a fundamental shift in attitudes, certainly from my generation, where people went out to have a few drinks and one or two might have had too many, to getting into a state of complete intoxication being the starting point for doing anything—"I am going out to get drunk tonight." It is the attitude, the behaviour, that has to be adjusted and pricing is part of that. Somehow we have to get at those attitudes, do we not?
Chris Sorek: I would agree. I think that changing—
David Tredinnick: I am sorry, I did not express that very well, but I was thinking on my seat, as it were.
Chris Sorek: Changing people's attitudes is probably one of the most important things we need to do in this country. Years ago, during my first time in the United Kingdom in the late 1970s and early 1980s—when I was working here—going out and getting drunk, at that age, was seen as losing face. People would think less of you. That has changed and there has been a cultural shift. As to what has changed those things, we are still trying to find more insights about to figure out how we might be able to address that. There are a number of things that we are looking at too. For example, we do know that with young people there are more 18 to 24-year-olds out of work and those 18 to 24-year-olds out of work have a slightly different attitude towards drinking to get drunk than those that are working. We need to address those people.

Q113 David Tredinnick: If we could get these glasses into public houses or get them given away as freebies in stores, it would be brilliant because one of the problems a moderate drinker has, I think, is trying to assess how much alcohol they are having in all kinds of hostelries where all the glass sizes are apparently different. I know we have statutory measurements for pints and half pints but certainly the measurements in glasses are confusing to interpret.
Chris Sorek: I can tell you that I gave one of these glasses to a senior member of Government probably about six months ago and, at that time, she said to me, "I cannot wait to show this to my husband and talk about how much alcohol we are drinking." So you could say that it is across the board. But I can say that this has had an effect in Scotland where we passed out almost 400,000 of those over the last three years.
David Tredinnick: Illustrating the impact of different strengths of wine and beers is very important.

Q114 Chris Skidmore: Very quickly on unit labelling, the Government are consulting on labelling at the moment and I want to pick up what Drinkaware's own position is. Obviously the industry is committed to this 80% coverage of labelling by 2013 under an enhanced self-regulatory framework, although the previous self-regulatory framework meant that only 15% of drinks were labelled with the overall number of units per drink. Does Drinkaware have a position on unit labelling? Do they agree with the industry's approach or should we be moving towards a tougher regulatory framework that does not rely on self-regulation?
Chris Sorek: What I can say is that I believe any information you give to consumers so they understand how many units are there is going to be extremely helpful. That is the reason why these glasses are really

important in some respects. But it is also for people who know—for example, we have started running a campaign with the British Beer and Pub Association and the Wine and Spirit Trade Association members where they will put up posters within their stores or pubs. Basically, it says there are two units in a pint of beer and two units in this kind of glass of wine, two units in another drink and then one unit in, say, a 25 ml pour of spirits. The issue is to get people to start understanding what units are about and also what unit equivalents are, so once they start making that connection between units and unit equivalents they will have a better understanding and, hopefully, reduce the amount of alcohol they drink. Any labelling that does talk about units is great. Our name is on the labels basically as a voluntary agreement. It is not something that is specified. It is a voluntary agreement—

Q115 Chris Skidmore: Would you prefer it to be?
Chris Sorek: I am thrilled that our name is on there because it draws more people probably to our website to get more information about alcohol.

Q116 Chris Skidmore: Would it not be more effective if every single bottle of drink had Drinkaware's logo and website on there?
Chris Sorek: They pretty much do. The only ones that do not are probably wine bottles, and we recognise that that is clearly an issue we would need to address. But that is something that we would address through a different forum.

Q117 Dr Wollaston: Have you produced a similar glass for wine, because I know one of the issues, particularly for wine, is the—
Chris Sorek: It is on the glass there.

Q118 Dr Wollaston: The trouble is, of course, that people do not drink their wine in beer glasses. People drink their wine in wine glasses. I have seen the beer mats that Drinkaware produces and they very often lead to an impression that there are two units of alcohol in a glass of wine when in fact, very often, there are three in a glass of wine. A real issue, particularly for women drinkers, is assuming that they are drinking less than they actually are. I wondered if you have an equivalent one in an actual wine glass-type glass.
Chris Sorek: We do not, although I have to say that, late last year, we did run a campaign that was aimed at women and drinking at home and wine. As it turns out, it was so popular that 15,000 consumers requested glasses, literally at the speed of the click of a finger, through the promotion that we were running. We are looking at it as something we can do. It could be, potentially, in a wine pourer, something that you would—as in many cases you have, for example—stick inside a bottle and you could literally dial up or dial down the amount of units, or, based on your ABV, how many units you would be getting out of there so it gives you an idea what is going on there. We are currently looking at something along those lines that might be helpful for somebody to use at home. That makes a lot of sense.

Q119 Dr Wollaston: I know you do not feel you are able to comment on policy, but certainly when you go to the continent, for example, and you are given a glass of wine at lunchtime it comes in a very small glass. Over here we are given a glass of wine in a huge glass. Does Drinkaware have a view on how important the size of the glass is?
Chris Sorek: As it turns out, we do mention in virtually every one of our releases or communications with the public that smaller measures are available. As a matter of fact, on our website when you look at our drinks calculators, or even on the ones that we pass out that are basically wheels, that are paper—and we passed out probably close to 5 million of those over the last three years—they do have 125 ml, a smaller measure, and then it goes up to 175 ml and then 250 ml. It gives you an idea of how many units you are getting in each one of those and also how many calories you are getting too.

Q120 Dr Wollaston: Again, that is very important. At the moment the glass says that Drinkaware recommends that you drink no more than two to three units or three to four units, depending on whether you are a man or a woman. But at one point you were saying this was the recommended daily allowance, so you were referring to it almost like a vitamin, that people should drink this quantity. That was changed following complaints. Does Drinkaware regret that that was there at one point?
Chris Sorek: In fact, yes and no. There were three screens that went with that view that you are talking about and in each one of those screens it kind of led you through—because it is one of those things that changes on your website fairly quickly so you read through them—and, as you get to the end, it does say, "Now regularly means" and it gives the definition of "regularly". So we have changed it to be clearer. We have done that.

Q121 Dr Wollaston: But do you not think it was a rather catastrophic error to refer to alcohol as a recommended daily amount?
Chris Sorek: Mark Bellis did the research on that. He was the one that brought it up and, as it turns out, out of 93 different mentions of the correct mention of the unit and unit guidelines on the website, that was the only one that was wrong and we changed it as soon as we found out.
Chair: We have probably covered the ground. You are, to a degree, as has been drawn out in the discussion, David dealing with Goliath. I hope you have not felt like that this morning.
Chris Sorek: Absolutely not.
Chair: Thank you for coming.

Q122 Dr Wollaston: Can I ask one final question?
Chris Sorek: Sure.

Q123 Dr Wollaston: You stated that Drinkaware spends £5.2 million. As a matter of record, what is the total spend on advertising, marketing and sponsorship

through the internet, film and all the different media? What do you estimate is the total spend on alcohol marketing, advertising and sponsorship?
Chris Sorek: I do not know.

Q124 Dr Wollaston: You do not know?
Chris Sorek: I do not know, and the reason why—

Q125 Dr Wollaston: Should Drinkaware not know that?
Chris Sorek: These are company-confidential bits of information and it is not something that they share with us, and nor would I expect them to share them with us as a charity. I have asked the question and I have seen numbers bandied about that are basically extrapolations from US data, but I cannot say what that actual number is. I can tell you that it is a lot more than what we have.

Q126 Dr Wollaston: What would you estimate it is?
Chris Sorek: We are in the single digit millions and I am sure they are in the triple digit millions. What that number is, I just do not know.

Q127 Dr Wollaston: Have you made an estimate yourself?
Chris Sorek: No.

Q128 Dr Wollaston: Have you not done so from reading the literature or talking informally to colleagues?
Chris Sorek: I have talked to them and everybody has a slightly different view of what that number might be. I really cannot tell you what it is. I have no idea. I wish I did.
Chair: Thank you very much for coming.

Tuesday 22 May 2012

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper
Andrew George
Barbara Keeley
Dr Daniel Poulter
Mr Virendra Sharma
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: **Brigid Simmonds OBE**, Chief Executive, British Beer and Pub Association, and **Henry Ashworth**, Chief Executive, The Portman Group, gave evidence.

Q129 Chair: Good morning. Thank you for coming to help us with our inquiries, as they say, about alcohol. Can I ask you briefly to introduce yourselves and your organisations, and then we will start some questions?

Brigid Simmonds: My name is Brigid Simmonds. I am Chief Executive of the British Beer and Pub Association.

Henry Ashworth: I am Henry Ashworth. I am Chief Executive of the Portman Group and co-chair of the Responsibility Deal Alcohol Network.

Q130 Chair: Could I start with some general questions about what you perceive as being the alcohol problem, if indeed there is an alcohol problem? Let me ask a simple question first: what is the problem we are trying to solve, in your view?

Brigid Simmonds: We are trying to solve the problem that a minority of people are drinking too much. I listened to some of the people who came in front of the Committee previously who rather shared that view. Alcohol consumption, by any measure, has gone down. It has gone down by 14% since 2004 and, if you are looking at young people or people who drink too much, it is certainly going down. But we do have a problem with a minority of people who are drinking too much and we need to tackle that.

Henry Ashworth: I would add to that and say that we are trying to encourage more people to drink within the Government's guidelines. According to the Alcohol Strategy, 78% of people are now drinking within the guidelines, but that does mean there are a large number of people who still are not drinking within the guidelines. While the trend for people who are drinking at harmful levels is reducing and has reduced from 6% to 3%, for example, for women or from 9% to 6% for men, of course—because 84% of the population drink—that is still a large number. What we are trying to do is help more people drink within Government guidelines and tackle that minority of people who are not. That is where the challenge lies.

Q131 Chair: Is it true that the numbers who are drinking to harmful levels are reducing?

Henry Ashworth: According to the Government's statistics that we have seen—and I could quote from them if you like—

Q132 Chair: The previous panel of witnesses we were questioning suggested that there was a developing problem of people drinking at home, not necessarily at a level that creates a law and order problem, but that creates a long-term health problem for those individuals.

Henry Ashworth: Drinking within Government guidelines, according to the Government's Alcohol Strategy, is 78% of the population. Therefore, drinking above Government guidelines, which could lead to harms over a period of time, is 22%. According to the statistics we have had from the Government of drinking at harmful levels—in other words, more than double Government guidelines—in 2010, 6% of men drank more than 50 units per week but in 2005 this was 9%, with the equivalent for women down to 3% from 5%.

Q133 Dr Poulter: It is quite dangerous to put those statistics forward to the Committee as being an idea that this country does not have a problem with alcohol, or that a lot of young people do not have a problem with alcohol. You are looking at what you consider to be harmful. We know, first of all, that very few people properly understand how much they are drinking in terms of units, so units are not always a good measure when we are doing surveys. Secondly, you are talking about harmful levels of drinking in terms of what are potentially immediately threatening to life, or have poorer outcomes and sequelae, but we know that a lot of the issues to do with alcohol are the cumulative effects over a number of years. It is somewhat misleading if we were to look at those statistics you have just put forward as being an indicator of the state of this country's relationship with alcohol.

Henry Ashworth: I hear very clearly what you are saying. I would go back to my first point that 78% of people are drinking according to the Government's Alcohol Strategy—within Government guidelines—so we must assume that 78% of people are drinking within the guidelines set down by the Chief Medical Officer of 21 units a week for a man and 14 units for a week for a woman. I absolutely accept that, therefore, there are 22% of people who are drinking over and above the Government's guidelines and recognise that we are about trying to increase the number of people drinking within the guidelines, which will help reduce harms.

Q134 Dr Poulter: But there is also the problem—and it does not come over in what you have put forward—of binge drinking and its cumulative effect, particularly among young people, not only those of university age but also elsewhere. They may well be drinking within certain limits but doing themselves a huge amount of damage from a massive binge once a week. It is very easy sometimes to bandy around statistics that can put across a distorted picture of what the reality is out there in the high street on a Friday and Saturday night.

Brigid Simmonds: While the statistics do show that young people are also drinking less—and the Government have to take some credit for the policies that they put in place that have led to that fall—we will not yet see any fall in the sort of thing Sir Ian Gilmore was talking about, which is the number of people entering hospital who have chronic conditions. There is a lot more work that we need to do. We are not sitting here being complacent about it. We are saying that some of the policies and understanding have changed. If we need to change anything, particularly about university students, it is social norming. The suggestion that you go to university in freshers' week and all drink too much—when a lot of young people who go to university do not necessarily want to drink too much—is a perception that we have to change over a period of time so that it becomes the social norm that you go to university and drink within sensible limits.

Q135 Dr Poulter: It is not to say that certain policies have not been effective; I am absolutely sure they have been. However, we heard in the evidence we were given by the medical experts last time that you can see fairly quickly—within a couple of years—an effect on A and E admissions in terms of binge drinking particularly, but also chronic alcoholism. We heard that A and E admissions are still greatly up now compared with where they were a number of years ago for binge drinking episodes, and we also heard that there is a similar problem with chronic alcoholism. So while there are some very good initiatives, some of which are having an effect, and there is laudable intent, the medical evidence we heard last time as to admissions related to alcohol—and, if anything, it was purported that they are under-reported—does seem to be pointing in the other direction as a trend.

Brigid Simmonds: The primary diagnosis for hospital admissions increased faster in 2002–03 but it has been slower in the last four years. Of course, the Government recently changed the way they report statistics. It is going to be primary diagnosis rather than the secondary diagnosis that we had up to now. To give you an example, I broke my leg when I was knocked down by a taxi. There was no alcohol involved, but under the old system a proportion of those sorts of accidents would have been included in the statistics. So it is a move forward.

Q136 Dr Wollaston: A proportion—

Dr Poulter: Quite rightly so. Actually, what was happening—I am sorry, Sarah, and I am sorry, Chairman, if you will let me go on—is some people, and youngsters on a Friday and Saturday night, will go out and may well be knocked over by a taxi or a car because they have had too much to drink. The point is that there may be some people who going to be hit by a taxi after, maybe, a glass of wine, but there are some people who are being hit as a direct consequence of drinking and that is the reason for their admission.

Brigid Simmonds: I was only saying that moving to primary diagnosis is important. I was giving, as an example, my case where there was no alcohol involved. Therefore, why should it be part of that statistic?

Q137 Chair: It must be right to have the statistics reflect whether alcohol was an issue or not, if we know.

Brigid Simmonds: Yes.

Chair: Virendra wants to come in because he needs to leave.

Q138 Mr Sharma: I am sorry; that is because I am leaving early. The Portman Group expresses concerns about alcohol trend data. What are the problems that you see and how would you like to see them resolved?

Henry Ashworth: One of the things—maybe this comes back to Dr Poulter's question as well—we would like to see is the Government presenting a consistent set of data looking at trends that can be followed, not for any complacent reasons but so that we can see whether the measures in place at the moment are having an effect in terms of consumption patterns and so that the various people who are engaged in trying to tackle alcohol-related harms can see consistently, from the Government, what is happening. We have been very carefully looking through the trend data coming from the Office for National Statistics, for example, or from the Department for Education. We think there should be one consistent set of data looking at all the trends around both alcohol consumption patterns, which are very important in regard to binge drinking, for example, and indeed alcohol-related harms, as the Government have set out in the Alcohol Strategy.

Q139 Mr Sharma: Thank you. Were you involved in discussions with the Department of Health or any other part of Government during the preparation of the strategy?

Henry Ashworth: I am the chairman of the Responsibility Deal Alcohol Network and, obviously, I have had detailed conversations with officials because of that role. In the lead-up to the Alcohol Strategy, the unit reduction pledge was a live issue that we were trying to get signatories signed up to from across industry, so I was involved with the Department of Health and the Cabinet Office, absolutely.

Q140 Dr Wollaston: I wanted to make one point about the statistics you used. While, of course, everyone would welcome the fact that fewer young people are drinking, is it not the case that those who do are drinking more heavily and that we still have a

very significant problem in this country with those young people who are drinking?
Henry Ashworth: I completely agree with you that we should obviously welcome the fact that the number of young people, for example, who have drunk—

Q141 Dr Wollaston: Yes. I am not disputing that. But it does not address the real problem we have with the proportion of young people who are drinking very heavily indeed, and in fact are going out to drink in order to get drunk.
Brigid Simmonds: We have to create a culture change, without a shadow of a doubt. We have to create a culture change that says that going out on a Friday or Saturday night and drinking to excess to get drunk is not acceptable. One of the things that I welcomed in the strategy was something around personal responsibility. That is not to suggest industry does not have a responsibility, but there was an attitude that, somehow, "It is not our personal responsibility when we drink to excess." We need to move that on in the Alcohol Strategy.

Q142 Dr Wollaston: Coming back to a point that, it seems to me, is often addressed by the drinks industry saying there is no link between the level of drinking and harm, is that not partly because you can reduce the overall amount that people drink—the total volume that is consumed—but it does not address the fact that most of the harms are coming from this small proportion of very heavy drinkers?
Henry Ashworth: I absolutely agree with you that there are, obviously, too many young people drinking beyond the guidelines. We should welcome the fact that the trends are generally moving in the right direction. For example, as to children of 11 to 15 years old drinking, there has been a 40% reduction in children who have ever tried alcohol in that age group in the last ten years. However, I absolutely agree with you that the very small number of children who are drinking are drinking too much and we must all work together collectively. That is absolutely a responsibility and it is exactly what the Portman Group is trying to achieve in conjunction with parents and individual responsibility.

Q143 Valerie Vaz: Dr Poulter asked you a question about the statistics and you seemed to imply that the statistics were wrong. I want to hear it from you. Do you think there is an alcohol problem in this country?
Brigid Simmonds: I think we have an alcohol problem, but it is a problem with a small minority of people who are drinking too much. There are an awful lot of people who drink responsibly but education has to move on in this area. For my generation, you drank one glass of beer on Sunday lunchtime. Our children—and I have three children of this age—have moved on, so we need to educate—

Q144 Valerie Vaz: I wanted to clarify something. I appreciate that more needs to be done in other areas, but, Mr Ashworth, do you believe there is a problem?
Henry Ashworth: I absolutely believe that more needs to be done, that we—

Q145 Valerie Vaz: But do you believe there is a problem?
Henry Ashworth: I think there is a problem with too many people who are drinking beyond the Government guidelines and there is a problem with the number of children who are still drinking. While the trends are positive and going in the right direction, we must all work tirelessly together to improve the situation at national level.

Q146 Valerie Vaz: Coming back to you breaking your leg, you did not tell us whether you had drunk or not. I am assuming that you did not have any alcohol when you broke your leg.
Brigid Simmonds: No. It was first thing in the morning, so definitely not.

Q147 Valerie Vaz: Do you accept the statistic that 70% of A and E admissions are alcohol-related?
Brigid Simmonds: I think we have to wait and see how this primary diagnosis works out.

Q148 Valerie Vaz: I was asking if you accept that or not. Wherever you get the figures from, that is a figure that has been quoted.
Brigid Simmonds: I am not sure it is a figure I have.
Henry Ashworth: The figure that I have does not give a percentage.

Q149 Valerie Vaz: Where does your figure come from?
Henry Ashworth: It comes from the Office for National Statistics.
Brigid Simmonds: It was 195,000 in England in 2009–10 and 142,000 in 2002–03.
Henry Ashworth: I am sorry. My figure comes from the NHS Information Centre. I am only using the Government's statistics, which is why, in response, I am saying that it would be helpful for everybody involved—

Q150 Valerie Vaz: To use the same figures.
Henry Ashworth: For everyone who is trying to reduce the harmful effects of alcohol to use the same statistics.

Q151 Barbara Keeley: You raised the point of norms of behaviour and talked about students and freshers' week. I have to say I think that is a very small part of the problem and I want to explore this idea of cultural change a little more. The concern that most people have—Members, police, lay advisers and the ambulance services—is the week-in, week-out flocking of young people into city centres like Manchester, which is an example that I know of. What happens is pre-drinking at home before they go out, drinking for many hours once they get into town, and then becoming argumentative—fighting and that sort of thing—being sick and becoming difficult to deal with, or vulnerable—falling, or potentially being at risk of being raped if they are young women.
You talk about cultural change, but I am surprised that the drinks industry does not take more responsibility for it. Apart from the pre-drinking at home, which I guess is from off-licences and supermarkets, we are

still in the situation, in a centre like Manchester, of having very cheap shots advertised—shots of vodka and other alcohol—the sale of very large wine glasses so that people do not know how many units they are drinking, and things like "Buy two glasses, get the rest of the bottle free"—all those sorts of offers. So there is the cultural issue about young people feeling that what they want to do is to go out and drink a massive amount on one night—Friday, Saturday and so on—with all of that pattern of drinking, but also an industry that has got them into habits of drinking which are clearly not healthy. Anybody out for six or seven hours, after drinking at home, is going to drink a lot. Offering them cheap shots or the rest of the bottle free after two glasses—the sort of thing you see offered—makes it easier for them to end up drunk absolutely past where they should be.

Brigid Simmonds: I would like to make a number of points. First, the industry supports a number of responsibility initiatives. There are Business Improvement Districts, and the Nottingham Business Improvement District is specifically aimed at the night-time economy. It has funding which provides street pastors and taxi marshals. If someone comes along and is behaving drunk they are asked to sit down and drink water, and they are only allowed to go home or into the venue when that has been sorted out. Business Improvement Districts have been hugely successful—there is one that is being operated in Newquay, which Henry knows as much about as I do—and we ought to take those further. There is also, on top of that, the Best Bar None scheme. The BBPA is the only trade association which puts serious money into Pubwatch, a voluntary organisation which allows people to be stopped from going in pubs in various areas. If you want to go and see the Reading Pubwatch or the Northampton Pubwatch, which has recently won an award for its work, I can arrange that. There is also Community Alcohol Partnerships. There is a range of initiatives. The industry is seriously interested in partnership. It is not in our interest that alcohol is sold irresponsibly. There has also been a change, coming to your last point—

Q152 Barbara Keeley: I have a further question before you go past the points you have made. A group of street pastors has started in Eccles, a centre of my constituency, but that is a new emergency service. They are good people who are going out on Friday and Saturday nights into Eccles town centre, taking a risk themselves and doing things like giving out flip-flops to young women who are so unstable after drinking that they cannot walk any more and might do themselves damage, and protecting shop owners and people in small convenience stores from gangs of drunken people that intimidate them. That is beyond the police and ambulance services. They are a new community grouping. Funding street pastors is, to me, an acceptance that the problem is getting out of control, and not even in places like Manchester but in places like Eccles, which is quite a small town centre. As to stopping people going into pubs, why is there an assumption that somebody who is already drunk in a pub is going to be served in a pub? Why should you have to stop them going in? Is it not the responsibility of a licensee not to keep selling alcohol to people who have already had too much?

Brigid Simmonds: It is against the law to serve people who are drunk.

Q153 Barbara Keeley: How are people getting so drunk then in town centres?

Brigid Simmonds: We have also had a change in terms of promotions for the on-trade. There was a ban on some of the promotions that you are talking about. The police and local authorities have plenty of powers under the Licensing Act to take action against premises where behaviour is irresponsible, particularly—

Q154 Barbara Keeley: But you are talking about every pub or bar in Manchester city centre. How could the police, in a place like Manchester, deal with every pub and bar that is serving drinks to young people who probably turn up already having had more than the Government's advised limit?

Brigid Simmonds: With the greatest respect, there are some really good partnership schemes and the BBPA would be very happy to help any local authority or police force who wants to set up a partnership arrangement with its licensees in a city centre.

Q155 Valerie Vaz: Where are they?

Brigid Simmonds: I run the BBPA, so the British Beer and Pub Association—

Q156 Valerie Vaz: Where are the partnership schemes?

Brigid Simmonds: The partnership schemes are everywhere.

Henry Ashworth: Can I give you an example, which is the Best Bar None scheme in Durham, where licensees have reported—and what is really important about partnership is that it works for everybody—an estimated 75% increase in trade because of the Best Bar None scheme? There has been a 50% increase in town centre footfall and an expected 87% decrease in violent crime. With inviting the on-trade in when it comes to Best Bar None, or through a Community Alcohol Partnership which involves the off-trade—retailers—working locally in partnership is a hugely important part—

Q157 Valerie Vaz: I understand that. I am just asking whereabouts because it is going on the record and it is quite nice for people to pick this up.

Brigid Simmonds: In Nottingham the industry puts in £250,000. There are examples like that all over the country. In fact, I think your next witnesses from Birmingham City Council will talk in a similar way about the schemes in their particular area. Most town and city centres have these schemes. There is a range of them and you decide how it suits your local partnership. We would be very happy to set them up if they do not exist.

Q158 Barbara Keeley: You have given a couple of examples but, obviously, we have very large numbers of city centres and it goes down even to town centres like Eccles. Could you say, where you have given

examples, that they have eradicated that problem I talked about, which is young people staggering about the streets at night, vulnerable in themselves or abusive or ill, and giving a job to the ambulance services and the police? Is that problem eradicated in those places?

Brigid Simmonds: No, because it has to be a partnership in terms of personal responsibility, which is very difficult for any licensed trade to deal with, and how they behave. But I will say that it has improved the relationship between the police, the licensed premises and the local authority. Certainly in Pubwatch the police will go and brief and discuss with licensees where the particular problems are or what they have as an event coming up where there may be an issue. BBPA has recently issued some guidance in conjunction with the police and the Local Government Association in advance of the European football championships this summer. So we are looking to lead in terms of partnership and to put into practice partnerships between the industry, the trade—there are 51,000 pubs in this country, so there is one in every city centre that you are likely to be talking about—

Q159 Chair: Can I ask a simple question about this? When you look at one of those schemes, how do you determine whether you think it has been a success? What is the definition of "success"?

Brigid Simmonds: The definition of success has to be that the police have to intervene less often and, as Henry has given the example, that you get reductions in crime and bad behaviour. But it is cultural change that is going to change people's, particularly young people's, views on how much they drink, how quickly they drink and how they move on.

Henry Ashworth: I think, absolutely, looking at reductions, those examples, in terms of violent crime, drunk and disorderly offences, and drunk and incapable offences, should be measures of success. Other measures of success for a partnership should be that more people are able to go out and enjoy a sociable time in that city centre and that responsible businesses which are part of the partnership should see their businesses flourishing. The real success in this area is that we have thriving night-time economies in which more people feel they can participate and the businesses thrive, and that the harms associated with the misuse of alcohol are reduced.

Brigid Simmonds: That was one of the reasons why the scheme in Nottingham was set up. It was partly because the chief constable at the time said, "Don't come to Nottingham because you are going to get stabbed," and almost immediately people stopped wanting to go to university there. It was a partnership that was set up between the universities and the trade to make Nottingham a safer place to go out at night.

Q160 Chair: It is striking that when I ask you about what success is, the answer is in terms of the effect on the police and law and order, and on business success—both of which are legitimate policy objectives—but neither of you mentioned measures of long-term health outcome.

Brigid Simmonds: It is probably because we do not work in that particular area, but that has to be, for all of us—in Parliament or those who are making policy—what we are looking at: for people to enjoy our product responsibly, to drink responsibly and not to cause themselves long-term health harms.

Q161 Chair: It would not be unreasonable, would it, if you were having that kind of partnership in a particular locality, to look for a reduced incidence of alcohol-related health effects as one of the definitions of success?

Henry Ashworth: In most of the effective crime and disorder reduction partnerships that you see, the local NHS is absolutely part of the partnership. In terms of the issues as to binge drinking that have been referred to, it tends to be the A and E departments, rather than the longer term chronic effects, that are affected.

Brigid Simmonds: I also think, under the new Alcohol Strategy, that the role of Health and Wellbeing Boards and their partnership and involvement are going to be key.

Q162 Andrew George: I want to move on to minimum pricing on which, Mrs Simmonds, you have views and, it seems, Mr Ashworth, you do not. In your evidence, Mrs Simmonds, you said that the heaviest drinkers are least responsive to changes in price. Do you believe that the heavy drinkers are born or do they become heavy drinkers?

Brigid Simmonds: I would not know the answer to that. There is some evidence that it can be genetic. There is lots of evidence that people become heavy drinkers because they drink too much and do not understand what they are drinking, which is the culture that we need to change.

Q163 Andrew George: So someone who is a heavy drinker would not have gone through any kind of progressive steps to become a heavy drinker.

Brigid Simmonds: I think they would have gone through progressive steps as their drinking has increased, and probably the variety of what they are drinking has increased. I am not an expert.

Q164 Andrew George: The reason I am asking the question is that you are saying that the heaviest drinkers are the least responsive to changes in price. On the assumption that heavy drinkers are light drinkers initially, one might then argue that it is at that stage you want to try and influence their drinking behaviour. Therefore, would you agree that your argument has no validity, in the sense that you are trying to influence people, to discourage them from becoming heavy drinkers in the first place?

Brigid Simmonds: It was the Sheffield study—which was in line with most international evidence—that found the heaviest drinkers are least responsive, but that does not mean that we do not want to encourage them to drink less over a period of time. The question is whether minimum pricing, as a whole population measure, is going to be the most effective. What we are interested in are targeted measures which deal with those heaviest drinkers.

Q165 Andrew George: You advance your case on that particular piece of rather inconclusive evidence. I was simply saying that if you are advancing your case primarily on that basis, your arguments have no validity.
Brigid Simmonds: I do not think we are advancing our arguments only on that piece of evidence. First of all, does any industry want the Government setting prices on what it sells? The answer has to be no. The second thing I would say very clearly is that minimum price affects everyone and I think it is unlikely, which is what I have said, to affect the behaviour of those who drink the most, which is where the problem lies. The real concern with beer is that because, in England, we have decided that the retailer will keep all the income it gets, there is a real danger the Treasury will suddenly have a black hole as people buy less alcohol and, therefore, will want to put beer duty up. Having seen a 42% increase in beer duty in four years—and where in community pubs 68% of what they sell is still beer—taxation is a huge issue for our industry, bearing in mind that 95% of the beer we drink in this country is produced here. It is a big manufacturing sector and supports almost 1 million jobs.

Q166 Andrew George: I want to come on to who would benefit from minimum price in a moment, but I wanted to establish—and you may accept—that the heaviest drinkers may not always in every circumstance have been pre-ordained to become heavy drinkers through some genetic abnormality.
Brigid Simmonds: No.

Q167 Andrew George: It might have been the result of progressive steps of which, perhaps, price might have discouraged them. That is a possibility.
Brigid Simmonds: That is a possibility.

Q168 Andrew George: Secondly, I wanted to ask what you thought about the Prime Minister's comments on where the Government are going with this and that they will be consulting soon on a minimum price. The suggestion is 40p per unit. He has said that if the minimum price of 40p would mean 50,000 fewer crimes and 900 fewer alcohol-related deaths each year by the end of the decade, it is something that we should all wish to achieve. Would you not wish to see those kinds of outcomes as well?
Brigid Simmonds: I would wish to see those outcomes, but those statistics are based on the Sheffield model, and it is a model. I do not think we have enough international evidence to suggest that those outcomes really will be the outcomes that—I agree with you—we desire to achieve because it is a whole population measure. I would rather see measures that tackle those people culturally in changing their behaviour from the earliest possible age, which is much of what we are doing with the Portman Group, with the Drinkaware Trust and with the amount of partnership into which the industry is entering.

Q169 Andrew George: So you are prepared to take the risk of allowing 50,000 crimes and 900 additional deaths per annum on the basis of your unwillingness to accept the case for a minimum unit price.
Brigid Simmonds: I have a number of members who have different views on minimum pricing. What I think we all absolutely accept is that the ban on below-cost selling without an element of production costs—so just doing duty plus VAT—is not going to make any difference. If you have an element of production cost, that would be a better measure for us and it would get rid of the irresponsible promotions, which do exist out there, rather than minimum pricing. Minimum pricing is giving the Government control of the pricing of alcohol and that is not something the industry welcomes.

Q170 Andrew George: Is it the 40p that worries you? Is there a minimum price below 40p that you think would be more acceptable to your members?
Brigid Simmonds: Take something like air passenger duty. When you introduce a tax like that, there is an irresistible decision that you will go on putting up that tax. So you start at 40p. By the time it becomes £1.80, in 10 years' time, it is a different issue. It is the principle. The industry does not believe that the Government should be setting a minimum price, but there is also an acknowledgment that we want our products to be sold responsibly.

Q171 Andrew George: You say in your evidence that it would have an impact on pubs—on your members—but do you not think that a minimum unit price would have a more significant impact on retail sales in supermarkets than on sales within pubs? Can you not see circumstances in which it might drive trade towards your members and away from the supermarkets?
Brigid Simmonds: I can and the BBPA has spent a number of years complaining that one of the reasons people are not going to pubs is because it is so much cheaper to buy alcohol in the supermarket. But I do not think that this will make a significant difference to that and I do not have any members who really believe that this is the answer to the problems that pubs face. Far more of a problem for us is beer taxation, red tape, legislation and lots of other things that stop community pubs from functioning. This is not the answer and I think we have to be careful that it should not be perceived to be the answer. But, if that differential is lessened, there will be some help. One of the big problems for pubs is that, unlike a big business like a supermarket, they cannot absorb that taxation. When taxation goes up—as it did by 5.2% this year—they have to pass it on to the customer, whereas the supermarket can absorb it.

Q172 Andrew George: You also say that there should be a ban on below-cost selling. How do you know when below-cost selling occurs?
Brigid Simmonds: The ban that was proposed by the Government initially was a ban on below-cost selling, which was VAT plus duty. So you know what your price point is. Our argument is that it will not make much difference and there has to be an element of production. If you had an element of production which was an average you could introduce a ban on

below-cost selling immediately because you can do it, as the Government have already proposed, under the Mandatory Code that exists in legislation. The minimum pricing will need completely new legislation, which was not, as far as I am aware, included in the recent Queen's Speech.

Q173 Andrew George: That also presupposes that there might not be any collusion between the supplier and the retailer, nor even that the retailer is the producer.
Brigid Simmonds: Obviously the tax is paid by the producer, so it is paid at the brewery. It is not paid by the retailer. The concern of some of my members on invoice pricing—which is a system that is used in the rest of Europe—is that we would not wish that information to be made public. But as long as that information remained confidential and under the mandatory code, it would allow local authorities to take action just as they do when the on-trade perhaps is considered to have behaved irresponsibly.

Q174 Andrew George: You also say that minimum pricing may be a breach of European competition law. I am not suggesting that you give us a legal answer to that now, but would it be possible for you to provide a further briefing for us giving evidence as to why you believe there is a risk that that may be the case?
Brigid Simmonds: There are two Ministers who have already said in this House that they believe it may be a breach of European competition law. The number of cases that have been taken in Europe have related to tobacco. If tobacco is not considered a health harm, I find it difficult to believe, in that sense, that alcohol is going to be different. But I am afraid I do not have a legal opinion. It will have to be tested through the European Commission, which is likely to be in Scotland, I would have thought, before it is here.

Q175 Andrew George: But you do not favour the kind of practices that go on in the retail trade where multi-packs and multi-deals are resulting in eye-wateringly low prices, which must be a major cause of undermining your trade.
Brigid Simmonds: The issue is loss leading: "Come to my supermarket to buy cheap alcohol". I do not think the issue is multi-packs. If we are not careful, any ban on multi-packs will affect something that is low strength, which is beer.

Q176 Andrew George: Mr Ashworth, you and the Portman Group are caught on the horns of a dilemma. You have no view on it. How come?
Henry Ashworth: I have two roles with the Portman Group. One is that I regulate the products, packaging and promotion. I cannot regulate on price, because it would be illegal. The second role that I have is to try and lead social responsibility issues. I cannot lead on this because it is illegal for me to bring members together and discuss price. With either of the roles I have, I cannot affect this. Quite rightly it is for Government to make decisions in this area.

Q177 Andrew George: You can simply observe. You think your role does not entitle you to express an opinion on it.
Henry Ashworth: I can neither lead on it nor regulate it. As I cannot do either of those things, the role of the Portman Group is to lead on social responsibility issues and to regulate, where we can, as the watchdog of the industry.

Q178 Valerie Vaz: On the point about EU law, I do not know what your members think about what is going on in Scotland, or whether they or you have formed a view about what is happening in Scotland.
Brigid Simmonds: The view I have given you would also be our view in Scotland, but there are different members with different views in this area, and there are lots of different activities going on. We would say, in Scotland, that it is important that it is notified to the European Commission. I will be interested to see what the European Commission says. I do not think it is helpful to have price points that are different in Scotland from those in England. You have only to see what happened between Northern Ireland and the Republic to know that it will be unhelpful if that is the position we find ourselves in.

Q179 Valerie Vaz: Would you be surprised to hear that media reports in Ireland quote the EU Commissioner for health and social protection as saying that EU rules do not prohibit member states from setting minimum retail prices for alcohol?
Brigid Simmonds: To be honest, we have to wait and see what happens when it goes in front of the European Court. There is lots of activity that will go on; it is not activity that will be taken by the BBPA.

Q180 Valerie Vaz: But the EU Commissioner has actually said that. Have you had any discussions with the European Commission about this?
Brigid Simmonds: No, we have not.

Q181 Valerie Vaz: Is there any reason why not?
Brigid Simmonds: We had discussions recently about another issue for the industry, which is to do with tax stamps and duty fraud, but the EU is quite clear that it will not have a view until it is notified.

Q182 Valerie Vaz: But you could have an informal discussion. You can talk about it as you have done with other—
Brigid Simmonds: You could have an informal discussion. It is not something the BBPA is leading, but I know there are a number of members of the BBPA who may be having those discussions.

Q183 Valerie Vaz: What is your view on what the European Commissioner says, as quoted in *The Irish Times?*
Brigid Simmonds: I think it will be something that will go all the way to the European Court, and we have to wait and see what the European Court says about it.

Q184 Dr Wollaston: I want to pick up a couple of points. How would a ban on below-cost selling that

includes production costs help when White Lightning cider costs so little to produce? Surely we need to address the alcohol content, not only the production costs, because it is the alcohol content itself that causes the harms.
Henry Ashworth: Could I make one comment? Heineken withdrew White Lightning cider from the market.

Q185 Dr Wollaston: Okay, but I am talking about white ciders in general.
Brigid Simmonds: Obviously, it is a decision by Parliament that they tax cider at a different rate to beer.

Q186 Dr Wollaston: I mean in general. That is not addressing the fundamental point that some alcohols—even vodka, for example—are significantly less expensive to produce than others.
Brigid Simmonds: Yes.

Q187 Dr Wollaston: And it is the actual alcohol content itself that does the harm. Further to that, is it not the case that when alcohol is too cheap it undermines any other public health measures or education measures simply because alcohol is a psychoactive drug, and that is fundamentally the problem?
Brigid Simmonds: I repeat what I said earlier. We do not believe that our products should be sold too cheaply. They need to be sold at a responsible price.

Q188 Dr Wollaston: But is that not the point about minimum pricing—that it is saying that there needs to be a responsible price that is linked to the health and social harms of alcohol?
Brigid Simmonds: A ban on below-cost selling with an element of production would bring the majority of those products that are sold irresponsibly to a much more responsible position. It would not end up with the Government having control over the overall pricing.

Q189 Dr Wollaston: You say "the majority", but is it not also the case that people who have a serious drink problem—an abnormal relationship with alcohol; drinking to get drunk—are very good at targeting the cheapest brands, and they would simply then target the next cheapest brand? It is only by setting a threshold that is linked to responsibility and the health and social harms that you can achieve that because production costs are so variable.
Brigid Simmonds: Production costs for cider, and indeed for beer, are much higher than they are for spirits. I could produce lots of information for you on that basis.

Q190 Dr Wollaston: Indeed, but that is what I am saying—that they are so variable. Therefore, the heaviest and problem drinkers—if you link it to production costs—are merely going to target the brand with the lowest production costs. You would also accept—and you quoted the Sheffield study, but again there may have been a misrepresentation there—that we know the heaviest drinkers in fact spend, on average, 40% less per unit on their alcohol, and although dependent drinkers may not modify their drinking because of a price elasticity, that is certainly not the case for the heaviest drinkers in general, which I think you might have been implying, without quoting. Would you not accept that heavy drinkers have any response to price at all?
Brigid Simmonds: Heavy drinkers may have a response to price, but I still believe that a ban on below-cost selling, which had a production cost that could be set either for different forms of alcohol, or at the highest common denominator—so the highest production costs, which is probably in beer—would have the same effect, because a lot of the products that are sold very cheaply are own-brand products. It is those products that would have to be brought up to the same sort of costs. But it is not going to change the cost of alcohol in the supermarket to the same price that you will pay in a pub. In terms of beer, we pay 40% of the total beer tax in Europe and we consume only 13% of the product. So there has to be some question as to whether price is really the issue that we have in this country, or whether it is a cultural and behavioural change that we need to influence. Price in other parts of Europe, which is much cheaper, does not seem to have the same effect on the population as it does here.

Q191 Dr Wollaston: Yes, but would you accept that if alcohol is too cheap, it undermines other public health measures and education because of—
Brigid Simmonds: I would, and I would love to see, particularly, supermarkets to stop loss leading in terms of alcohol.

Q192 Dr Poulter: Picking up on that point, you have talked about pricing and duty. The British Beer and Pub Association says it is concerned that minimum price could ultimately be achieved through, or result in, higher beer taxation. Is there any evidence to support that? Do not the levels of alcohol duty and VAT on beer sold in pubs already equate to 40% per unit price?
Brigid Simmonds: No. Our concern is that—

Q193 Dr Poulter: I am reading your concerns on record. I am looking at consistency here in argument.
Brigid Simmonds: Our concern is that the Government continue to put up beer taxation by 2% plus inflation each year. They are not getting much more revenue from that beer taxation, but beer taxation is an important part of Government revenues. Our concern is that the Treasury will see a reduction in beer taxation because people are drinking less alcohol and will want to put up beer taxation as a result because, under the scheme that they are looking to introduce for minimum pricing, the retailer keeps the margin.

Q194 Dr Poulter: But you have said in answer to Dr Wollaston that you do not see a link necessarily between price and alcohol consumption, and now you are saying you are concerned that the Treasury may see a reduction in income if beer taxation goes up. I do not follow the consistency of your argument.

Brigid Simmonds: If a minimum price is introduced, there is no doubt that people will drink less alcohol. The question is: is it the people who drink to harmful levels that will drink less alcohol? This is going to affect the poorest in our population who then would not be able to afford it. So, without doubt, the Treasury's income for beer taxation will reduce.

Q195 Dr Poulter: Hold on a second. Certainly from my frontline experience and from some of the evidence presented previously, if you deal with the most vulnerable street drinkers and the people who are binge drinking, there is evidence that increasing pricing among that group will mean they cannot afford to buy as much alcohol. I do not think there is anything controversial about saying, with vulnerable street drinkers and other people who are also, on the other end of things—looking at it from an economic point of view—of great financial concern to the NHS, that to protect that group from doing harm to themselves is probably a good thing. I think one would say it is definitely a good thing. I am struggling to follow the consistency in the argument here. On the one hand, from your earlier evidence, you are saying that having a per unit price does not affect behaviour, and now you are saying it would and it would reduce Treasury revenues. I am struggling to follow your logical thinking. You seem to tailor the argument depending on the question and who is asking it.
Brigid Simmonds: What I am saying is it will not affect dramatically the behaviour of those who we really must tackle in terms of alcohol abuse. It will affect the whole population because it will make something more expensive and, in this economic climate, people will drink less. Therefore, the Treasury will get less taxation out of it and there will be a tendency to put that taxation up. Their argument the other way is that they will get more income because fewer people will go to A and E and fewer people will be involved with the police.

Q196 Dr Poulter: You have just said that the people who are most vulnerable and who drink the most are the street drinkers. Why are you saying it will not affect their consumption of alcohol when it will affect the whole population's consumption of alcohol? How do you make that distinction?
Brigid Simmonds: Because people who really do drink too much alcohol will stop spending on other things to fuel their particular wish to buy alcohol. I do not think that is true for the majority of us in the population who drink to sensible levels who, when it becomes very expensive, will drink less. So it will have less of an effect on those people.

Q197 Dr Poulter: But does not the evidence show that they do that already? People who have a very serious alcohol problem already forgo eating and paying their bills in order to support their alcohol problem.
Brigid Simmonds: Yes.

Q198 Dr Poulter: Again, that seems very contradictory.
Brigid Simmonds: I do not think it is contradictory. I do not think minimum pricing is the measure that will make the greatest difference to those people who drink too much alcohol. It will make a huge difference to the majority of people who drink alcohol responsibly. A ban on below-cost selling would be a better way of achieving what you are talking about.
Chair: Sarah Wollaston wants to ask some questions about advertising and marketing, moving it on.

Q199 Dr Wollaston: Both the Portman Group and the BBPA argue that the link between advertising and alcohol consumption is marginal at best. Is there a fundamental disagreement between the industry and Government on this issue? Of course, if advertising and marketing do not have an effect on consumption, why does the industry spend so much on them?
Henry Ashworth: I do not think there is a disagreement between the members of the Portman Group and the Government on this issue. The Government recognise that the Portman Group code, the Advertising Standards Authority code and obviously Ofcom's involvement mean that we have some of the strictest regulations in Europe on this. They do not believe there is any evidence that has been presented to suggest that a ban on advertising is a proportionate response. They have absolutely challenged us and we have accepted that challenge through the Responsibility Deal to review our code of practice as the Portman Group, as we have with our sponsorship code of practice. We are absolutely tirelessly working to make sure that we are innovating, as industry regulators. The Government believe that we are effective as industry regulators and that that is the best way forward.

Q200 Dr Wollaston: If you are not wishing to target young people—children—with alcohol advertising, why do you have alcohol advertising at films which are for under-18s? If you go and see a 15 film, you will be bombarded with alcohol marketing.
Henry Ashworth: Obviously, advertising in cinemas is under the regulatory control of the Advertising Standards Authority, not myself, but the rules are very clear: to advertise alcohol 75% of the audience for a film must be over 18. Those are the rules. The Advertising Standards Authority strictly enforces those rules. I went to see "The Best Exotic Marigold Hotel" film. I was the youngest in the audience by quite a considerable margin, and it had a 12 certificate.

Q201 Dr Wollaston: But what if you went to see a "Harry Potter" film, for example? If you look at the proportion of the population who are under 18, having a cut-off at 75% surely is unreasonable.
Henry Ashworth: As I say, we have some of the strictest rules for advertising and marketing in Europe. The Advertising Standards Authority and ourselves are constantly reviewing those rules to make sure that we are effective as regulators and that we are absolutely committed. I absolutely reassure you that we are committed to ensure that marketing does not particularly appeal to under-18s. It is not in the interests of my member companies. They want to target their marketing at people who can legitimately

buy their products. They invest heavily in supporting Challenge 25 and Challenge 21 schemes. The Portman Group rules are very clear that images of people who are or appear to be under 25 cannot be used. We operate very strict guidelines and we enforce them.

Q202 Dr Wollaston: Further to that, there is a code stating that you cannot claim that alcohol improves your sporting prowess, in which case why do we allow sponsorship of major sporting events, which not only create that link but also are widely viewed by young people? Why do we have alcohol sponsorship of the rugby world cup, for example, and the FA cup?
Henry Ashworth: The Portman Group code includes sponsorship. We are reviewing the code of practice at the moment, as we are committed to doing through the Responsibility Deal. The Scottish Government obviously have a sponsorship code. We are working very closely with them. We have looked at the review of the Scottish sponsorship code that Ipsos MORI has recently carried out and we are currently reviewing the situation. I believe that sponsorship is a positive form of marketing and that it supports grass-roots development of the sport that it is sponsoring. If I could put it into context, the vast majority of people in this country drink responsibly and in a way that is sociable. We all enjoy sporting events.

Q203 Dr Wollaston: How does sponsorship of the rugby world cup support grass-roots rugby?
Brigid Simmonds: I must declare an interest. I am a director of the Sport and Recreation Alliance. It was the previously named the CCPR and I was the chairman for six years until last year. I have been involved in promoting grass-roots sports all my life. The RFU, along with every other national governing body of sport, uses those funds that it gets from its sponsorship to promote grass-roots sports. The Sport and Recreation Alliance has given this Committee lots of evidence of grass-roots sports that are supported by some of my members, from Shepherd Neame in Kent to Theakstons in Yorkshire. The average sports club makes a surplus of only £1,000 a year, yet we have a range of 30% of sports clubs that received £2,500 in sponsorship. It is hugely important to them. I have real doubts that there is a causal link between advertising and actual consumption, and if you look at the FA cup—

Q204 Dr Wollaston: Then why do you spend money on it?
Brigid Simmonds: Because it is about brand promotion. The FA cup also produced 50 million people who saw the responsibility messaging that went with AB InBev's promotion of it. That would cost millions of pounds if you had to pay for it. If you watched on television or you watched it from the third round on you saw, around all those billboards, quite clear, responsible marketing about Drinkaware. That would be true of the Grand National and it would be true of the Heineken cup, which has just finished. So there is an advantage that people who go to those events are seeing a lot of responsible messaging on the product and around the stands.

Q205 Dr Wollaston: Surely you would accept there is a huge disproportion here if you are spending over £800 million a year on marketing that is telling people to drink and then you are spending a tiny fraction on responsibility marketing. I think even the WHO accepts that that is hardly responsible.
Brigid Simmonds: I do not think there is enough evidence—and there is not evidence from France or Norway, where there were bans—that it actually changed people's consumption. The Joseph Rowntree Foundation and Demos have recently done quite a lot of work that indicated, particularly with young people, it is much more to do with parents and peers as to how much they drink, than it is about advertising.

Q206 Dr Wollaston: You would not accept that increased advertising exposure causes young people to start drinking earlier and to drink more when they do.
Brigid Simmonds: I would not. I would say that it is about the brand that they particularly drink. I do think that young people go through a phase where they possibly want to drink the brand of the team that they support, but it is a phase that you go through and I do not think that that increases the amount of alcohol that they consume.

Q207 Dr Wollaston: So you would not accept the findings at Stirling university that exposure to large volumes of alcohol marketing—saturation marketing, which is seen by young people, even if it is not deliberately being targeted at them—causes young people to start drinking sooner and to drink more when they do?
Henry Ashworth: I think the most recent findings from Stirling university say that that was inconclusive. I would say that the trend data—and this is the reason why trend data is so important to all of us—show that fewer young people are drinking now. As I say, 55% of young people have never had an alcoholic drink, with the percentage reporting drinking in the last week dropping by half, from 26% to 13%.

Q208 Dr Wollaston: The point being that those who do drink are drinking earlier and drinking more when they do.
Henry Ashworth: But sponsorship, as you have quite rightly pointed out, is a mass-marketing tool. Sponsorship is about some very positive use of brands to get across responsibility messages and to ensure that Drinkaware is seen by everybody who watches those events. The trends are moving absolutely in the right direction. Do we need to do more? Of course we need to do more, and we need to target those young people who are still drinking. Only 17% of parents have a conversation with their children about alcohol specifically. We need to up that. Everybody needs to—

Q209 Dr Wollaston: Can I stop you there, Mr Ashworth? What proportion of young people own alcohol-branded merchandise?
Henry Ashworth: I have no idea.
Brigid Simmonds: I did quite a lot of work in relation to gambling on this subject and to do with young people wearing branded T-shirts where we agreed, as indeed the Portman code also specifies, that you

cannot have T-shirts or other forms of merchandise for young people which have the brand of the sponsor on it. One of the difficulties with that is that when your child is 13, and possibly more vulnerable to that sort of messaging, they become big enough to wear an adult shirt. But I do not think there is any evidence—and there was no evidence when we introduced this for gambling that anyone could give me—that it was actually going to have that effect, but it is something that the Portman Group and the industry clearly support.

Q210 Valerie Vaz: I am confused. Are you saying that advertising does not make people want to buy the product?
Brigid Simmonds: It does make people want to buy specific products. The question is: does it make people buy more products and therefore drink irresponsibly?

Q211 Valerie Vaz: What does your research entail in terms of when you place an advert, say, on television or wherever? You must see an increase in sales. Do you keep those measures or do you not keep them?
Brigid Simmonds: It is not something the BBPA would do. That would be a particular brand. They would say that it is about increasing, yes, their brand but in a socially responsible manner. It is not about encouraging young people to drink more of a particular product.

Q212 Valerie Vaz: But it is encouraging people to buy, is it not? It must be. Advertising must have that effect otherwise people would not do it, would they?
Henry Ashworth: Brand marketing is all about encouraging people to buy a particular brand. The question was whether sponsorship encourages more young people to drink alcohol. The trends are all moving in the right direction. There are fewer young people drinking alcohol now than ever before.

Q213 Valerie Vaz: I understand that, but we used to be way down the bottom of the league and now we are third. You sniggered when I mentioned *The Irish Times*—I do not know why—but both Ireland and Britain have gone back up the league table of people who are drinking much more than they used to, and there could be all sorts of reasons like 24-hour drinking and that sort of thing. Clearly, people have noticed that there is a problem. It may be coming down, quite rightly, because everybody is working together to do something, but I am surprised at some of your comments in terms of you advertise and it does not have an effect. Of course it does. It is there for people to buy the product. If you show some cool young people drinking, lots of other young people want to do that. It happens to me. If I see a Mars bar being advertised, I want to eat a Mars bar.
Henry Ashworth: Brand marketing is hugely important. It is important to any industry sector. It is about differentiating between one product and another. If I may say so, under the Responsibility Deal, the most recent pledge has been a significant unit reduction pledge. The way that will be delivered is using the power of brands to help people enjoy their drinks and to drink a little bit less alcohol at the same time. Brand marketing is a very important part of the partnership mix in changing the culture around drinking in this country. I am not sure if that answers your question.

Q214 Valerie Vaz: You have no specific measures of whether this Responsibility Deal is working or not. Do you have any specific indicators of performance?
Brigid Simmonds: The Responsibility Deal has a monitoring and evaluation group, which is looking at the change it is making. Henry was talking about our most recent pledge that came out on the same day as the Alcohol Strategy, which is that we would take 1 billion units of alcohol out of the system by 2015. That is being done in a number of ways. I have one major member of the BBPA who is reducing the strength of its three main premium lagers from 5% to 4.8%. That will take a million units from the market. We are obviously introducing newer, lower-strength beers—you will be aware that the Government reduced taxation for 2.8% beers—and we have over 30 brands out there which will be creating that change over a period of time.
Henry Ashworth: If I could add to that, it is obviously very early days. The monitoring and evaluating group is chaired by Professor Mark Bellis from the north-west health observatory. This will be monitored using both CGA and Nielsen data at a national level. We are also going to be looking at some behavioural trials to see what happens when you change, for example, the alcohol strength of a bottle of wine from 14% to 12%, or if a beer product, for example, came down from 5% to 4.5%. The behavioural assumptions are that people will continue to drink the products that they enjoy because they enjoy the drink and are loyal to the brand. Brand marketing is going to be crucial in the delivery of this unit reduction pledge. It will take a significant number of units out of the market and enable the growth of a lower-alcohol market. We may well be looking back in five years time and saying that this was a paradigm shift.

Q215 Barbara Keeley: I wanted to come back to what I think is one of the most important things we have touched on: changing norms and making cultural change. This is a comment really, but the major sporting events that I attend—I do not attend a lot of football matches, but certainly cricket events and test matches—are full of people who spend all day getting drunk. It is a useful thing to have an overall target of taking units of alcohol out of what is consumed but it would be useful, in terms of breaking this link between sport and drinking, to—
Brigid Simmonds: That is a cultural change, but if you have someone drinking three or four pints of 2.8% strength beer, that is considerably less alcohol than if they had had 5% beer.

Q216 Barbara Keeley: Indeed, but if you sit anywhere near the Barmy Army at an England test event, they get drunk and spoil the event for everybody else.
Henry Ashworth: Those grounds all have alcohol licences and those licences are all overseen by a local licensing authority. There is a very significant

difference between the people who are vending at a particular event and the sponsorship of an event.

Q217 Barbara Keeley: What I have reflected to you happens at every different venue that I have been to. I think this link between alcohol and the sort of behaviour we see at sports is very important and I wanted to ask you about it, not only in terms of things like the police can do, and city councils and Health and Wellbeing Boards, because it is putting a lot of onus on them, but is there not a case, in terms of cultural change, of trying to get younger people in particular to understand the health impact of the level at which they are drinking? I do not think a lot of young people properly understand what it is doing to their bodies and what it might do by the time they are in their 30s and 40s. There is perhaps an opportunity to look at this over the next six months as we have sports elites performing—very many young athletes. I heard a young discus thrower in the House here yesterday who said that, in the end, he had to tackle in himself the fact that he was never going to become a champion or do well in his chosen sport of discus throwing when he spent some weekends partying. What is going to make young people understand the extent to which it probably does bring their physical wellbeing down if they do go out and have these binge nights on Fridays and Saturdays?
Brigid Simmonds: I was in Beijing for the last Olympics. I do not think there is a culture of drinking that goes with the Olympic games and a lot of good work has been done on the legacy of the Olympics, which is about getting people more interested in physical activity and sport. As you rightly say, you will not become a champion if you also are drinking too much while you are doing that.

Q218 Barbara Keeley: Or at all.
Brigid Simmonds: Or at all. That has to be part of that cultural change we are talking about and I would hope that the Olympics are part of it. On the 1 billion unit reduction, we have an issue that we cannot promote lower strength. Under the BCAP and CAP rules of the Advertising Standards Authority and the Portman Group, just as you cannot promote something that is high strength, you cannot promote something that is low strength. It would be helpful if this Committee was prepared to support our efforts to have that changed because the 1 billion unit reduction is going to be difficult to achieve if you cannot say, "In my pub or my supermarket, why don't you buy that because it is lower strength?"

Q219 Chair: Do you want that promotion to be associated with a particular brand, or possibly as educating the public to look for lower-strength alcohol and then have labelling that supported the assertion?
Henry Ashworth: We are collectively committed to developing a market for lower-strength products. That is what the unit reduction pledge is all about.

Q220 Chair: It sounds like good news for Kaliber.
Henry Ashworth: And many other brands. There are a number of different steps. One will be the reformulation of existing brands that people know, love and drink, and helping people to consume a little less. Another will be tremendous amounts of innovation. Over 30 new products—new beer brands—have taken advantage of the government's new 2.8% reduced duty rate to launch. Of course, it is all good and well launching a product, but you then need to establish a market for it. Having all of the big supermarkets sign up to agree to support this unit reduction pledge will make all their retail practices available to support growing this market for lower-alcohol products. That is the same in all different categories.
Brigid Simmonds: It will be combined with some of the unit awareness that we are doing, both in pubs and in supermarkets, which gives you an idea of how much you are drinking in terms of units, which I think is important to the point that you were making about people not understanding what they are drinking. On most cask beers you would have the ABV, but we now have this promotion of unit strength so it tells you how many units there are in a pint of beer, a glass of wine or a glass of spirits. That is an important part of the Responsibility Deal that the industry is offering.
Barbara Keeley: I think it needs to go a lot further than understanding units. It needs to make clear, "What am I doing to my body every time I go out and drink seven, eight, nine or 10 or more units?" I do not think people do understand that; what it does to your liver and what it does to your circulation. There was a good campaign on tar dripping into your lungs if you smoked, but I have not seen that with alcohol.

Q221 Dr Poulter: I want to come back to this point about taking units of alcohol out of the system. You gave an example there of saying, "We hear of one drinks company that is reducing the amount of alcohol from 5% to 4.8%" and then, at the same time, we hear that this is going to be a paradigm shift in the way that we are moving in alcohol policy and responsibility in the industry. But in reality, in terms of the percentage of alcohol drunk, it would be about 25 pints before that 0.2% reduction, from the example you gave, would be an effective reduction in alcohol. There is no realistic reduction at all.
Henry Ashworth: Can I give a slightly different example? If you were to go to a restaurant, for instance—

Q222 Dr Poulter: No. Let us deal with that example because that was the example given about the Responsibility Deal being put across. With a reduction from 5% to 4.8% you would have to be drinking something well over—from my very basic maths, and I may be wrong—20 pints before you see that it makes any difference, in real terms, to someone's units and alcohol they are consuming.
Brigid Simmonds: Yes, but I do not think we assume that everyone drinks 20 pints. If you are drinking a couple of pints, you are obviously taking a reduced amount. Where this has worked best so far has been associated with sport. People who come off a golf course want to drink less alcohol, so they have something that is lower alcohol. In Spain, the market for no alcohol is 15% of the beer market. We want to move beer and part of our responsibility initiative is

that we drink less alcohol. I agree, but I do not think, on average, that most people drink 25 pints of beer.

Q223 Dr Poulter: No, but I am saying that the net effect is that someone would have to drink, effectively, 25 pints before they saw a meaningful reduction in the number of units they are consuming in terms of the health effects of alcohol.
Brigid Simmonds: Yes.

Q224 Dr Poulter: If we are looking at this as an effective policy in having a Responsibility Deal and if we are tackling the underlying health care challenges, we may have taken, overall, some steps towards having a very slightly weaker beer on display, but if people have bad drinking habits and are already drinking far too much, effectively the difference between one of those people drinking 24 or 25 pints is pretty minimal in terms of the amount of damage it is going to do to their bodies.
Brigid Simmonds: The World Health Organisation was quite clear that we ought to be encouraging people to drink lower strength and the industry should be supported in exactly that. There is obviously a bigger difference if you then move to a 2.8% beer.

Q225 Dr Poulter: Indeed, and I think that is the point. If we are giving as an example of how we are trying to cut—how the industry is standing up to the challenge of reducing—alcohol consumption that we are reducing the percentage strength of beer by 0.2%, I do not think that is going to be effective in public health terms at all and it would be very misleading for you to say that it was.
Brigid Simmonds: You have to see it as a trend and look at it as a step in the right direction, because we have to take consumers with us on this journey. Making a jump between something that is 5% to 2.8% does indeed change the taste. Making a move between 5% and 4.8% is not so much of a change, and then you can be moved on to something different. We did a lot of research before we introduced the unit awareness in pubs and people were quite clear that they did not go to the pub to be told what to do, so we had to be careful in our messaging. But we do need to move consumers—and I think we need a tax system that helps to move consumers—towards drinking lower strength.

Q226 Dr Poulter: Sure, but on the 5%-4.8% issue, my understanding, from speaking to a major and growing producer in my own constituency, is that to reduce the percentage of alcohol in a cider, in that case, or a beer by between 1% and 0.5% would not significantly change the taste, whereas the case for reducing alcohol significantly, or halving it, would—such as the example the Chairman gave of Kaliber as opposed to a premium strength lager. I fail to see, if you are taking this issue seriously, why a more meaningful increase cannot be pushed for in terms of the amount per pint, shall we say, and why 0.2% is going to make any difference. Practically, in terms of tackling binge drinking and the public health consequences, it is not going to make the blindest bit of difference.
Henry Ashworth: Could I come in? That was one example. It happens to be in the public domain as to what that company is doing. It is a 4% reduction in the amount of alcohol in that particular drink. There are many other examples as well. If you were to look, for example, at a bottle of house wine in a restaurant, at the moment most restaurants and consumers do not even consider the amount of alcohol in that bottle of wine, whether it is a 12% or a 14% bottle of wine. In fact, it is number 18 out of 25 considerations when buying a bottle of wine. We are trying to help people who want to enjoy a bottle of wine when they go out for a meal to do so, and if you reduce the alcohol content from 14% in your house wine to 12%, you would be taking 16% of the alcohol out of that particular product. People would still enjoy a bottle of wine and be able to drink more responsibly.
The whole purpose of this unit reduction pledge is to encourage more people to be drinking within Government guidelines, which is one of the Government's stated aims. That was one example, and certainly a 4% reduction helps, but it is only part of the answer. We need to look at this across the piece and use the practices of the big retailers to encourage people to open up this market, looking at their own-brand products as well. All the big producers are looking at their portfolio of brands to see what they can do. This is an absolutely innovative step taken by the industry to help more people drink within the Government guidelines.

Q227 Chair: We have more or less run out of time, but could I ask a last question on the 1 billion units out of the system by 2015? What proportion of the alcohol currently consumed is 1 billion units?
Henry Ashworth: It is about 2% of the total market–a significant amount in public health terms. That is what the collective group of companies have signed up to. We are at the very early days of this. Do we think it could be more? It could well be more. The most important thing is opening up the alcohol content of a product, in some cases, to the people who are shaping the choices. We were talking about nudge, social norms and helping people to make choices that mean that more people are drinking within Government guidelines, which is a shared objective.
Brigid Simmonds: Encouraging industry to do things that are voluntary are much more likely to be effective than lots of legislation.
Chair: There is likely to be an extensive discussion if we start off down that road, so at that point I will draw this part of the proceedings to a close. Thank you for coming to give evidence to us.

Examination of Witnesses

Witnesses: **Barry Eveleigh**, Lead Commissioner for Drug Treatment, Birmingham Drug & Alcohol Action Team, and **Jacqui Kennedy**, Director of Regulation and Enforcement, Birmingham City Council, gave evidence.

Q228 Chair: Thank you very much for waiting. You heard quite a lot of that evidence. Could I ask you, briefly, to introduce yourselves and tell us perhaps a little about the role that you have played on behalf of your organisation in the development of Birmingham's local strategy?

Barry Eveleigh: I am Barry Eveleigh. I am acting strategic lead for the Birmingham Drug and Alcohol Action Team. My responsibility is for the oversight of both the drug and alcohol Government strategies and translating that into local practice. It is then making sure, once we have those strategies in place, that we deliver upon those.

Jacqui Kennedy: I am Jacqui Kennedy. My day job is Director of Regulation and Enforcement for the city council. I look after trading standards, environmental health, licensing, laboratories and other bits and pieces. I also have the strategic lead for the community safety partnership in Birmingham, so I work closely with the partners, be it through the DAAT, health or the police. I was the project sponsor for the development of the Birmingham Alcohol Strategy.

Q229 Chair: That is where I want to start—to understand how this strategy emerged and where the leadership function was located. Was it the city council that led the process with support from the health service and from the police, and so forth? How did it happen?

Jacqui Kennedy: We had a previous strategy that ran from 2007 to 2010. The local authority had led the development of that strategy. But we then worked closely as part of the community safety partnership. As our partnership matured, it was very clear that the replacement strategy could be a true partnership strategy and that is exactly how we have developed it. DAAT took the lead in terms of developing the strategy with colleagues and that was contributed to by all of the agencies.

Our strategy is very much an holistic approach to alcohol harm in Birmingham. We have based it on the framework that was the national strategy because we felt that that gave us the golden thread from neighbourhoods through to the national strategy. We have tried to consider the implications around health, crime and disorder, young people and antisocial behaviour. The strategy has tried systematically to structure a response to alcohol harm, and there are benefits associated with that. Birmingham is promoting itself as host to the American and Jamaican teams in terms of the Olympics, but also as a conference city. It is that balance of the tourism and the convention and conference offer, but also connected with the harm associated with alcohol in its neighbourhoods.

Q230 Chair: In terms of the history and where it came from, when was the first strategy and what have you learned, do you feel, along the way from your experience?

Jacqui Kennedy: Our first strategy was in 2007. It took us about a year to get to a public strategy. "Reducing Harm and Empowering Change" was the actual title of it. The key lessons learned were about how important it was not to have only one single agency approach to tackling alcohol. It was very much about understanding the impact of alcohol for the whole city but also within communities. Our key lesson learned, for when we were developing the new strategy, was that we needed to engage and consult more widely. The other thing that had been a little bit disappointing from the previous strategy was that it was underpinned by a strong delivery plan and some elements of that were not delivered. So the benefits that we could have got in that period had not emerged by 2010. It was very clear that we had not ensured that some of the partners were as included as they should be and the governance was not as strong as it needed to be.

The new strategy has very strict and strong governance around it. It is responsible and accountable through the Health and Wellbeing Board; it is accountable through the community safety partnership board; and it is also responsible through a corporate management team of the local authority. The city council is the sort of guardian for it, but all those partnerships are absolutely key to govern how we deliver because the strategy has been developed, again, with another strong delivery plan underpinning it and each of the partners is called to account as part of a scrutiny approach to make sure that we deliver against the plan. It is very much business as usual.

Barry Eveleigh: In terms of on-the-ground work, it has led to the expansion of a number of services that were piloted in the first strategy. For example, in the north of Birmingham, around Sutton, we piloted the notion of arrest referral schemes. That has now gone city-wide and has led to further development on alcohol treatment requirements, which again is something that is mentioned in the strategy. They are proving very effective. To give you an example, last year the target for alcohol treatment requirements was 20. We exceeded that target and delivered 71 successful completions on that that have led—

Q231 Chair: I am sorry, 20 and 70; what was that?

Barry Eveleigh: It was for 20 successful completions of people being placed on that alcohol treatment requirement order. The target was exceeded and we hit 71.

Q232 Chair: Alcohol treatment order. How do you define "success"?

Barry Eveleigh: It is basically those people who attend the treatment requirement hours and who do not re-offend.

Q233 Valerie Vaz: How do you identify them in the first place?

Barry Eveleigh: They are identified through the court system. We have a dedicated number of individuals

within the courts who look at what somebody's alcohol use is and whether it is significantly related to their type of offending. Then a suggestion is made before the court and it is entirely the court's decision as to whether that individual will go on an order or not.

Q234 Valerie Vaz: The court makes the order.
Barry Eveleigh: Yes.

Q235 Dr Wollaston: But success is judged not only on if they attend the course, but of they then do not re-offend.
Barry Eveleigh: No. It is by the behaviour change.

Q236 Rosie Cooper: Is everybody who requires that treatment, or is to be referred, taken on? Do you have enough provision and facilities?
Barry Eveleigh: Yes. That is one thing we have managed, which is looking at the overall capacity issues to make sure that we take that on board. The one thing that was interesting as to the development of alcohol treatment requirements is that we did it without additional funding. It was based on a partnership arrangement that could work within existing resources. That is the idea and what this strategy is about, how we can work together to achieve more with the same, if not fewer resources.

Q237 Rosie Cooper: That deals with the ones the courts referred. How many people who need an intervention because of their drinking in Birmingham do you actually deal with? What is the percentage of the overall figure? It is all right telling us how successful little pockets are, but the reality is that it is part of a much bigger thing that Birmingham has had.
Barry Eveleigh: Absolutely.

Q238 Rosie Cooper: Are you able to meet the requirements of the people of Birmingham?
Barry Eveleigh: Yes. I think it is fair to say that we are still in the early stages of developing the alcohol treatment system. It is only in the last three years that we have taken this on board and extended it out to what it needs to do to match the treatment system.

Q239 Rosie Cooper: So when I walk out of here, I know that you are able to help everybody who needs an intervention of whatever sort in Birmingham because of their alcohol dependency.
Barry Eveleigh: With the demand at the moment, yes, we can. There is no evidence of waiting lists for people to access treatment. In terms of the wider population, last year we delivered over 22,000 brief interventions within custody suites, GP practices and for students in colleges.

Q240 Valerie Vaz: What about people in their homes, if they are victims of domestic violence or if they are perpetrators of domestic violence? Are you picking up people inside as well as those who are creating public disorder?
Barry Eveleigh: Yes. That is through the alcohol arrest referral scheme. Those people who are arrested and go into the custody suites are seen by an arrest referral worker who is trained in brief interventions. Whether the individual is then further charged or not, they get that provision in the cells. There is also the issue of fixed penalty notices. With somebody whose alcohol consumption is such that they do not want to put them through the courts, and in order maybe to encourage people into treatment, they are given the option of seeing a treatment worker for two one-hour sessions to get brief interventions. If they attend that, they are not charged.

Q241 Rosie Cooper: Brief interventions, I hear, are quite successful. Are you saying that if we could get two-hour interventions throughout the country, our alcohol problem would disappear?
Barry Eveleigh: I am not saying it is going to disappear, because the evidence is that it is only effective in one out of eight individuals, but at least it is a start, and it is a cost-effective method.

Q242 Rosie Cooper: Of those people in Birmingham you are able to help, only one in eight are able to be helped in the brief intervention. Are you able to financially meet all the requirements of the other seven?
Barry Eveleigh: Those individuals get an intervention. At the moment, the numbers that we deliver on are above the recommendations that the Department of Health sets—around 15%.

Q243 Rosie Cooper: I am not bothered about the Department of Health. I am asking you the question. You told me you were able to help everybody who needs it, and now only one in eight are helped with the brief intervention. Are you able to fund whatever intervention or help those people need to get off alcohol? Are you able to fund it? You said you could before and now I am not sure you can.
Barry Eveleigh: No. As to the one in eight of those people who get a brief intervention, that is the evidence of the success of that brief intervention. We do not have any waiting times and there are certainly no capacity issues in terms of delivering brief interventions.

Q244 Rosie Cooper: After that what happens?
Barry Eveleigh: After that, in terms of those people who are dependent and have hazardous, harmful dependency issues, they get into treatment systems without any waiting lists.

Q245 Rosie Cooper: All of them?
Barry Eveleigh: Yes.

Q246 Rosie Cooper: How many of them would you—
Barry Eveleigh: Last year we treated over 2,000 individuals.
Jacqui Kennedy: That is about 10% of our dependent drinkers.

Q247 Rosie Cooper: Okay. Birmingham does not have a problem, then, because you are able to deal with it.

Barry Eveleigh: It has a problem. It is how we deal with it. As I say, the treatment system was in its early stages and we looked at how we could work with individuals and develop our treatment systems so that we had the capacity—

Q248 Rosie Cooper: I am only interested in outcomes. This is all it is for me—outcomes. How many people did you get off alcohol in Birmingham last year?
Barry Eveleigh: It was 575 individuals.

Q249 Rosie Cooper: How many people do you think are alcohol dependent—or more than that—in Birmingham?
Barry Eveleigh: As to alcohol dependents, we have 22,000 individuals.
Jacqui Kennedy: As to harmful and high risk, it is 39,000. We know exactly what our numbers are and we have an incremental plan through some community alcohol partnerships in the local areas, but also some pan-Birmingham approaches. We are trying to address it neighbourhood upwards and through pan-Birmingham approaches plus, obviously, we have a whole strategy around domestic violence where alcohol is a big issue for us. We have a whole strategy around the night-time economy where alcohol is also a big issue. It is pulling all those strands together and this Alcohol Strategy has tried to pull those strands together.

Q250 Chair: Are the 39,000 all named individuals referred into your services? Where does that number come from?
Barry Eveleigh: No. That is using the Department of Health's alcohol calculator in terms of the numbers we have per head of population within Birmingham.
To come back to your point, the problem we have—and it is outlined in your strategy—is getting people to recognise that they have a problem and want to change their behaviour. That is the issue that we face. As you touched upon earlier, there are issues about the advertising. Whether or not that encourages young people, I think it does act as a trigger for those people who are dependent on alcohol, who have maybe come off alcohol but are exposed to these triggers of alcohol consumption through advertising. That is something we need to look at.

Q251 Barbara Keeley: You have answered some of the points I wanted to make. I do not know how much you heard of the previous panel's session, but there was a lot said about cultural change, although not many ways offered to achieve it and I think it is very difficult. Could you predict how far down the drinking scale you think you will be able to go? Our brief says that there are 28% of men who drink more than 21 units and 19% of women who drink more than 14, which is the norms, is it not? Do you see the brief intervention strategy being able to get into that? Also, could you touch on—whether it is working through licensing authorities or behavioural aspects—how you are dealing with the problem that we did touch on quite a lot in our session of young people going out and having a massive amount to drink on one night? It is clear to me—and I mentioned it in the last session—that both sporting venues, and clubs and pubs in city centres, go along with this and carry on selling alcohol to people, including young people, who have already had too much. Is that an aspect of what you are doing or do you think the right way to deal with that one-off or maybe a couple of nights a week of drinking a lot is something you could do through interventions? Or is it both, I suppose, is what I am asking?
Jacqui Kennedy: I will take the licensing bit first. I think it is a whole combination of the toolkit that we use. For instance, as to the night-time economy in Birmingham, in 2004 Birmingham got a really bad reputation for high crime and high levels of antisocial behaviour, all associated with Broad Street. We put in place—working with the licensing authority, the council and the police—a business improvement district. That has had a massive positive impact, with the venues themselves realising that they can make more money if they do not have 18 to 24-year-olds throwing up in the street. That has had a massive impact. We have a business improvement district there for Broad Street, and that gave us a sustainable solution. We now have one for Southside, which is our other main night-time economy area, and that has had a positive impact.
We also introduced the no-drinking-on-the-streets policy—alcohol-restricted areas—for the whole of the inner ring road for the city of Birmingham. You cannot walk up and down the street carrying or consuming any alcohol. That had an impact as well. We also introduced—although we did get challenged by the Office of Fair Trading on this—"no irresponsible pricing promotions on a Friday and Saturday night". There were venues previously that would offer five double vodkas and a Red Bull for a fiver. We stopped all of that. That was done through a voluntary agreement with the venues in Broad Street and in Southside. We have had some challenges from the Office of Fair Trading that that is anti-competitive but, while it is a voluntary agreement and code, that has really worked for us. It has reduced antisocial behaviour significantly as well as crime and disorder.
In terms of young people pre-loading and coming into the city, that is still an issue for Birmingham as it is elsewhere. I was in Bristol last week and it was exactly the same sort of situation. What we are trying to do there is work with the licensed premises and with the police, and say that if they continue to serve people who are drunk—and it is really difficult because there is no objective definition of "drunk", but if there is drunkenness in the venue—the police or the licensing authority will actually suspend or revoke their licence or limit their times. The problem with that, though, is you now have venues not allowing youngsters to go into their venue at night. They are trailing up and down the street but, because they cannot drink on the street, they are having to go somewhere else. It is a combination of all these things. There is not one silver bullet for the problem of alcohol in Birmingham anyway, so it is the combination.
The other thing we did was a communications campaign about people understanding the potential

impact of drinking too much, such as having a pint at 9 pm and then having a pint of blood at 2 am—that sort of thing. We have tried to use the nudge campaigns and the communications campaigns. At the moment we are looking at playing on the vanity—though vanity might be the wrong word—or self-image of people. There are a lot of calories in alcohol and we do not tell people how many there are. But we have to balance that. You do not want to make people become anorexic, so it is about getting that balance. We are looking at that as well.

We have tried to combine all the tools that are made available to the local authority and to the police. The police use a campaign where they do an early intervention if there is any sort of rowdiness, lairyness or antisocial behaviour. A yellow card is issued, using the football term, and then people get banned from the area if they continue to behave badly. That early intervention has improved the general offer. The other thing about the business improvement district is that we have now changed the age profile by promoting the ICC. I think that there is something about people from the age of youngsters right the way through to older people mixing together in the street which dilutes some of that bad behaviour as well. So, again, we have looked at the marketing mix, particularly in the city centre, but also in some of the suburbs that are growing now into night-time economy areas.

Q252 Barbara Keeley: Does it cover your major sporting venues, football grounds and cricket grounds?

Jacqui Kennedy: Yes.

Q253 Barbara Keeley: There is a huge amount of drunkenness at football grounds.

Jacqui Kennedy: Yes. In the football grounds, and certainly Villa Park, which is my team—not that I am biased in any way, and we are still looking for a manager if anybody is interested—I know, because I am a season ticket holder, that there is occasional drunkenness but the stewards are brilliant and we work, as a licensing authority, tightly with them. I was interested to hear the comments about the cricket. I do not know what it is like at Warwickshire, so I am going to have a little visit and see how it is there. But we are very strict as a licensing authority. We have a group of elected members responsible for each of the sports grounds to make sure they comply with licensing.

Q254 Barbara Keeley: It tends to be test matches, in my experience.

Valerie Vaz: In which case you want to go to Edgbaston.

Jacqui Kennedy: I need to go to Edgbaston, yes. That was my bit.

Barry Eveleigh: From the health aspect, we are looking at various ways to try to communicate messages to individuals because not everybody wants to go to a treatment service where they are seen as perhaps being alcoholics or alcohol dependent. There is a variety of different initiatives. Sporting venues is one, in terms of putting messages out—advertising drug and alcohol services—that people can just see. Something printed on the back of a ticket is an idea of some of the campaigns that we have had. We have recently launched, in conjunction with the city council, a website called "MyLife4Me" where people can access a range of health information. In addition to that, they can also undertake their own health assessment to see whether they have some form of alcohol and drug dependency. Then there is a further IT package where they can start to undertake their own recovery, to try and cut down on their drinking or drug taking behaviour through a package that is called "Breaking Free Online".

Jacqui Kennedy: One of the other points is, obviously, with the demographic of Birmingham there are a lot of people who do not want to go for a night out clubbing, or where there is alcohol anyway. So Barry and I have recently met to talk about the possibility of trying to get somebody from the trade to open up an alcohol-free venue in the city. We think in Birmingham there would be quite a lot of demand for that because not everybody wants alcohol. We are looking at seeing how we can court our trade representative colleagues to see if somebody would like to try investing in that. I know there is such a venue in Merseyside.

Q255 Chair: You referred to a yellow and red card system and said that a particular individual with a bad behaviour record would be excluded from a part of the city. I think that is what you said.

Jacqui Kennedy: Yes.

Q256 Chair: What is the legal basis of that? That must be quite difficult to enforce.

Jacqui Kennedy: No. It is really straightforward. It is basically a dispersal order that is already a tool in the police's toolkit if somebody is causing a problem. They are only sent away for 24 hours. It is not something like a drink banning order. It is only if they go a bit too far in terms of the night out. I do not think we have had to issue any for quite a long time. There is a whole self-regulation aspect to the night-time economy as well in terms of if it is feeling nice it dilutes that behaviour. So we have had some positive moves, although recently there has been a creeping in, because of the financial situation, of some venues dropping their alcohol prices. We want to nip that in the bud quickly. We will use all our powers as a licensing authority to challenge that because that does undermine the licensing objective.

Q257 Chair: Are you acting within your powers to enforce what is effectively a minimum pricing policy through the licensing system?

Jacqui Kennedy: We have not been legally challenged on it yet, but I have been threatened with it several times. I am anticipating that and then we will have to revisit it, but at the moment it is a voluntary code among the businesses. For the businesses—certainly in Broad Street and Southside—commercially it is more beneficial to them to have people paying full price rather than "buy one get seven free".

Q258 Chair: But presumably, in dealing with the business community, you will get many who will buy

into your responsibility message and then you will get the maverick that sees an opportunity in not buying into it.

Jacqui Kennedy: Most of them are in the business improvement district and there is an element of peer and self-regulation. If you are a member of the business improvement district, there is a duty to the board.

Q259 Chair: It becomes part of the contract between the operator and the business improvement district programme.

Jacqui Kennedy: Yes.

Q260 Chair: What incentives can you offer through the business improvement district programme?

Jacqui Kennedy: Being a member of the BID in terms of the communications is one thing. Our BID in Broad Street, for instance, offers things like environmental improvement and street cleaning—all the environmental factors to make the area a nice place to be. Those would be the sorts of things that the BID might withdraw. The other issue is that we are very hot on any data associated with any spikes in crime, disorder or antisocial behaviour, which then would potentially, if that was allocated to that venue, take them straight in for a licensing review anyway.

Q261 Dr Poulter: In terms of working with many of the bars in the city centre, as well as dealing with irresponsible behaviour towards the sale of alcohol, there is an issue about encouraging people in some cases to choose soft drinks or incentivising those people perhaps who drive or who use their car. In parts of America it does quite well, I understand. They incentivise people to have soft drinks in restaurants and bars. Have you looked into this? If you have, have you found any appetite for that from the bars and clubs in the town centre?

Jacqui Kennedy: We operate Best Bar None. You get extra points if you have a policy as to the Best Bar None scheme, so they get accredited and potentially appear high up the scoring level. We do that. We do encourage designated driver status. That has been piloted—we have tested that—but we have not evaluated any outcomes yet. I think that is exactly what we should be doing because, at the moment, being nearly always the designated driver when I go out with my husband, it costs nearly as much to buy me an orange juice and bitter lemon as it would cost to buy me a pint of lager. It is something that we have not sorted yet in Birmingham, but we are looking at it.

Q262 Dr Poulter: That is good because it is not just orange juice but other soft drinks, for example, which I know have a huge mark-up in many bars. Nevertheless, young people—who we are aware we are dealing with here—sometimes, to make the alcohol palatable, will have Coke or something else in their drink. But this is something you think can be positively looked into, can be further developed and would be a good thing to do, not only in Birmingham but elsewhere.

Jacqui Kennedy: I think it would be a very good thing to do. The other thing we need to do is enforce more licensed venues to offer tap water. That was a big issue for us as to the nightclubs where they turned off the tap water. We used our health and safety powers and closed them down, or threatened them with closure, because they were saying that you had to buy your drink and you could not drink out of the tap. Our water is from Severn Trent and it is fantastic. It is better than some bottled water. It was a whole issue, but that is the sort of thing that needs to be dealt with. There are lots of tools and powers available to local authorities and to the police that need to be used efficiently. I think we are moving in the right direction in Birmingham.

Q263 Chair: You have obviously been working on this for some years in Birmingham and you would have been aware that the Government was developing its own Alcohol Strategy and Responsibility Deal and so forth. Were there things that you were looking for in that Strategy before it came out that were not there when it did come out?

Jacqui Kennedy: No, because we have fed in on every stage of the consultation. We were quite pleased with the content of the strategy when it came out and we have tried to take it to a local level. We have followed the national strategy rather than trying to create something different.

Q264 Chair: In terms of the role of the pubs and the clubs and the private sector in supporting your strategy, are you asking them to do things that they demur from?

Jacqui Kennedy: We have—and I do not know if we are just really lucky—a very responsive licensed trade in Birmingham. They have been very responsive and have worked collaboratively with us on most things. But the business improvement district is the model, I think, that has delivered on that because the businesses themselves can see the commercial benefit, plus the conversations that we have. Public health moving to the local authority is going to be a positive thing. In Birmingham we have worked very much as, "It is business as usual", but working even more closely with public health colleagues will be very positive.

Barry Eveleigh: To expand on that one, we are about to launch a scheme called Community Health Champions, which is basically recruiting individuals from their local communities and training them up on various public health messages, not only alcohol but smoking and sexual health. They will be going into bars and clubs to give people the sort of information that they need. You talked about the idea of soft drinks. What we will be doing within this is trying to get through the message that if people drink water regularly throughout their evening's entertainment, they probably will not wake up with a headache in the morning. It might possibly have an impact on crime reduction, in terms of people going a bit over the top, ending up in a fight and then in the cells.

Q265 Chair: We finished up in the discussion with the last panel talking about the target of reduced sale of units of alcohol over a period and it appeared that the national target was a 2% reduction in units of

alcohol sold between now and 2015. How do you react to that?
Barry Eveleigh: I think it is a good start. The figure of 2% sounds small, but the impact of 1 billion units on somebody's liver across the nation is going to have some impact—

Q266 Chair: On one person's liver it would have quite a significant impact.
Barry Eveleigh: Yes, it would have a huge impact. It is about how we get that message across. The previous speakers talked about low alcohol and how that is advertised. If it is done effectively, you can achieve great success. For example, in Coventry, in a pub that I drink in, which is a bikers' pub, they have a low-alcohol real ale. For bikers to drink low-alcohol real ale is quite an interesting idea. With this product that is a real ale that has bike promotions behind it, rather than if you were to have Kaliber on the shelf, people do not lose their cool. It is about how you sell those products to enable people to reduce their alcohol consumption.
Jacqui Kennedy: One of the things that somebody suggested there, which I have written down to take back—because we do environmental health as well—is the idea that the house wine should be a lower percentage. I tend to order a bottle of house wine and it would not occur to me to check the percentage. If we can encourage some of our restaurants to offer that, it would be a positive thing, so I have learned something.

Q267 Chair: I know you will not have had that conversation yet, but what do you anticipate will be the reaction?
Jacqui Kennedy: I think it will be positive. Again, a lot of our restaurants are looking at the health, nutrition and obesity agenda. We are working on healthy offers in takeaways. That sounds like a contradiction, but we are looking at how we can do that. I am thinking of a whole batch of restaurants that we are working with at the moment as to the nutrition, health and obesity agenda that I am confident would sign up for that virtually straightaway.

Q268 Valerie Vaz: I want to follow up on that. Is your strategy primarily a health one as opposed to a crime and disorder one?
Barry Eveleigh: No. Our strategy, as we alluded to earlier, is a holistic approach that covers all areas that, basically, is a replication of the national strategy. There is no one approach to this. We are dealing with complex human behaviour and, therefore, you need a range of interventions from an enforcement level to a public health message.

Q269 Valerie Vaz: Which Department would you think it should sit in?
Jacqui Kennedy: We think we should sit in partnership and it should—

Q270 Valerie Vaz: I mean a national Department. Should it be the Home Office, the Department of Health, or—
Jacqui Kennedy: With all due respect, it has to be everybody. If I look at my day job, I have licensing, which sits with the DCMS; crime and disorder which sits with the Home Office; health which sits with the Department of Health; and I am tackling underage drinkers which sits with the young people's Department. I cannot compartmentalise my job into Government Departments and my service is not broken up into services. You have to take it as holistic. You might have a lead, so in our partnership, the local authority is the accountable body for the community safety partnership and Health and Wellbeing Board, but you need to have all partners. Even DEFRA has a role because of rubbish, recycling and litter—alcohol litter. I think it has to be across all—

Q271 Valerie Vaz: It is a Cabinet Office-type role.
Jacqui Kennedy: I think so, yes.

Q272 Valerie Vaz: I was not quite clear.
Can you quickly—and we might be changing tack slightly—tell us what your view is on a minimum alcohol pricing level?
Barry Eveleigh: It is something that we support. The early indications from Scotland are that it is starting to have an impact in terms of the sales of alcohol. I think we have to be cautious in light of recent reports that have shown an increase in counterfeit alcohol being sold. In the past two years there has been a fivefold increase. We have to be very careful if you push the price of alcohol up that there is not a shift—especially when we are talking about young people—and you do not move then to consumption of drugs, especially with the advent of legal highs. It is a good idea, but we need to keep our ears to the ground in case something happens.
Jacqui Kennedy: Certainly, with my trading standards hat on, we have seized a lot of counterfeit spirits, but we have also seized a lot of low-standard non-counterfeit spirits. They have just used a different name, so it is not Vladivar but it is called Vladi or something like that. It is not counterfeit, but it is pure, badly-constructed vodka.
Chair: There is historical precedent for that.

Q273 Barbara Keeley: I have to say that it sounds as if you are doing a really good job. At a time of council budget cuts, are you having to justify the funding of your posts, if you like, and whoever else works with you on the things you have talked about? Is it financially cost-effective or is there some goal, over a number of years, that it will become so? What sort of measures are you looking at, in health or police and antisocial behaviour, to assess the outcomes of the work you are doing?
Jacqui Kennedy: In terms of funding for the local authority, this is our day job. It is linked into licensing, trading standards and environmental health. It is the day job. It is not a specially-funded activity.

Q274 Barbara Keeley: But other authorities are not doing what you are doing. That is all I am thinking. There must be some extra expenditure on it because other authorities are not doing it. Setting up a business improvement district must take some doing.

Jacqui Kennedy: That was pump-primed by our city centre partnership, and as part of the development offer—so building employment and jobs—they funded the ballot for the business improvement districts. They now have not only those in the city centre; I think we have 11 in different parts of the city. They are sustainable and are all funded through the BID levy. My job is the day job and I happen to have the council lead on alcohol, so there are no issues about savings there in terms of the DAAT.
Barry Eveleigh: In terms of the DAAT business, at the end of the day this is public money. What we have to do is to demonstrate that we are using that money effectively and that it is achieving something in terms of what is actually happening. We have been working over the last number of years to look at it not only in terms of the number of people that we see, but what we do with those individuals. We have been working in terms of outcome measurements, looking at where it goes with the drugs PbR and trying to continue that justification of what it actually achieves.
Jacqui Kennedy: In terms of what we set ourselves in our strategy, we are looking to stabilise the rate of alcohol-related hospital admissions by reducing the rate of increase by 2% year on year. We have said we are going to reduce alcohol-related crime and disorder by 10% by the end of the strategy period, and we are looking at reducing the months of life lost due to alcohol by 10% by the end of the strategy period.

Q275 Barbara Keeley: Are you trending okay on that? Are you starting to meet that?
Jacqui Kennedy: We are just kicking off. This is a new strategy, but the trajectory is positive so far. We still have increases. Our old strategy had measurements as to A and E admissions. We think that these indicators and outcome measures are far more outcome-focused and holistic than output statistics.

Q276 Chair: You plan on monitoring them real-time, not waiting till 2015 to see if you have it right.
Jacqui Kennedy: No. We are monitoring in real-time through the Health and Wellbeing Board and through the community safety partnership.
Barry Eveleigh: We are looking at six-monthly reviews from creation of the strategy, and then a lower level with the providers, on a monthly and quarterly basis.

Q277 Valerie Vaz: Can I quickly ask about A and E? Do you have anybody from your strategy team there, like alcoholic nurses or—
Barry Eveleigh: Yes. What we actually have within the city—
Chair: Alcohol service nurses, I think, was what you meant.
Valerie Vaz: That was what I meant.
Barry Eveleigh: This is where, to an extent, we were some way ahead of the game. We developed a service called RAID—Rapid Assessment Intervention Discharge services. They are based across the four PCTs within the city so that anybody admitted with some sort of alcohol-related illness is seen, assessed and referred to appropriate treatment teams. If their alcohol dependency is quite severe and they are going into withdrawal in hospital, that team then automatically works with the consultants to start the detox within the hospital. But then, to prevent bed blocking, they are transferred back into the community where the detox is continued and then there is an aftercare package in place.

Q278 Dr Wollaston: Can I clarify a point that Rosie made earlier? If you are a GP in Birmingham and you refer somebody for alcohol treatment—not brief intervention, but for alcohol treatment—there is no waiting list in Birmingham.
Barry Eveleigh: No.

Q279 Dr Wollaston: What about for self-referrals, though? Would that be the same?
Barry Eveleigh: There are no waiting times at the moment.

Q280 Dr Wollaston: That is quite remarkable. Also, touching on health, the Government are consulting on allowing licensing authorities to take health-related harms into account when making decisions on licences. Do you support that move? Secondly, what effect do you feel the number or density of licensed premises in an area has on health-related harms within Birmingham?
Barry Eveleigh: Okay.
Jacqui Kennedy: I will help.
Barry Eveleigh: In terms of bringing in health for this, it is a good move because it has been sliced out of the equation in terms of a valuable input that can say, "We think there should be some restriction in terms of what is going on in these areas because we are constantly getting people brought through who have been assaulted. They are coming through with various alcohol problems and they are creating a nuisance." I think it takes it back to that. In terms of density, it is an interesting one, and I am not quite sure how that one plays out. I would look to Jacqui on that one.

Q281 Dr Wollaston: Alcohol Concern has produced a paper on this and I wondered if that is your experience, and whether you would agree with its work on this.
Jacqui Kennedy: In terms of the paper you are referring to, I do not know exactly what it contains, but, as a licensing authority, we need to be clear. It is easy for the police to bring up a review of the licence because they can say they have had 10 assaults or drunkenness or whatever. It is more difficult than that. There will be parts of the city where we have community alcohol partnerships in place and where I think health representations around more venues or more licensed premises in those areas may have an impact. One of the areas we talked about was Moseley, which has a street-drinking issue, and it has recently been awarded some funding from Baroness Newlove's pot to tackle that issue. There is a whole question mark there, from the health impact view, about opening another licensed venue in that area and would that have a disproportionate impact or tip it over the edge. We are not absolutely sure how it is

going to play out yet. I need to acquaint myself with the Alcohol Concern document.

Q282 Dr Wollaston: Finally, returning to the issue of minimum pricing, the Birmingham strategy is supporting minimum pricing, as you pointed out, and the Core Cities Health Improvement Collaborative has called for a 50p minimum price. Are you going to be lobbying now for the minimum price to be set at 50p or, referring back to the evidence you gave earlier, do you think that is going to be too high? What would be your view?
Jacqui Kennedy: We have recently changed the city council so we have to get a political mandate for how much further we take it in terms of lobbying. But any issue as to minimum pricing, we think, is a positive thing. As to what the level should be, we are not sure.

Q283 Rosie Cooper: Are alcohol-related deaths in Birmingham going up or down?
Barry Eveleigh: For males it is not as high as females.
Jacqui Kennedy: Is it increasing or decreasing is the question, I think.

Q284 Rosie Cooper: Is it increasing or decreasing?
Jacqui Kennedy: We have it here, I think.
Barry Eveleigh: It is still on the increase.

Q285 Rosie Cooper: It is still on the increase.
Barry Eveleigh: Yes.

Q286 Rosie Cooper: You do not have a waiting list for treatment.
Barry Eveleigh: No.

Q287 Rosie Cooper: So is the increase in deaths due to the failure of that which you say is your treatment?
Barry Eveleigh: No.
Jacqui Kennedy: No. We think it is because people do not realise that they have an alcohol problem and that is resulting in them dying.

Q288 Rosie Cooper: People do not realise they have an alcohol problem. So should you be concentrating more on making them aware than on treatment, because you have no waiting lists? What can you do? What intervention will stop alcohol-related deaths increasing? That is what you are about.
Barry Eveleigh: Sure.

Q289 Rosie Cooper: So if you have no waiting list and no obvious problem with time, money, facilities, capabilities or volume—however you want to describe it, you have no problems with any of those—but deaths are still increasing, where are you targeting?
Barry Eveleigh: We are pretty much targeting everywhere. It comes back to the old—

Q290 Rosie Cooper: You are targeting everywhere. That is a misnomer, is it not?
Barry Eveleigh: We are trying to target everywhere—GP practices, colleges and universities where there is that problematic drinking in freshers' week. The first thing people want to do when they go into university is make sure that they go out and party. We are trying to work within the local delivery groups and to work with communities—anywhere that we can get out that message—whether that is through treatment services or—

Q291 Rosie Cooper: But that is my point. You obviously cannot be reaching the parts that you say you need to reach because, if you were, alcohol-related deaths and illnesses would not be increasing.
Barry Eveleigh: The phrase is that you can take a horse to water but you cannot make it drink. It is about getting the message through to individuals that they are causing damage to their bodies. Whether they decide to act upon that information is their own choice at the end of the day. That is why the Government strategy is quite important. For some individuals, we need to coerce them into treatment, as has happened within the drugs criminal justice service. Some people do not consider themselves to have an offending problem—a drug problem—but once they go through that legal system and they have to go to treatment, the penny sooner or later drops.

Q292 Rosie Cooper: But a lot of people are escaping all of you because they are dying.
Jacqui Kennedy: Yes, but there is a whole intergenerational step change that we are trying to make. We have an increase in young people not drinking, which is positive, but we cannot pull back from what has gone 20 years ahead of us. A lot of our people who are dying are dying not at 20, 21 or 30, but they are older people dying as a result of a lifetime of hazardous drinking. We are making that change, but it is an intergenerational thing and it is not something that we are going to be able to do in three years.

Q293 Rosie Cooper: So you are concentrating on young people and the older ones are just going to die off.
Barry Eveleigh: No. We try to go right the way across the board. It is the prevention of young people from going on to develop liver disease and working with those people who are also on the verge of liver disease and doing something with them. What we have to accept is the reality for some individuals who have chronic liver disease and are going to die; it is not going to change their drinking behaviours.
Rosie Cooper: Fine. Thank you.

Q294 Barbara Keeley: Could I ask a point of information? Is it like smoking? If people stop or really cut back, do things return to normal, or is there likely to be a lag in the results in that if you have done the damage you have done the damage?
Jacqui Kennedy: I am not a medic. If Jim McManus—our public health man—was here he would say there is a point where the damage is already so far—
Barbara Keeley: It is understandable that there is a substantial lag in figures, but I do not even know if—
Rosie Cooper: Professor Gilmore said that you cannot predict who will recover and those who will go on to suffer irreparable harm.

Q295 Barbara Keeley: But there are some points where, if people stop now, they can—
Jacqui Kennedy: Yes.
Barry Eveleigh: Yes.
Jacqui Kennedy: Our hospitals put interventions in place. Ward D15—I do not know what it is called—in the city hospital put an intervention in place if somebody is admitted with chronic liver disease.

Chair: That probably takes it about as far as it can. Thank you very much for coming to give evidence. I have been enjoying the irony, during the course of this morning's session about the problems of alcohol-related disease, that we sit taking this evidence under a portrait of Pitt the Younger who died of an alcohol-related disease at the age of 46.

Tuesday 12 June 2012

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper	Chris Skidmore
Barbara Keeley	Valerie Vaz
Mr Virendra Sharma	Dr Sarah Wollaston

Examination of Witnesses

Witnesses: **Anne Milton MP**, Parliamentary Under-Secretary of State for Public Health, **Chris Heffer**, Deputy Director, Alcohol and Drugs, and **Dr Mark Prunty**, Senior Medical Officer, Alcohol and Drugs programme, Department of Health, gave evidence.

Q296 Chair: Good morning. Thank you for coming. Welcome to the Select Committee. Minister, we know your background and role here, but could I ask you to introduce the two officials you have brought with you and tell us, briefly, their roles in the Department?
Anne Milton: Chris Heffer is one of the officials in the alcohol team. He covers a number of other areas, but specifically alcohol for today. Dr Mark Prunty is an addiction expert. I am looking at him to check if he wants to add anything.
Dr Prunty: I am an addiction psychiatrist.
Anne Milton: He is an addiction psychiatrist, yes. Mark is the science and Chris is the policy.

Q297 Chair: In the policy context, that is both policy in terms of the Alcohol Strategy and prevention as well as service delivery.
Anne Milton: It is both ends of it, yes, the preventative work and indeed the treatment.

Q298 Chair: Thank you very much. Could we start with a general question? It would be helpful to the Committee to hear from you, Minister, your view of what the problem is that we are trying to solve.
Anne Milton: Yes, with pleasure. I must apologise. I am a bit hoarse but feel very well, so do not be sorry for me.
Over half the population drink below the recommended guidelines, and 15% of people actually abstain. However, those remaining are suffering harm from alcohol. From my point of view, it is about seeing harm in every respect. There are the harms to health, both primary and secondary. The obvious one is alcohol-related liver disease, but you also have the contributory effects of alcohol to other diseases, like cancer.
There are harms to local communities from antisocial behaviour caused by people being drunk. That can just amount to noise, which indeed can be very disturbing, but also criminal damage to cars and all the rest of it. We have harms to the economy. That is time off work due to alcohol misuse. In the extreme, that would be somebody who is dependent on alcohol, but, to a lesser extent, there are hours lost off work due to hangovers, late-night parties and so on.
There is harm to families. People who misuse alcohol often find themselves losing jobs, so there is the impact of poverty on families. The other thing that possibly does not get as much attention as it should is the harm to children, both in terms of some of the safeguarding issues that arise—violence—and domestic violence generally. Alcohol is something that affects our lives in all sorts of different ways.

Q299 Chair: It is quite striking that you started off by defining out, as it were, the ones that are not a problem. However, you regarded only 50% of the population as not a problem and, therefore, by implication and in varying degrees, half the population are part of the problem.
Anne Milton: I would not put it in those terms. I would say that they are not part of the problem but alcohol probably impacts on their life in some way or another.

Q300 Chair: What is the cut-off point in terms of alcohol consumption between those who are completely in the clear, on that view, and the other half?
Anne Milton: By definition, if you can drink and it does not affect your life, your family's life, your neighbour's life or, indeed, the community in which you live, and is not causing any primary or secondary disease, you are probably drinking within the recommended guidelines.

Q301 Chair: That is understood, but I am surprised because the implication of what you are saying is that half the population drink above recommended guidelines, which I do not think is—
Anne Milton: No, I am not quite saying that, and I will turn to Dr Prunty to elaborate. I think it is important to recognise that over 50% of the population do not drink above recommended guidelines and 15% of the population abstain. Of those who are left, we may or may not have a problem that they may or may not be affected by. But it is important to recognise that alcohol causes quite a large ripple among families and communities.

Q302 Chair: I understand that. I was trying to get to an understanding of the proportion of the population that gives us a problem.
Anne Milton: I can give you facts and figures. There are 9 million people who say that they drink above the guidelines, and there are 1.2 million hospital admissions. I can give you lots more statistics, which I am sure you have already had access to through your officials. Alcohol misuse costs the NHS £3.5 million

a year, but, as I have said already, the human cost is not always quantified in those terms.

Q303 Chair: But it is quite important, is it not, if we are trying to develop a set of policy instruments to achieve an outcome, to be clear to whom those policy instruments need to be directed: how big the population is; who they are; how they are identified, and the characteristics of the population that are the targets of the policies we are seeking to develop?

Anne Milton: Absolutely, and they are wide and varied. As I say, all the harms I talked about will affect different sections of the community to different degrees, and some people pass through and come out the other side. Students would be a good example. They go off to university and probably drink way above recommended guidelines, and when they get jobs and settle down they stop drinking so much. So they are a problem for a brief period of time. I know what you are after, but there is a danger in being very simplistic about this because it is not a simple story. I do not know, Mark, if you want to add anything to this.

Dr Prunty: You can pick out a range of harms that are caused by alcohol consumption. It contributes to a minority of cancers and to 60% of alcoholic liver disease. In different areas and different populations, regionally and locally, you have a different balance between dependence and risky drinking. In order to look at the need that you are addressing, you have to look at the data at a national level but, in terms of planning for responding, you need to look at the balance of the different types of drinking at a local level—and that information is made available through the North West Public Health Observatory—and at the range of harms. Local areas then need to determine their priorities against the whole range of different harms in their local communities. So it is difficult, as the Minister says, to give a simplistic answer on that. There are priorities that might be seen at national level, such as admissions to hospital, with a huge impact directly on the NHS, and then the way in which alcohol affects communities varies in the way communities drink; the kinds of services available; social deprivation and so on. It is not easy to give that answer without quite a complicated analysis, but that local analysis is available and is produced for all areas.

Q304 Mr Sharma: The way that young people use alcohol is often extreme. The strategy notes that about one third of alcohol-related A and E attendances are by under 18-year-olds, that those under 25 report being drunk more often than any other adult age group and about 50% of students drink more than the lower-risk guidelines. How will the strategy help to address this issue?

Anne Milton: It will help in a variety of ways. We have started by highlighting that it is a complex problem. If you take students as a population, a proportion—Mark or Chris will have the exact figures—will pass through that phase and come out the other side. In terms of hospital-related admissions, there is no doubt that the brief interventions which are mentioned are important, as indeed are alcohol liaison nurses and the powers that local authorities will have to change some of the licensing. The consideration of the harm as an opportunity for opposing licensing applications, I think, sends an important message. That is exactly what the Alcohol Strategy has done. It has gathered together a complex problem and made sure that a lot of the agencies involved have the powers to take some action. There is also action that we can take at the centre, such as the Change4Life campaign which raised the whole issue of the harms done by drinking alcohol at just above the recommended guidelines, which is targeting a different audience. It all has an impact.

As I say, the strategy is bringing together a number of things. But I have to add, as Minister for Public Health, that, in conjunction with that and also as a constituency MP with a university in my patch, the move of public health to local authorities will give, in an area like mine, the local authority opportunities to do specific things that might be targeted—students—on top of that.

Q305 Mr Sharma: The national strategy sets out a series of outcomes the Government wishes to see but sets no specific targets or objectives. Why is this? How will you measure the effectiveness of the strategy?

Anne Milton: We have a public health outcomes framework out at the moment with two high-level objectives and looking at a number of public health issues in four domains. We will be developing that and are consulting on specific objectives and high-level outcomes as we go along. But, essentially, the money given to local areas on public health in the light of the strategy will be against the public health outcomes framework.

Q306 Chair: Reverting to the general picture for a second, it is slightly paradoxical, is it not, that we are having this discussion about alcohol-related harm, of which there is clear evidence, but that alcohol-related harm seems to be rising at a time when alcohol consumption is falling?

Anne Milton: Yes, correct.

Q307 Chair: I wonder whether the Department has a view about what is behind that paradox.

Anne Milton: I will leave an opportunity for officials to come in here, but that is interesting. It is really why I started where I started, because, as you say, a small number of people are drinking more and more alcohol. It should focus our attention on the fact that a message is getting through to some people, but not everybody. That is why I think the Alcohol Strategy in many ways is so important and that a very cross-Government approach is important. Obviously, we are failing to hit a number of people.

One has to look at some of the parallels with smoking, although it is different. We have passed a great deal of legislation and run a lot of public health campaigns and no one is in any doubt. If you look at awareness of the harm of smoking, I think 96% of the population agree that smoking harms your health, whereas with alcohol the figure is much lower. Despite that, one in five continues to smoke. With alcohol—and officials

will get cross with me—we are not seeing the same pattern. We are meeting a proportion of the population but not hitting everybody. That is where I think the Alcohol Strategy has some good things, such as the alcohol liaison nurses; the opportunity for brief interventions; as I say, a change in the licensing laws; and the acceptance that alcohol harm is a valid reason for opposing a licensing application. They are all important.

Q308 Chair: I am struck, again, that the way you reconcile the paradox is by saying that the problem is becoming progressively more concentrated on a number of people who are abusing alcohol. One of the answers that we have been given by previous witnesses refers to the delayed impact, that alcohol-related harm can be built up over a period of years and that is part of the reason why the caseload is increasing. Clearly, both of those things can be true, but which one is relatively more important?
Anne Milton: I would always struggle to say any one thing is more important than the other.

Q309 Chair: I will say "statistically more significant": which one is the more significant driver of the current rising load of alcohol-related disease?
Anne Milton: I hesitate to say one or the other. They have different impacts of concern for different reasons.

Q310 Chair: What evidence is there of the increasing concentration of the problem in a reducing population?
Anne Milton: Chris, do you want to come in on this?
Chris Heffer: There are a couple of things. As you say, consumption has risen over 30 years and quite dramatically peaked—if you want to use that word—in about 2004 and is down about 10%. But one needs, I think, to be cautious of over-interpreting year-on-year falls in that. There are a number of measures of alcohol harm. We can look at deaths, which fell the year before last but then did not fall last year. So has that followed? You may come back to hospital admissions as a measure and, as you know, we are consulting now on both a broader and narrower definition of that, looking at both primary and secondary coding. The primary coding has only grown about 2% or 3% over the period, not quite in line with falling consumption but certainly not growing rapidly while consumption falls. So I think the time-lag theory that Ian Gilmore talked about is very real. You might expect deaths to respond faster, which may be why you saw that in one year. We know that the higher social classes drink more but the harm occurs more in the lower social income groups. Professor Brennan, I think, spoke about some reasons why. So the harm is definitely more concentrated in some groups. I am not sure we know whether it is becoming more concentrated.

Q311 Chair: That relates back to some of the earlier questions. If it is true—which is why I asked what the evidence is—that this is a problem that is becoming progressively more concentrated, it puts greater importance, does it not, on identifying which are the populations where the risks arise and targeting those populations rather than relying on population-based initiatives?
Chris Heffer: I am not sure we know it is becoming more concentrated. It always has been that harm has been found—if you look at alcohol-related hospital admissions—more in the lower social classes than the higher ones, despite the fact that they drink less. Professor Brennan spoke about some reasons why he thought that might be true. I do not know that we know it is becoming more concentrated. As the Minister said, there are 9 million people drinking above the guidelines, and you could argue that is targeted equally. That is a quarter of the population and is quite a large number to find. That is based on self-report, so the actual number could be higher still. It is a large group to try to target and cannot always be defined that narrowly.
Anne Milton: The other thing I would add, which is stating the obvious, is that if you take deaths, for instance—and this is in the light of increasing opportunities for medical care and increasing improvements in medical care—one has to be quite wary of statistics per se. You would expect deaths from a disease to have gone down, so maybe the figures are worse. The other thing is that we tend to collect numbers, not people. The same people who have been treated for the alcohol-related liver disease may be the same people who are causing a problem in the town with violence. You have to be wary. This is a complex picture of a number of groups, all of whom have to be targeted at different times. That is why our whole approach to public health has been a life course approach to it.

Q312 Mr Sharma: Are you satisfied that the Alcohol Strategy has the right balance between health and social policy and public order issues?
Anne Milton: Yes, I am. I have to add that it is in light of the changes we are making elsewhere to public health.
Chair: That was a straightforward answer.
Anne Milton: I will not be long winded if I do not have to be.

Q313 Barbara Keeley: Witnesses have noted that the most serious problems arise from the chronic long-term impact of drinking. Clearly, binge drinking at a weekend might cause the antisocial behaviour—noise, town centre problems and then the hangovers—that you talked about. Maybe that is one population. But in terms of the other things that you discussed—chronic health problems, loss of job, poverty, harm to children and families—and I know both are problems, clearly they are very serious, with an impact on a wider group. How will the strategy affect those chronic problems? There is a concentration on the town centre problems, the licensing and those sorts of things, but those longer-term harms should concern us as well.
Anne Milton: Yes, and it is very important to raise it. As you say, there is a lot of attention on the antisocial behaviour problems and possibly less attention on the long-term chronic problems. The strategy will address it because it is a cross-Government strategy. It has

been discussed with all the other Departments because some of those chronic long-term problems will not be solved by one Department alone and it needs a cross-Government approach. So, in its very self, the approach to developing strategy will have an impact. As I say, the brief interventions—and the inclusion of what the NHS can do in terms of intervening, not just treating but trying to prevent some of the further harms that might ensue—are important, but also the involvement of local authorities particularly, and I can think of quite innovative schemes that the strategy, in a way, acknowledges. I cannot remember whether it is an example, but, for instance, linking noise-nuisance helplines to domestic violence teams. So the acknowledgment within local authorities, the powers given to local authorities on licensing that raises the awareness of what local authorities can do in an area that they have not traditionally been involved in except for the antisocial behaviour, I think is very important.

Q314 Barbara Keeley: Could I follow up on that? You have mentioned brief interventions a couple of times, and we heard from Birmingham council, which seems to have a good strategy and has done a lot of work. But other areas are not doing well and a lot of GPs do not use brief interventions. It is fine to cite good practice somewhere but for this to work across as many as 9 million people these things are going to have to take off a bit better than they seem to be doing.

Anne Milton: That is right. You will probably have to stop me if I go on too long on this because you have touched a button. Why we continue to do what we know is not very effective and fail to do what we know is effective, and why we fail to adopt other people's best practice is a story that goes on for a long time in healthcare, and it is a shame. We are putting together more opportunities, but we have to understand why people are reluctant to share. If Birmingham is doing good things, why does not Brighton follow it? What is quite interesting, and you have possibly raised street pastors before—Was it you?

Barbara Keeley: Yes.

Anne Milton: Take something like that which, actually, has been adopted. There is a piece of non-Government intervention, if you like, interestingly, which has been copied. We have a very successful one in my patch. It is about who makes the decisions. The Alcohol Strategy, combined, as I say, with the changes in public health, is devolving a lot of the responsibilities to local authorities and giving them the opportunities. It seems odd, but giving people a licence to work together will maybe free up the system. Birmingham has examples of all sorts of good things, not only in this area. They feel free and more liberated to do the sort of things that they know work but had failed to do because somehow the framework was not in place.

Q315 Barbara Keeley: In fact, my first question was: how will the strategy enable more of the Birmingham outcomes, if you like, to happen in other places if it is left entirely up to a local authority?

Anne Milton: The strategy is not a piece of legislation.

Barbara Keeley: Indeed.

Anne Milton: It is not a permissive document. It is setting out what the Government think. It will inform local authorities and their new public health responsibilities. That is perhaps the point, actually. The reason why places do not do things is that it is not a piece of legislation. A lot of the things could be done anyway. It will give—

Q316 Barbara Keeley: So it will be up to any local authority to do it or not do it?

Anne Milton: No, it will not be, because the moneys for public health are ring-fenced and it is quite clear that they will be set against an outcomes framework.

Q317 Barbara Keeley: Coming on to the units system, and we have obviously had it for some time—we are talking about 9 million people drinking more than the recommended level, and it might even be more than that—do you think we should now conclude that the system of units is not the best way to help people measure how much they are drinking? There is a second part to this question, but that is the first part. A unit is not working as a measure.

Anne Milton: I think that public understanding of units is quite poor. In fact, there has been quite a lot of voluntary work from some of the producers and supermarkets on units. Most people look at how much alcohol they drink by the number of glasses they drink and glasses are very large now. They can hold a lot more units than they used to when I was younger. The CMO is reviewing the guidelines across the piece and that will be important. It is a recognised thing. Scientists and Government can use units but what we have to do is get across messages that are easy for people to understand. It is about the messaging more than whether the unit itself is a useless thing.

Q318 Barbara Keeley: On messages, how can it be put across to people that may be turning from problem into chronic drinkers that, even if they do not see immediate or many problems in their health, they still may be developing a long-term health problem? Is that not a difficulty—

Anne Milton: It is.

Barbara Keeley: —that you can go around binge drinking for a number of weekends or across a year or in your student life, as you mentioned earlier, and not really understand the impact on your health? How can the messages get that across?

Anne Milton: That is right. I talked about smoking and awareness of the harm that smoking causes being so much higher than alcohol. I think that is an area that has long been neglected. People do not understand that and if they see it or hear it talked about they do not quite believe it yet. I do not know if you saw any of the Change4Life adverts on television. They were designed to address exactly that issue, with the website with some tools and tips to suggest to people ways of cutting down their alcohol. But we do have a battle. We cannot make people understand. We have to provide information in a way that people

accept that alcohol and chronic use of alcohol can harm their health.

Q319 Barbara Keeley: As an example—and I think I have said this in other evidence sessions—in my local authority area, Salford, there has been some wonderful success with campaigns on smoking and quitting and a whole celebration of people who have managed to quit. I do not see anything like that sort of messaging and support for people either to cut down, and radically cut down, or give up drinking. I think, partly, you are not going to get success until you make it, "You are helping your children and your family if you cut down the amount that you drink". We seem to be able to do that as to smoking and not get anywhere near it for drinking.

Anne Milton: Of course, the message for smoking is a little easier because it is "Do not smoke". We are not saying to people "Do not drink at all". We are saying "Drink moderately within recommended guidelines". That is the first complication in the message. I would fully acknowledge that this is an area that has been neglected. The Change4Life campaign is a start. In fact, we were quite pleased with how successful it has been. It has raised awareness and there were 92,000 hits on the website because of it. So it demonstrates that there is a receptive audience to some messaging. What we have to do is make sure that gets across. A lot of those tools will be made available to local authorities to use and build on in different areas. Stopping people drinking harmfully in an area like Salford is very different from doing it in Cornwall. Local authorities will reinterpret those messages, but there is some national work that we have done and will continue to do on that.

Q320 Chair: Presumably the definition of "safe" in Cornwall is broadly the same as it is in Salford.

Anne Milton: Indeed. But, of course—Yes. I will not get complicated.

Q321 Chair: I thought that was a one-word answer.

Anne Milton: It is. It is a "Yes". It is just that—and this is the other problem—there is a science to this that we have to catch up with, and I do not want to make this more muddled, which is that individuals react to alcohol in very different ways.

Q322 Barbara Keeley: I think people in Salford are quite capable of taking in health messages.

Anne Milton: No, I am not saying that they are not. I am certainly not saying that. I am saying that there is some science, which we need to catch up with, about the impact that alcohol has on our health. It is not the same in every person but it is not necessarily geographically attributable.

Q323 Dr Wollaston: Can I move on to the problem of the heaviest drinkers? The figure of the cost to the NHS of £2.7 billion a year was based on figures in 2006 to 2007 so it is likely to have significantly increased since then because the number of admissions has increased. My understanding is that 70% of the cost to the NHS actually comes from the in-patient admissions for the heaviest drinkers. Turning to one of the issues that the Department itself has acknowledged, it is very likely that there is a significant under-provision overall of treatment for people who are dependent. These are the patients who are causing the most cost to the NHS and the greatest harms to themselves. How will the strategy enable the best practice in some areas to be taken up—this is focusing only on treatment, not what happens in local authorities—for that in-patient provision and treatment for those most severely affected to be improved, and nationwide, not just in some centres?

Anne Milton: That is right. What is quite interesting—and, Mark, I will leave you to add a bit, if I may—is that the work we have done on the Payment by Results co-design project for drug treatment has unearthed a huge willingness in the treatment sector to provide similar opportunities for people with alcohol problems. That work is ongoing and will produce a model that is about best practice. As I say, what is very encouraging is the enthusiasm from the sector because it is widely acknowledged that it was poorly provided. I have mentioned brief interventions, alcohol liaison nurses, which I think are going to be quite important in terms of referral, and also the specialist alcohol treatment. Mark, do you want to add anything?

Dr Prunty: It relates to the earlier question on how one decides to allocate interventions or resources against the need identified. At the moment, in treatment services, demand is relatively well met: 82% of people seen are starting treatment within three weeks, 54% of those successfully complete treatment and the numbers of new entrants into treatment are increasing. As I say, there is success. The experience within the services in general is that there has been improvement and there is continuing improved access. The difficulty, to some extent, is knowing the need and how you make that decision at a local level. That, again, relates to this whole issue of the complexity. In some areas there are much higher rates of hazardous and risky drinking—people who do not need treatment but would be very likely to benefit from interventions and brief advice—other areas which have higher levels of dependence and other areas which have higher levels of social deprivation and, therefore, more harm. So each area has to look at that information.

There has been a general consensus about the kind of capacity requirements for services—of the order of 10% to 15%—and it has been advised that services across the country ought to aim for 15% of their dependent population having treatment places in any one year. But it is important that the consensus on that, which is in the NICE guidance, the National Audit Office review and in various sources, is getting on a bit, so we also need to look at driving this by the evidence. The DH is now commissioning research to identify how you best make that decision with the range of detailed tools that are available. How do local commissioners make that decision taking all those other factors into account? What is the evidence now for what is the balance? We have said we have a 1.6 million dependent population. In any one year you would not expect more than a minority of those to

need treatment places because a large number of them are not ready to change yet. They need support, encouragement, assessment, access to services, IBA and all those things. So local commissioners have to balance all these different pieces of evidence to try to determine how best to focus resources in order to reduce their hospital admissions to meet their other local priorities on alcohol-related harm. Work will be published in 2014 which looks at a research-driven, evidence-based capacity model to try and help local commissioners to bridge that gap. The information is there. The question is how we help commissioners to make those decisions and invest in the areas that require that investment locally.

Q324 Dr Wollaston: So you are confident that, with those tools, you will see it appropriately rolled out depending on the pattern of drinking in different areas?
Dr Prunty: Yes. That is because the demand, as I say, is largely being met. The trouble is there is variation across the country. You will always get that and that is an issue. NICE is encouraging that everyone should be doing IBA because the evidence for the impact of treatment of dependence on reducing hospital admissions is high. In fact, the biggest single action you can take to reduce your hospital admissions immediately is to improve your treatment for dependence. So the evidence is out there. The issue is about how we help local areas, local authorities and partnerships in future to bring that together.

Q325 Dr Wollaston: So you will be able to target those areas which you think are significantly under-providing?
Dr Prunty: The information will be available for all areas on how they determine what their need is, their under-provision, and put that into action. That is the aim of the research.
Anne Milton: I will add for the Committee's interest, if I may, something about Transport for London. Employers are doing some good work and I highlight that done by Transport for London in terms of offering opportunities for treatment for its workforce. There are absolutely excellent schemes. There are a few and that is growing. That is some of the work we are also doing in the Department, which is about responsibilities of employers and encouraging them to invest in their workforce.

Q326 Dr Wollaston: Can I reflect something back from a director of public health whom I met recently about a measure they think would help dependent street drinkers? That is that dependent street drinkers congregate in certain areas, and there is a high density of off-licence providers providing alcohol to dependent street drinkers. They would like to have greater powers to prevent those premises from selling alcohol. Do you think that is something the strategy will help them to be able to do?
Anne Milton: Without a doubt. It is clear, and I think that is an important part. I have mentioned it before, that one should not underestimate the importance of making the public health considerations a factor in considering licensing applications.

Q327 Dr Wollaston: So for those premises that already have a licence to sell alcohol in areas where there is a serious health issue with street drinking, licences could retrospectively be taken away from premises that are supplying alcohol to dependent street drinkers?
Anne Milton: You are taxing my knowledge of licensing laws. Could you take away a licence, Chris?
Chris Heffer: Yes, you can. At the moment you would have to do it on the existing objectives, which would include health and safety and public order. What the current changes do is encourage health authorities—

Q328 Dr Wollaston: This is the trouble. It is the health objective, and I am wondering whether, retrospectively—
Anne Milton: No. What it depends on is how long the licence lasts for.
Chris Heffer: Yes, you can take them away. In particular, if you saw them presenting at hospital or you saw public order issues locally you could go for an existing objective. The strategy says, "We will look at a density power", which includes health. That would explicitly, with the point taken, address that issue about the concentration in the area. That would give local authorities a power to do exactly that, to refuse—
Anne Milton: I think Dr Wollaston is drawing a distinction between an existing licence and a new licence.
Chris Heffer: Yes, depending on how it is framed.

Q329 Dr Wollaston: An existing licence, yes. But I think very often those are not public order issues, so they do not have the power.
Anne Milton: No, it is about public health.
Dr Wollaston: But with health as well now they could actually say—
Anne Milton: It is clear in the strategy.

Q330 Dr Wollaston: With existing licences, where there is excess density contributing to the problem, they could address that?
Anne Milton: Yes.

Q331 Chair: In making that decision, the licensing bench or authority, presumably, has to balance the public health angle for the problem community and the legitimate interest of the majority community in reasonable access to off-licence alcohol sale, do they?
Anne Milton: Absolutely. It is a decision made by the local authorities and it has local councillors sitting on the committees. It is the best place to address exactly those things. It is, as with planning, a balance.

Q332 Mr Sharma: The NICE guidelines on treatment for people with alcohol-related conditions have been praised in evidence to us. Are you encouraging the use of these guidelines? Secondly, why are they not more widely adopted? Is it because services for alcohol-related conditions are not given a high priority in some areas?
Anne Milton: The short answer is yes. We would always encourage people to adopt NICE guidelines. That is precisely what they are there for. It comes back

to the point I made earlier. Why do some places do things well and some places not do things well? Why do successful schemes like Birmingham—and I could cite other places as well—not get adopted? The changes that we are making—and one of the big drivers of the changes is going to be the Health and Wellbeing Boards whose work will be informed by the Joint Strategic Needs Assessment and the strategy—will help that. I think that will help it along, but we have to continue to do more to encourage areas to adopt what we know does work and the NICE guidelines will be in there.

Dr Prunty: As a practising psychiatrist working in drug and alcohol services, I have already had to do an audit on whether my services are compliant with the NICE guidelines. That would be true, I am sure, for trusts across the country because of the monitoring of the quality of NHS services. I have had to go through a detailed itemisation of "Do we provide this? If not, are we going to provide it?" and that sort of thing. So there is a process that automatically follows for services to consider whether they are "consistent with".

Anne Milton: What you are saying is that you do not feel it is consistent.

Dr Prunty: That's it, yes.

Anne Milton: But I think this is the point of the strategy being a cross-Government strategy. Addiction psychiatry is something that has not touched the lives of local authorities and I think it is about to start to do so. The impact will be extraordinarily positive and possibly enlightening to some areas.

Q333 Valerie Vaz: I do not know whether I have misheard, Minister, but did you say earlier that the strategy is only guidance and that no one need take any notice of it?

Anne Milton: No, I did not say that. I said it is not a piece of legislation.

Q334 Valerie Vaz: So you expect people to take notice of it?

Anne Milton: Yes.

Q335 Valerie Vaz: It feels a bit—and I do not know whether it is because I have a cough as you have—like wading in treacle. I thought your job as the Minister for Public Health, with immense power, which apparently we all want, was to pull together this strategy, and you can get the best practice and tell everybody how it is done.

Anne Milton: Correct.

Q336 Valerie Vaz: Are you doing that?

Anne Milton: Yes, I am.

Q337 Valerie Vaz: How are you doing that?

Anne Milton: I am flattered that you believe I have immense power.

Q338 Valerie Vaz: Why are you there then, if you do not have immense power?

Anne Milton: We could wade into a discussion about individual ministerial levers—

Valerie Vaz: No, I do want to—

Anne Milton: Just to say it is absolutely my job to put forward what I know works. It is my job to make sure that what we do is evidence based. I think Professor Brennan—I cannot remember which of your witnesses—said that this is a good example of evidence-based strategy, which is very important if we are going to get messages across. It is my job to make sure that we have the framework and the levers in place to ensure that local areas adopt the strategy and are held accountable.

Q339 Valerie Vaz: That is what I am hoping you are saying. So you can pull levers then?

Anne Milton: Yes, absolutely. I can pull levers—never as much as I would like, but that is because I would love to rule the world, probably.

Q340 Valerie Vaz: I know that we all hate structures and things to a certain extent, but it seems to me that it needs someone at the centre to get a grip of it because a lot of people are doing different things. The Home Office seems to have responsibility for alcohol. The Department of Health seems to have some sort of strategy. There is not someone pulling it all together. Can I refer you to your evidence at paragraph 13? There is a plenary group chaired by the Secretary of State for Health. My imagination about the new structures and the new NHS is that these Health and Wellbeing Boards could report to someone. But what I am hearing from you is that they are just going to sit and talk among themselves within their local authorities and the information is not going anywhere. Perhaps in your answer you could explain how you see the structure from the Health and Wellbeing Board being fed back to the centre, and also refer to this plenary group which is chaired by the Secretary of State for Health.

Anne Milton: That is quite a long question, forgive me—so different areas.

Valerie Vaz: I am sorry.

Anne Milton: I think there is a problem inasmuch as we all want Government to work together. We do not like silos. We talk endlessly about how the fact that working in silos is not effective and we do that in national Government and locally. Then, when we produce something that is truly not working in silos and not confined to one Department, we say, "Who is responsible for this?" In the framework, the Home Office and the Department of Health take the lead responsibility. There is the Public Health Cabinet Sub-Committee, which the Secretary of State chairs, which is an opportunity to bring together all the other Departments as well because this has an impact on all the rest of them. If we do not want the students to turn into chronic drinkers, if we want the public better informed and if we want our 15-year-olds not to drink, we have to involve education in the process of informing young people about the harms alcohol does. So it takes everybody together.

As to who eventually will crack the whip, I turn back to Health and Wellbeing Boards. Health and Wellbeing Boards and local authorities are accountable to local people through the democratic process. They will be held to account by the centre through the public health outcomes framework and we

will give that more definition and clarity. But we are only giving them ring-fenced money on the basis that they improve the health of their local population and that they improve the health of the poorest fastest. Those are the two overlying objectives, if you like. Also, it will protect the public's health. As to the Health and Wellbeing Boards, if they are just a talking shop, the local authority will not achieve the objectives that you are talking about. So when it comes to the local elections, the councils will be held to account for that and they will also be held to account by the centre. But not everything—

Q341 Valerie Vaz: By whom in the centre?
Anne Milton: As I say, in terms of public health it will be myself. In terms of licensing, it will be the Home Office. In terms of education and whether the local authority is delivering on appropriate preventative measures and educative programmes, it will be education. I understand your difficulty. You would love to put one person on the spot for this, but that will not work.

Q342 Valerie Vaz: I think you have got me wrong. It is not "on the spot". It is simply that there is a problem for society and someone needs to take responsibility for it. It seems to me, given all these structures—and I am not saying that someone has to be blamed, that is completely different—
Anne Milton: I know you are not.

Q343 Valerie Vaz: It needs someone to pull all the strings together, and whether it is you—I think you are able and perfectly capable of doing that, a wonderful Minister—
Anne Milton: Thank you.
Valerie Vaz: It just seems to me that someone needs to get a grip of the whole thing.
Anne Milton: That is right. That is absolutely right. Every time I listen to Mark I am reminded of the complexity, and you have listened and will be reminded of the complexity of this. It is a cross-Government strategy because no one Department will solve this problem that we have. As Public Health Minister, it is down to me to crack the whip on health. For the Home Office it will be on licensing and for Education it will be education. That joint working is important for spreading best practice. We all have a responsibility. You talk about responsibility but we all, as individual Members of Parliament, have some responsibilities.

Q344 Valerie Vaz: I mean responsibility. But, as I said, it is not someone to blame.
Anne Milton: No. I am saying it is an opportunity.

Q345 Valerie Vaz: Normally, you can have incidences of cross-Government and you can have strategies, but clearly this is a huge issue for society, both in terms of cost to the NHS and to wider society. So it seems that someone should be at the heart of Government taking a lead on this, and you can do that. Different Departments do.
Anne Milton: As I say, we are, yes.

Q346 Valerie Vaz: So is it the Department of Health that is taking a lead on it, as opposed to the Home Office?
Anne Milton: We have dual responsibility for alcohol, but Health has responsibility for the public health side of it. It is absolutely clear. The Secretary of State chairs—the more I say, the more we go backwards, sorry, but just to say—the Public Health Cabinet Sub-Committee which brings together all of Government. So obviously that is the central role. Public health is in the Department.

Q347 Valerie Vaz: Is that the plenary group that you talk about? It is in paragraph 13 of your statement.
Anne Milton: I think so. We will get an answer, but carry on.

Q348 Chris Skidmore: In terms of there being joint responsibility between the Home Office and the Department of Health, do the Health Ministers sometimes feel compromised in terms of the health messages you might wish to promote because they might get clouded by the messages on reduction of violent crime, for instance? In terms of the evidence that you presented, a lot of it, as to the Alcohol Strategy, will help reduce violent crime, with a focus on binge drinking. But the evidence we have received from people like Professor Gilmore is that, obviously, looking at the Department of Health, an issue is middle class drinkers who are drinking lots of bottles of wine which is detrimental to their health and they will get chronic liver disease in 40 years' time. For him, the Alcohol Strategy is not dealing with that and, in a way, the focus on violent crime, binge drinking and antisocial behaviour is pushing that issue away from the centre of the agenda.
Anne Milton: First, I do not feel compromised. I never do because I will say what I think and that is it. There is no more about it really.
Secondly, the danger is that whenever you produce a strategy—and I always read the draft strategies with this in mind—somebody is going to count up the number of lines that are dedicated to issues A, B, C or D and say there has not been enough focus on X, Y or Z. In fact, the words used to describe some of the problems and complexities in violent crime get more lines, which is why I started where I did about the different harms. There are a huge amount of harms. I do not think that sexual violence gets mentioned a huge amount in the strategy, but it is no less important because of that. The antisocial behaviour and crime associations of alcohol affect almost everybody's life in some way or another. The health harms affect probably fewer people's lives but they are still very relevant. There are huge financial costs, and we have concentrated on the financial costs, but I say that we should also concentrate on the human cost. I do not feel compromised. I do not think there is any diminution of the other harms that alcohol causes at all.

Q349 Barbara Keeley: I wanted to come back on what you said about the impact of addiction psychiatry because we have obviously heard it discussed that different local authorities are tackling

this in different ways. How will addiction psychiatry affect and get through to and help with the complexity of these issues in every local authority? How will that happen?

Anne Milton: The Health and Wellbeing Boards are probably the vehicles. I do not know if you want to add to this, Mark, but I think the Health and Wellbeing Boards are the vehicles. The Joint Strategy Needs Assessment will highlight some of the problems.

Q350 Barbara Keeley: How will they get the input? You specifically said you think that local authorities will start to feel the impact of addiction psychiatry. How?

Anne Milton: As I say, with their new responsibilities to improve the public's health, which is about treatment and prevention, they will go to places where they will find the answers to solving some of those problems. Addiction psychiatry is one of them. I do not know if you want to come in at all on that.

Q351 Barbara Keeley: I do not understand. You seem to feel—and you volunteered this—that the impact of addiction psychiatry is going to be felt. I want to know how. It seems that some areas are doing this well and pursuing the answers. They are looking at the complexity and trying to understand it. They are doing something about it. Other areas are not. Talk to me about the areas that are not.

Anne Milton: Quite. I will let Mark come in, but we are in the early stages of the Health and Wellbeing Boards. I was talking to a group only yesterday morning who are striding ahead at enormous rates. They have a joint chairmanship with a local GP. It is going great guns and they have opened their doors to everybody to come in.

Barbara Keeley: But what if—

Anne Milton: Give me a minute. So we are in the early days. What we have to do is identify areas and put support in, if necessary, to areas that are doing less well. I could glibly sit here and say, "We need to share best practice". I could say that. What I know is that we do not find it very easy to do. I think that Public Health England is going to have an important role to play in ensuring that weaker areas are helped to gather the strengths. Some of it will be about enlightening the local members. Some of it will be giving officer organisations some support. Some of it will be things like the work that emerges from the Payment by Results projects, which will help inform them.

I think we have not always traded as well as we should do on the goodwill of local councils. I am a walking advert for local councils because I think there is a lot of goodwill and people do want to make things better. They have not always known how to do that and they have not always had the powers. The strategy talks about some of the powers, some of the changes in the Health and Wellbeing Boards or the opportunity, if you like, to bring all that together, with Public Health England having some input as well.

Q352 Barbara Keeley: But the Boards are a DCLG responsibility rather than a Department of Health responsibility.

Anne Milton: No. You see, you are wanting to put things in silos.

Barbara Keeley: No. They are.

Valerie Vaz: We do not. You did it.

Q353 Barbara Keeley: You have us entirely wrong, actually, but the difficulty is that they are a DCLG responsibility.

Anne Milton: The Health and Wellbeing Boards, as I see it, are the local authority's responsibility. There are some things that are laid down in legislation, but they can go to whatever lengths they want to improve the public's health.

Q354 Barbara Keeley: But I am concerned about the ones that do not.

Anne Milton: Aren't we all? Absolutely. This is where Public Health England will come in. Its biggest role—the most important impact it will have—is in facilitating, giving areas the tools to bring themselves up to some of the best. That is what we should be doing, as you know. We should be excelling. Do you want to come in on that?

Dr Prunty: The Health and Wellbeing Boards' responsibility to develop the Joint Strategic Needs Assessment and the health and wellbeing strategy plants that responsibility for need and priority with them. They are also going to be involving the directors of public health who will look to the question of medical expertise. But addiction psychiatry—in a sense, the responsibility of the Joint Strategic Needs Assessment to look at the issue—suffuses through NICE, and that is largely driven by addiction psychiatrists, by all the tools that are out there, as well as by questions about understanding local need. But I think, again, local areas are inevitably going to determine locally what their need is for more input and more information and what sources they are going to draw on. But the responsibility is there, and that now sits with local authorities. The output will need to be a Joint Strategic Needs Assessment and health and wellbeing strategy.

Q355 Dr Wollaston: Could I follow up a question with Dr Prunty, please? Concerns have been expressed that some private providers of addiction services are excluding patients who have mental health problems and yet, of course, the mental health problems and dependent drinking are very often closely knit. Would you recognise that concern? Do you think that is a concern?

Dr Prunty: Different providers will have different levels of expertise and competence within a system in mental health experience and clinical skills. That exists currently and different organisations locally allocate resources in different ways to address problems with dual diagnosis, increasing the use of the IAPT services, the psychological therapies locally. That is because, in a sense, you cannot exclude completely, whatever service provider you are, because of the level of mental health problems, that you will have anxiety and depression within the treatment population.

There is an issue about what are the most effective care pathways to identify need and to respond to it. Sometimes that will involve dedicated dual diagnosis services, sometimes it is about having joint working and sometimes it is about having good access to specialist services. Clearly, it is a risk when providers change and providers may have different levels of competence and experience. I cannot answer on the specifics, but the risk, in a sense, needs to be managed. Services are not perfect at the moment for addressing complex needs. It is difficult. An individual may only want to go to one service and they may not want to deal with a severe mental health problem, which is predominantly the responsibility of specialist mental health services. They may not be ready to attend IAPT services. It is a risk, but I think there are potentially a number of solutions.

Q356 Dr Wollaston: What I am getting at is: do you think there is any evidence at all that services for patients with a complex dual diagnosis have been worsened?
Dr Prunty: I am not aware of that evidence.
Dr Wollaston: Thank you.
Anne Milton: Interestingly, it has not come to me. Did you—
Chris Heffer: Can I come back on the earlier question about the Cabinet Sub-Committee? I will refer you, slightly earlier, to our written evidence at paragraphs 3 and 5. Paragraph 3 talks about the Cabinet Sub-Committee on Public Health, which is a sub-committee of the Cabinet Home Affairs Committee, and that is the one chaired by the Secretary of State for Health. Paragraph 5 talks about the joint responsibility for alcohol policy between the Department of Health and the Home Office. Paragraph 13, about the plenary group, is in the context of the Responsibility Deal, which has four different networks—the health network, the food network, the alcohol network and the physical activity network—between industry, NGOs, the Government and that plenary group, which is the one chaired by the Secretary of State Health. So he chairs two.

Q357 Valerie Vaz: I understand that. Thank you. I just wanted to know whether that was the group that could slap people across the wrists if they needed to.
Anne Milton: No.
Chris Heffer: No.

Q358 Valerie Vaz: So there is not actually a group that can slap people across the wrists if they need to, "Please put forward this strategy. This is very important. This has not been taking place." You pull your levers and get something done.
Anne Milton: As I say, the responsibility will lie in the local authorities.

Q359 Valerie Vaz: So they were all talking shops really?
Anne Milton: No.

Q360 Valerie Vaz: Is something happening? Is something coming out of them then?
Anne Milton: What are you referring to? The Responsibility Deal plenary group, which is completely different and out of scope on this, in a way—

Q361 Valerie Vaz: But the Alcohol Strategy must feed into that Public Health Responsibility Deal. You are talking about public engagement.
Anne Milton: No.

Q362 Valerie Vaz: That is what I am trying to get at. It is in your evidence so that is why I was asking the question.
Anne Milton: I am happy to talk about the Responsibility Deal, but it is slightly separate from what we were talking about. It is nothing to do with policy, slapping people over the wrists or ensuring the enforcement of Government policy.

Q363 Valerie Vaz: No, but we are moving along now, are we not, to doing something? We are not simply sitting and chatting about an alcohol strategy. We want something to be done.
Anne Milton: We do. That is right.

Q364 Valerie Vaz: That is our job, to find out from you what is going on and how we can make it better.
Anne Milton: The Alcohol Strategy, yes, that is right.

Q365 Valerie Vaz: I am trying to get the information from you.
Anne Milton: Do you want me to—
Valerie Vaz: No, that is fine. Maybe you can write to me then.
Chair: Go on. If there is an answer to Valerie's question, we might as well hear it now.
Anne Milton: The Responsibility Deal is an opportunity, as Chris has said, for Government to work with industry and NGOs to take voluntary action. I think, in our evidence we have talked about some of that. It is not a substitute for Government policy. It did not feed into the Alcohol Strategy. That has meant major cross-Government. So the Responsibility Deal is not a substitute for, it is in addition to—
Valerie Vaz: The strategy.
Anne Milton: To the strategy, yes.

Q366 Rosie Cooper: Who implements it? How does it happen? This feels like a meeting of West Lancashire Council where everybody develops strategies for England but nobody has any money and nobody is in charge of measuring the real outcomes. Who is going to make this happen?
Anne Milton: Local authorities.

Q367 Rosie Cooper: With what—money?
Anne Milton: Yes, the ring-fenced money for the first time.

Q368 Rosie Cooper: How much?
Anne Milton: We have put out initial figures which were based on previous spend by PCTs. It has been quite difficult for PCTs to disaggregate what they actually spend on public health. So that was the first

stab, if you like, and any allocations will only be upwards from that point, and we will make further announcements on that.

Q369 Rosie Cooper: What about alcohol? Are they going to be able to spend X on alcohol or is any money being ring-fenced? This agenda is huge. How are we going to deal with this problem?
Anne Milton: It is not simple. I am sorry, but there were too many questions all in the same breath. The money is ring-fenced for public health against an outcomes framework. Chris, do you want to say a little bit more about the payment for alcohol specifically?
Chris Heffer: The total ring-fenced grant I think was £2.2 billion, which was the initial figure. That covers the wide range of services that are going to local government, to public health, and that includes—
Rosie Cooper: Alcohol.
Chris Heffer: Alcohol and drugs. All the money spent on alcohol at the moment transfers from the PCTs, so that money is for prevention, for Identification and Brief Advice, for treatment—hence the link—and that goes across from PCTs to local authorities alongside the drugs budget, sexual health, obesity, weight management and a bunch of things. That is ring-fenced, as the Minister says, overall in public health. So that transfers across to local authorities to invest as they see fit against the outcomes framework. Clare Gerada—of the RCGP—sat in this very House and said that she was optimistic about alcohol in that new world, and you heard from Birmingham about how they would look at the strategy and how they would spend that money across a range of priorities.

Q370 Rosie Cooper: They do not have any waiting lists or any difficulties and the world is fine. Do you know what, I would be more successful nailing blancmange to that wall than getting any sensible answers?
Anne Milton: From whom?

Q371 Rosie Cooper: The people involved here seem to think that the problem will be solved simply by taking it from the PCTs and dumping it on local authorities where the pressures are great. Social care is going to be a bigger and bigger problem and it is wrong to think that alcohol is going to be a really high priority unless somebody is in charge of actually making it happen. If we just say, "The local authorities can do it" we are going to be still talking about this in 10 years' time with very little difference from where we are.
Anne Milton: Can I come in? I feel your frustration but I have to say that it is somewhat offensive to say that we have simply "dumped" public health on local authorities.

Q372 Rosie Cooper: You have dumped public health on local authorities. They would need a massive injection of resources to make that really work. They are desperate in terms of social care and, because of the cuts that have been made to local government, they are in a really difficult position. This is only a strategy—which is great, whatever—and you are passing it over. Since I have been here, I have heard a lot about Health and Wellbeing Boards, but I do not know what power Health and Wellbeing Boards will have to deliver. They will influence and do all those great things. They will talk and they will formulate strategies and get involved in public health. But who is going to be the person who makes it deliver?
Anne Milton: Nobody could be more with you on the fact that the world is littered—and has been over the last 30 or 40 years—with strategies, frameworks and accountability regimes with nothing actually delivered on the ground and nobody ever held accountable. This is not dumping public health. This is putting public health where we think we can make a difference, not just improving the public's health—

Q373 Rosie Cooper: Without the money—money, money, money—and power.
Anne Milton: —but reducing inequalities in health which continue to rise. Public health has a good home. It is not about dumping it. We are not the Public Accounts Committee or a committee that is enabled to discuss the public finances. I know local authorities are having a difficult time at the moment, as indeed is everybody, but we are where we are. I think the strategy will make a difference. It is not always about—and I have to say it emphatically—the amount of money you spend. It is how you spend it.

Q374 Rosie Cooper: But it needs power as well.
Anne Milton: What is quite interesting in my job, going round the country, is seeing examples of very good practice. Birmingham has been mentioned and I can mention a number of other places that, with no additional resources, are having quite a significant impact. It has an outcomes framework against which the money will be spent. If these are only talking shops, they will not deliver the outcomes that they are expected to deliver on the basis of the money they will receive. I agree that we need to make sure we pull up areas that do not do it so well and actually celebrate the excellence of areas that do it well. It is particularly tough if you look at public health and at inequalities in areas that really struggle to get through the day—individuals who struggle too—but until we move public health into local authorities we will not achieve that because, my goodness, the solution is not found in one area only.
Rosie Cooper: I would 100% agree with you, with money and power.

Q375 Chair: Can I bring us back to the specifics of alcohol policy?
Anne Milton: Indeed.
Chair: Virendra was going to ask you a question, I hope, about liver disease.

Q376 Mr Sharma: It is not forgotten. The strategy, Minister, states—in my view, incorrectly—that a liver disease strategy has been published. The Department's memorandum says that it will be published "in due course". Are you able to say when that will be and can you give the Committee some idea of the approaches that the strategy is likely to promote?

Anne Milton: "In due course" is what Government always say, is it not? It is a bit like "the spring" and I always wonder whether it is before the daffodils come out or after.
Chair: It is not as immediate as spring.
Mr Sharma: But we are expecting it.
Anne Milton: One of the frustrations that you and other people must feel is when we say "in due course". Why do we say "in due course"? It is because events buffet politicians and Departments around, so you never want to make promises that you cannot fulfil. It is imminent. In other words—and I shall probably get shot down in flames for saying this—it is likely to be out before the summer recess. It is important and it is an important part of this.

Q377 Mr Sharma: So we are talking about the next four or five weeks?
Anne Milton: No. You see, you are wanting to pin me down.

Q378 Mr Sharma: You never said the summer recess of this year or the next year.
Anne Milton: I congratulate you on that point. For somebody who is as pedantic as me, it is frustrating. I find it frustrating and sometimes things suddenly speed up. It is important—critical.
Chris Heffer: You are quite right that it has not been published. That error was spotted and there is a correction on the Home Office website alongside the strategy pointing out that it has not been published.
Anne Milton: No.

Q379 Chair: But it is planned to be published before the summer recess?
Chris Heffer: As the Minister has—
Mr Sharma: 2012.
Anne Milton: I have discovered—talking about ministerial powers—that the one way of making sure something does happen is to say it in a session like this which is recorded and then it will happen.
Chair: We are glad to have been able to influence events to that extent.

Q380 Dr Wollaston: Can I turn to the minimum price? There is some evidence that the Government is considering the price of 40p per unit but it would be helpful for the Committee to understand: is the final decision going to rest entirely on the outcome of the consultation? Where are you heading, and what is the impact of the Scottish Government's decision to set a minimum price of 50p? Do you think there would be significant problems if we set a different minimum price from Scotland? Would it not be more logical for us to go for the same minimum price across the United Kingdom?
Anne Milton: You have probably highlighted all the things that will be taken into consideration in deciding where the minimum unit price is set. You rightly highlight what the Scottish Government are doing and that has to be a consideration and I think we have to consider the responses to the consultation. All these things are about balance. I cannot tell you where we are heading because it would be premature to do so until we are at the end of this. Probably this Committee's deliberations will add to our view on that. It is important to set it at a level at which it is effective. That is the thing. We know that alcohol is, to a greater or lesser extent, price sensitive, so it is important to have something that is effective. I go back to what I said earlier, that it has to be evidence based.

Q381 Dr Wollaston: The point is often made that the higher you set the level, the more of an impact you will have on drinking. But at some point you might start to see other harms such as people using alcohol substitutes which would be harmful in themselves. Have you taken any evidence about where that cross-over might occur?
Anne Milton: We are collecting evidence and it is interesting that you talked about alcohol substitutes. I did ask officials yesterday if people still drink meths because, in my youth, when alcohol was very expensive, we used to talk about meths drinkers. People used to drink it. So your point is valid. It is about getting that balance right.

Q382 Dr Wollaston: But have you heard any evidence yourself about where that cross-over might occur?
Anne Milton: Yes, I have seen some evidence. This is how policy is formed. I have seen lots of evidence saying all sorts of things. Also all evidence—and it is maybe important to say—should always be seen in the light of whence it comes.
Dr Wollaston: Yes, of course.
Anne Milton: It is "of course", but people do not always take notice of that.

Q383 Dr Wollaston: But you are not able to share with the Committee what evidence you have heard?
Anne Milton: No, I cannot. I am sorry.

Q384 Dr Wollaston: One of the issues that arose in Scotland when they set the ban on multibuys, for example, was that some of that policy was undermined by big supermarkets mailing customers and offering to send multibuys from south of the border. How concerned are you that we would see the same thing happen if we had different prices set between Scotland and England and that that could then undermine policy with our neighbours?
Anne Milton: Probably the unintended consequence of Government action is what took me into politics in the first place, and it is always a desperately important consideration. You raised two important things. One is the unintended consequences. We have to be very forensic and robust in our look at evidence to ensure we avoid that as much as possible. The other thing that you alluded to is the opportunities for buying things elsewhere. We have seen it certainly in drugs, with drugs sold on the internet—legal highs sold on the internet. People's opportunities to buy things are hugely expanded. So we have to bear that in mind as well. There is no point in solving one problem if you create another.

Q385 Chris Skidmore: Can I come back to the evidence and, in particular, your own Department's

evidence? Is there not a risk that minimum pricing is effectively using a sledgehammer to crack a nut when you look at, say, point 57 of your evidence, that the Sheffield university study shows that "a 40p minimum unit price will reduce alcohol consumption by 2.4%"? In paragraph 49 of the evidence you say: "Government analysts have estimated that a 40p minimum unit price would lead to an estimated 30,000 fewer alcohol-related hospital admissions per year after 10 years", but if we set that in the context of alcohol-related hospital admissions having gone up from 510,200 in 2002–2003 to 1,057,000 in 2009–2010, then, with the Alcohol Strategy looking to 2023, you would only have brought alcohol-related admissions down to 1,027,000. So even the Government's own analysis, and Sheffield university's own analysis, suggests that minimum pricing is not really going to have the desired effect, apart from to take us maybe back to 2009–2010 levels of hospital-related admissions, and barely reduces overall alcohol consumption at all. Taking a billion units out of alcohol looks more effective in terms of reducing alcohol consumption compared with minimum pricing.

Anne Milton: You have highlighted the fact that there is no one tool that is going to hit this on the head, which is why the Alcohol Strategy is a cross-Government strategy and why it involves a number of different Departments. There is, I would say, good evidence to suggest that alcohol consumption is price sensitive. The point about the sledgehammer to crack a nut is always the argument used by people who do not want you to do something. I am not suggesting you do not want us to do it, but it is an important thing.

Chris Skidmore: No. I think we should do it, as you have provided a menu of options.

Anne Milton: One of the problems and frustrations about science is that it is never absolute. There is a lot of evidence—and Mark might want to come in here—on price and its impact. The trouble with these things, although good science takes account of it, is that you can never isolate things. You see the same in advertising as well, that you can never isolate it. The mere fact that we have produced an Alcohol Strategy and talked about minimum unit price will, in itself, have an impact on people's drinking habits because it has raised awareness—any discussion in the newspaper. I do not think it is a sledgehammer to crack a nut. The mistake is to put all your money on that solving the problem, which is why we have to approach this in a number of different ways. We have not talked a lot about education and information—we will raise it a little bit with chronic drinkers—but that is also in there. Do you want to add anything?

Dr Prunty: Not particularly.

Chris Heffer: Can I add one thing? You talked about consumption and admissions. The other alcohol harm measure is deaths. I think that, because the MUP tends to target the cheaper alcohol which is drunk by the more harmful drinkers, the impact on deaths could be rather larger, and I have some estimates here that there could be up to a 10% reduction in deaths. There could be over a thousand fewer deaths by the end of 10 years. So it seems that the figure for deaths might be rather larger than for admissions.

Anne Milton: Do not forget—just to come back—that the billion units out of alcohol is in addition to, not instead of.

Q386 Chris Skidmore: Yes. I have a couple of other issues with minimum pricing. We saw over the past two months—and it reflects evidence we have had from the Wine and Spirit Trade Association—a suggestion that minimum pricing could, therefore, represent a barrier to trade and be illegal under EU law. That is obviously something which the Minister of State for Universities and Science, David Willetts himself, has picked up, and written in a private letter to the Cabinet, as being an issue. I was wondering whether that is being looked at by Government lawyers as part of the consultation. It is something that may handicap the actual implementation of minimum pricing in the longer term.

Anne Milton: Legal advice, a bit like evidence, is never completely absolute. Of course, we will seek legal advice. I am not disclosing any secret if I say that, like tobacco legislation, I have no doubt the challenges will come down the tracks at us.

Q387 Valerie Vaz: Did you say you had not sought legal advice yet?

Anne Milton: No. We have sought legal advice on a number of occasions.

Q388 Valerie Vaz: Yes, because you did say you would continue to take it?

Anne Milton: We have sought it on a number of occasions and will continue to do so.

Q389 Valerie Vaz: Presumably it must be kind of good, otherwise someone from the Cabinet Office would not have come up with 40p.

Anne Milton: Yes, it must be kind of good. I do not think I am allowed to discuss the legal advice that we received, but, yes, it must be kind of good.

Q390 Valerie Vaz: You can say yea or nay, can you not?

Anne Milton: That is such a good way of putting it.

Q391 Valerie Vaz: We are paying for it, after all. The other quick question is: have you or your officials had any discussions with the Scotland Office on how they have taken things forward, because I know sometimes that takes place when legislation is put through?

Anne Milton: Yes, there has been. I have also had discussions at the European level on this.

Q392 Valerie Vaz: There is no barrier to the minimum price that you know of, as such, that you are able to tell us?

Anne Milton: The advice, as such, is that we can do this. It is critical on a few factors.

Q393 Dr Wollaston: Can I follow up this from the points that Chris made about the figures that are available for the projected benefits from 40p per unit?

Could you clarify what those figures would be for a 50p per unit minimum price?
Anne Milton: I cannot, but somebody on my right probably has the figures to hand. We could send it to you in writing for sure. It is probably easier if we do.

Q394 Dr Wollaston: Yes, because I gather the choice is between 40p, 45p or 50p. It would helpful for us to have clarified what the exact benefits would be. That would be helpful.
Anne Milton: Yes. We can do that. We have them.

Q395 Dr Wollaston: In Scotland they have also decided to have a sunset clause so that if there is not an impact after six years they would withdraw a minimum price. Are we planning to do something similar?
Anne Milton: No, but interesting things like that are coming out through the consultation, which I think is quite important.

Q396 Dr Wollaston: Yes. There is no point introducing a measure just to irritate people, but if there are real benefits, then—
Anne Milton: That is why the evidence and the science are so important, and frustrating when they are not clearer.

Q397 Dr Wollaston: But is there a danger that if we set the minimum price too low, we would possibly risk abandoning something that could have been effective?
Anne Milton: There is a danger at times. Actually, on this, I can feel like I am standing in the middle of the road and two juggernauts are heading towards me driven by those who feel that this is nannying and penalising responsible drinkers and those that think it is a solution to all ills. I think it is important to not stay in that middle. What we do has to be based on the evidence, the consultation and the legal advice. We have to be absolutely convinced that it will have some effect.

Q398 Chris Skidmore: In terms of looking at how this would affect the industry and where costs would be applied and, in addition, where costs might be pushed into different areas, is anybody looking at how minimum pricing—even though it affects bottles of White Lightning, or whatever cheap alcohol, but then suppliers would pass those costs on in a different way—would affect the on-trade in pubs, for instance? Do we know that everyone will end up paying for minimum pricing even if minimum pricing is designed to target those people who are harmful drinkers who, we know, buy 15 times more alcohol than moderate drinkers yet pay 40% less per unit? Then everyone ends up paying rather than just the targeted drinkers who would necessarily pay more but the costs get shunted over into the rest of the drinks industry.
Anne Milton: The industry is obviously scurrying away having a look at the impact that it will have. Generally there is a feeling that it is unlikely to affect the pubs and places like that because they are charging quite a lot for alcohol as it is.

Q399 Chris Skidmore: Could there not be a risk that you will have brewers and suppliers who produce similar drinks across the off-trade and the on-trade passing over the additional costs to minimum pricing, in some way, to pubs?
Anne Milton: I do not think we have received any evidence that that will happen. I am looking at Chris.
Chris Heffer: No. Obviously, the impact is primarily on the off-trade. Links to the on-trade are relatively limited. We know less about how the excess profit in the retail sector will be shared—if that is the right word—between the retailers and the suppliers and whether, if that materialises, they compete with retailers across other goods, pass it on beneficially to the suppliers or how they share that out. I do not think we know yet whether it is a cost or in fact a profit which, if it were to be shared, might even reduce on-trade. But who knows?
Anne Milton: Yes. That will be interesting.

Q400 Chair: Can I ask where you have got to on your thinking on regulation of multibuys?
Anne Milton: It is my understanding that we are going to consult on multibuys because it is an issue and people end up buying alcohol that they do not need.

Q401 Chair: Is it a consultation about how to implement regulation on multibuys or is it a consultation where the Government is saying, "We are against retailers selling cheaper by the dozen"?
Anne Milton: It is a consultation on how we do it and the legislation. The officials know more of the detail of where we have got to on this, but it is quite an important part of the mix in terms of pricing.
Chris Heffer: We are planning consultation on two things. One is the level of the minimum unit price, as just discussed, and a consultation on the policy of banning multibuys.
Anne Milton: So it is whether we do it or not.
Chris Heffer: It is whether we do it or not.
Anne Milton: But also out of that, we hope would come how you do it as well—unintended consequences.

Q402 Chair: I have a simple question about the policy on multibuys. The wine trade regularly sells wine by the case. Is that to be illegal in future?
Anne Milton: That is why we are consulting, exactly. That is the one representation that I have already had, whether the newspaper offers, for instance, would be affected by anything like that.
Valerie Vaz: You could say a case is not a multibuy.
Chair: It would be quite difficult to distinguish a case of claret from a CAMRA case of Cameron's cans of lager.
Chris Heffer: Under Scots law you could still set minimum purchase limits. In other words, you could only buy it by the case but you could not by the single bottle. The Scottish legislation is framed such that, at whatever price you sell the multiple, it has to apply to the single as well. If you took a wine club, it might say a minimum buy is that every time you buy something you have to buy a minimum of 12. It looks like that would be absolutely fine but you could not

price 12 at less than proportionally 12 times the single bottle.

Q403 Chair: I hasten to add that I have no interest other than being a customer, but it would be a substantial change in the way they do business.
Anne Milton: It is unlikely to affect, possibly, many of those buys because they are already quite expensive.

Q404 Chair: No, but as to the principle of a multibuy, that is exactly the point, is it not? The principle of a multibuy has nothing to do with the minimum price. It is whether a retailer can sell multiple units—multiple packages, bottles or cans—at a cheaper price than single cans or bottles.
Anne Milton: Yes. I have no doubt that this will emerge at the consultation.
Chair: I look forward to it.
Valerie Vaz: I think we are heading towards the final post.
Anne Milton: I am not in a rush. Health questions are not till 2.30pm so we have two and a half hours.

Q405 Valerie Vaz: We are very appreciative that you are here anyway. Advertising. I do not know if you could let us know what the current Government thinking or the Department's thinking is about advertising, whether it has an effect on young people given that the Portman Group says it does not. If you could, tell us what you think. Does it affect people's behaviour and is there any likelihood of following France and having a ban on advertising before the watershed?
Anne Milton: Yes. The Sheffield review, I think, found that there was substantial uncertainty in the evidence on the impact of advertising restrictions, including the effect of complete bans on advertising. It goes back a little to what I was saying earlier. It is quite difficult to demonstrate causality. Current thinking is not to do anything further than we already do and there are reasonably strict regulations on advertising. But the evidence is thin indeed.

Q406 Valerie Vaz: But your strategy says that there is known to be a link. Does the Department feel there is or is not one?
Chris Heffer: As our written evidence says, there is a link between exposure to advertising and when young people start drinking. The uncertainty is on the scale of that impact, potential policy interventions that mitigate those and, in particular, the proportionality of any of those. It said there is significant uncertainty on all of those. So in the light of the existing controls that the Minister talked about, the question is: are those appropriate for purpose, given that uncertainty as to what interventions might be appropriate?

Q407 Valerie Vaz: Are you looking at that?
Anne Milton: I would say with regard to that, as I would say with regard to everything, that I keep an open mind on all these things. At the moment, it would appear that it would be disproportionate so I would not consider any further action. But I will keep an open mind because there is always evidence emerging. As I said, evidence is often inconclusive. It is, at the moment, on that and the disproportionate nature of it. So I am open-minded always.

Q408 Valerie Vaz: But I am sure Sir Richard Doll would disagree with you if he were around. He was plugging away at tobacco and then, finally, people realised there was a link. So alarm bells should be ringing, should they not, at this stage, that there is some sort of influence? In your very own memorandum, do you say that—
Anne Milton: It is about the proportionality of it. What I am saying is that we are not planning to take any action at the moment. It is about the proportionality of it and there being insufficient evidence that the rules need to be strengthened further.

Q409 Valerie Vaz: Are you aware of the Joseph Rowntree Foundation evidence? Have you had a chance to look at that at all? Would it be helpful for you to look at it?
Anne Milton: I know Joseph Rowntree have done quite a lot of work in this area. I do know that.

Q410 Valerie Vaz: They talk about what was used, a strategy called the Florida truth campaign. There are no such campaigns that you are considering at all.
Anne Milton: No. Tell me more about that campaign.

Q411 Valerie Vaz: They focus not on the actual person who is doing the smoking but on the tobacco companies. That might be slightly difficult because you have them on board in a number of ways, have you not, with the alcohol? Diageo and various other groups are very much part of your strategy, are they not?
Anne Milton: Not part, no. They are part of the Responsibility Deal, which is a voluntary deal.
Valerie Vaz: There is Drinkaware.
Anne Milton: But that is it. Tell me more about this study. I am sorry, I do not know the details of it.

Q412 Valerie Vaz: I am reading from their evidence and wondered if you knew about it, or if it was something that you could look at.
Anne Milton: I do not know the detail of it. Do you, Chris?
Chris Heffer: I am not aware of that one. It sounds like a non-Government organisation targeting inappropriate companies. I am aware recently of an NGO in the UK that has written to a cider manufacturer about inappropriate stuff on their website. They have now taken that down and are having a conversation with them. In other words, there is clearly a role for non-Government organisations.
Anne Milton: They are quite useful.

Q413 Valerie Vaz: I do not mean targeting companies. I mean the actual strategy, the campaign. It might be worth your having a look at the evidence because they also point to someone called Velleman who notes that: "Young people who see, hear and read more alcohol advertisements and endorsements are more likely to drink, and to drink more heavily, than

their peers". That was done in 2009. So I am saying that there is something out there.
Anne Milton: There is something, yes.
Chris Heffer: Yes, and I think our evidence evinced that there is a link between—
Anne Milton: Yes, there is a link.
Chris Heffer:—exposure and initiation.

Q414 Valerie Vaz: You definitely think there is a link between advertising and—
Chris Heffer: Yes. I think we have said that in writing and I have just said it on the record here.
Anne Milton: So there are no plans to ban or to change anything at the moment.
Valerie Vaz: No. But you accept there is?
Anne Milton: But I accept there is, yes.

Q415 Chair: On advertising, are you familiar with the Loi Evin, as I understand it, that they operate in France which requires an advertiser to restrict messages to verifiable statements of fact and make sure these messages only reach adults? France is not a country of teetotallers, nor is it a country that has gone wholesale on the wagon. Do you think there are some lessons there that could be applied here?
Anne Milton: I am going to ask Mark because you know quite a bit about this.
Dr Prunty: No, I do not.
Anne Milton: No, it is Chris who knows quite a bit about this. I have talked about it at length because I know Dr Wollaston raised this. As you say, it is important to gather information. Comprehensive analysis is difficult to draw on the impact of this. In fact, if you look at the figures and when there was a change in drinking habits, they do not necessarily correlate with the changes in the advertising regulations. Do you want to say anything else?
Chris Heffer: The Loi Evin has quite a long history in France. It had a sort of voluntary agreement in the 1970s and then, when regulation came later on, there was, I think, an evaluation done in French—and one of my team is going to plough through it—which found—
Chair: It is not unreasonable for them to conduct their own examination in French.
Anne Milton: We are a Department of many talents, Chairman.
Chris Heffer: I think they have found a positive impact in reducing alcohol consumption harm but it was not possible to quantify it. The impact on the young, from the substance of it, was unclear. Therefore, in a sense, you are left with a picture, in fact, that something has changed but whether it was due to that or whether it was not—whether in fact we are focusing on pricing and licensing, and that is where the evidence is strongest in the UK context—it is difficult to pick out a direct example. We do have some content regulation and we do have some volume regulation. We are working with the regulators to say, "Is that working and appropriate?" We do not measure, for example, particularly regularly the actual exposure of young people. We know there is a link between their exposure and their intake but there are no systematic measures of the exposure that happens. There are only occasional ones. We are working with the ASA to say, "Can you put in place measures to measure the exposure?", and then you could begin to see if you have a problem that we admit exists but we cannot quantify.
Anne Milton: I would add—not exactly on that point but it is important—that if you look at behaviour changes, which is the opposite, messages about the social norms do have quite a significant impact. Going back to the point about university students, where they put up signs saying, "The average university student only drinks one pint of beer a week", it does have an impact on reducing the amount of alcohol consumed. Messaging, both in terms of advertising and positive messages to change behaviour, are quite complex.

Q416 Chair: The reason it caught my eye is that it comes back to this principle of accurately defining the problem and accurately targeting a solution at the problem. It does not seem to me, almost independent of the evidence, to be that hard to defend the proposition that if you are dealing with a substance such as alcohol an advertiser should confine themselves to the truth and be mindful of who their audience is.
Anne Milton: Yes.

Q417 Chair: If those are the principles in the law operated in France, it seems to me that there is quite a big evidence base there that might be worth looking at.
Anne Milton: We continue to do so. The important point—and maybe I ought to take this opportunity to say it—is that we have accurately defined the problem and we will accurately target a problem which is very complex. The trouble is that, in defining it, we have discovered a very complex picture.

Q418 Valerie Vaz: And we want to help you.
Anne Milton: I know you do, and I take my appearance here and your investigation into this as a positive thing, not a negative thing. Do not worry.
Chair: We are glad you see it in that light.
Anne Milton: I always do, though I am probably alone in that.

Q419 Dr Wollaston: While France is not a nation of teetotallers, they are drinking significantly less than they used to. Do you feel that part of the problem, if we want to say that advertising is not being directly targeted at children, is with the definition of a child and an adult audience in that the threshold is set at 25%? If you were to throw a random set square down anywhere in the country, you would find that, if you look at the number of children that were caught by that definition of people under 18, because of the demographics, it is no longer appropriate. Should we not set the bar a bit lower and say that the threshold is set at an audience where at least 90% are adults as opposed to 75%? Is that part of the problem? Regularly, for example, you can go to a 12-rated cinema showing and find yourself bombarded with alcohol advertising. Surely that cannot be right. We have our definitions wrong.
Anne Milton: What is a child, indeed? It comes up on a number of public health issues. If we are talking

about advertising—and you talked about going to the cinema with a 12 rating and alcohol adverts—you have all the social media out there. This is a very complex world, which is why it is important to keep it under review. In terms of influence on children, there is good evidence to suggest that family and what happens in the home probably has far more impact than anything else.

Q420 Dr Wollaston: Indeed, it has a huge impact but looking at the saturation marketing to children, at the branded products that the children aspire to and the way that you have "advergames" on the internet, there are so many vehicles through which children are being bombarded with marketing—be that sponsorship right through a huge range. Yes, family is important, but could we not take a very significant step by changing the thresholds at which we define an adult and a child audience?
Anne Milton: I do not know who would actually take that. The ASA, I think.
Chris Heffer: They are in the codes, are they not, the CAP and the BCAP codes, which the ASA supervise under the aegis of Ofcom and the DCMS? They are regulators and they have to take account of evidence and be proportionate in that. So, in a sense, you go back to the evidence question. If there was strong evidence showing the links, they would have to take that into account as regulators.

Q421 Dr Wollaston: But there is evidence to say that you start drinking younger and you drink more when you do, and that is the evidence that comes from Stirling university. Is that not right? As you say, the scale of that impact is uncertain.
Chris Heffer: It is unclear and the age of initiation is rising and the number that is drinking below is falling. So you go back and ask: is that proportionate, given that context?
Anne Milton: And the definition of "child" in all that forms a natural chain. But it is important to keep it under review, as I say, because of the social media.

Q422 Mr Sharma: What do you see as the role of the drinks industry in tackling the health problems alcohol causes? Is it appropriate for the industry itself to play a role in the developing policies to address alcohol-related health problems?
Anne Milton: It is not my job to define the role of any industry. They create it themselves.

Q423 Mr Sharma: But you can encourage them.
Anne Milton: There are three things I would like to be absolutely clear about. First, it is not the role of the industry to develop or dictate policy. It never has been and it will not be. Priorities and policy should be informed by research, advice and evidence. However, we would be crazy to ignore the reach that business has. I think 17 million families use the supermarkets every week, so the opportunities to influence are very great. The Responsibility Deal, which is where industry, NGOs and we come together, is an opportunity to persuade industry to be responsible, if you like, to recast responsibility for the industry as doing something that is seen to be in the public good. It is an opportunity to add something. It is not a substitute for and it is not a forum for developing policy. Anything that we can do without legislation is quick and easy. What will be quite interesting is that with any of the pledges made by the Responsibility Deal—for instance, if you have 82 companies signed up to have health and alcohol unit information, which was raised earlier, clearly labelled on cans and bottles, and 80% of cans and bottles with that information on—there could be evaluation of the Responsibility Deal. We could test how effective it has been, and it will be independent.
This is anecdotal—and I speak not so much as a Minister but as a constituency MP who has a significant night-time economy—but I think that the industry's attitude to drinking has changed inasmuch as there were some very negative images, with a lot of it centred around antisocial behaviour and criminal damage. But I think that there has been a change, and I felt it from the industry. They do not necessarily want to have that association any more. So there are other drivers going on outside Government that have encouraged them to take a slightly different attitude. But, as I say, it is no substitute.
Mr Sharma: I am sorry, Chairman, but—
Anne Milton: Was that a long answer? It probably was.

Q424 Mr Sharma: No, it is a good answer, but you agreed that the drinks industry has a role to play. I withdraw the term "policies" if you say they have developed strategies to work with other agencies to tackle this problem.
Anne Milton: They could play a role if they choose to do so.

Q425 Mr Sharma: Do you not think they should be encouraged to do so?
Anne Milton: The reduction of 1 billion units could have quite a significant impact. That would be a drop of 2% in the alcohol sold in this country. A few companies are stepping up to the crease on this and trying to lead the way on reducing the volume of alcohol in bottles and things, and that is to be applauded. So they do have a role to play, absolutely, and we would be, as I say, daft to ignore it when 17 million people go into a supermarket every week.

Q426 Barbara Keeley: I want to follow that up. You talked there about lowering volume, but is there not a question of lowering strength?
Anne Milton: I meant lowering strength, I am sorry, yes.

Q427 Barbara Keeley: Is that not a major thing?
Anne Milton: It is.

Q428 Barbara Keeley: That comes quite strongly from the evidence we had from Birmingham who were, for instance, going to go away from here and start to talk to restaurants and places like that about having, as their house wine, the lowest alcohol because if anything has changed—and I think the units thing is complicated because people think of it as a glass.

Anne Milton: Yes.

Q429 Barbara Keeley: They think of a bottle as 11% or 12% and it is not. A lot of red and even rosé wines are 14%, are they not, so could that not be a major focus for the industry?
Anne Milton: It is a major focus. In fact, one example is of a company who have developed a whole range of wines, potentially removing 25 million units, and they are trying to promote that and working with the supermarkets to promote it. Your example of restaurants which have low-strength house wines is positive. It is going to take a bit of time. I would not be naive enough to think that this is going to happen, but that could have a significant impact on the amount of alcohol we drink. I think it is poorly understood by the public. How many of us look at the strength of the bottle of wine or anything else before we buy it?
Barbara Keeley: It is not printed in very large letters.
Anne Milton: It is fairly small and, as you get older, it is more difficult to see.

Q430 Chris Skidmore: A particular issue with wine is in terms of strength, and probably the most relevant thing the Government could do would be to look at variable rates of duty. I know the Treasury produced a document last November looking at lower duty for beer or ale under 2.7%, with higher rates of duty over 7.5%. That seems to be, if you take those two parameters, quite a wide parameter by which the duty should be charged when you compare it to other countries. Personally, I would think that it would be more favourable to have a lower duty for beers under 4% and then a higher duty coming in at maybe 6%. But you cannot do that because of European regulation and you cannot even touch wine on variable duty. So if you have 14% wines at the moment, European regulations mean that the Government is hamstrung. I wondered what your thoughts were about that. Obviously it extends beyond your brief at the Department of Health, but the Health Secretary raised this as an issue, that there are wider arguments to be won over duty which then would have a knock-on effect on the strength of beers and wines.
Anne Milton: That is right. Of course, I am not allowed to discuss anything like this because it is a matter for the Treasury and I would get into really big trouble.

Q431 Valerie Vaz: We should get you to commit to something now.
Anne Milton: Good heavens. A career-limiting move possibly. That is because, as you have highlighted, of some of the problems with it. Anything that we can do voluntarily in the meantime, which can be done quite quickly, would be good. In fact I have heard at length from a wine producer that it is quite complex because the people who produce the wine have to have the ability to work with the people who are growing the grapes because the volume is dependent on the grapes and when they are picked. So it is not that easy to reduce the alcohol strength. Those are incentives and we should look at those. But those are slow and have long lead-in times. Anything we can do voluntarily will be quick. Also there is highlighting to the public that they should have a look at the strength of things, and restaurants offering us low volume house wine. I wonder what the House of Commons does.

Q432 Chris Skidmore: You could almost have a wine strategy. Looking at the evidence, there is the fascinating graph on page 11 of the "Annual Alcohol Consumption per UK Resident 1900–2010". When you look at the growth, with spirits they have gone up slightly but they have only gone back up to between 1900 to 1915 levels, before prohibition came in. It is the wine which is the real problem here.
Anne Milton: Yes, it is.

Q433 Chris Skidmore: I do not think, in terms of the strategy, apart from the 1 billion units, that there is much to tackle this whole growth area of wine and middle-class drinking. The people drinking the bottles of wine are not the ones going out causing violent disorder. The minimum pricing is focusing on the White Lightning tax but at the same time the health issue of chronic liver disease is going to be generated from wine.
Anne Milton: I feel very acutely as Minister for Public Health that it is desperately important to have the evidence always behind everything we do. We tend to talk about the group in an area like alcohol, where the harms are very varied and where the target population are very varied. We always focus on those that actually do not concern us. I am sure, with one of the sessions on antisocial behaviour—and at one point that was all you could read about in terms of the harm alcohol caused—we focused on that because we are not those people. So you are right that wine is an issue but then you have—if you take the average 15-year-old—the super-strength lagers and the ciders and all the rest of it. It is across the board. Anything we can do voluntarily with the industry to reduce the amount of alcohol that is consumed per bottle will benefit us all in numerous ways.

Q434 Valerie Vaz: And you have the power to commission that evidence.
Anne Milton: We do have the power to commission that evidence.
Valerie Vaz: There you go.
Anne Milton: The other very unpublicised part of my job that nobody is ever terribly interested in, but it does give me two minutes to mention it, is, of course, that I have responsibility for European and world health and so I have opportunities to talk to other European health ministers about this. In fact, it is encouraging to note that there is growing enthusiasm for doing something about non-communicable diseases, certainly in Europe. Awareness of the vested interests, particularly for some countries, is an important part of my role as well. As I say, it is unpublicised and not terribly exciting, I know, but it is important and it is how we move things in terms of the restrictions of EU legislation.

Q435 Rosie Cooper: I would like to ask, off beat, about the Department of Health statistics on alcohol. The penultimate paragraph talks about the increase in the number of prescriptions for drugs for the treatment of alcohol dependency prescribed in primary care or NHS and dispensed in the community. Did you collect those figures? Obviously it talks really about a 5% increase on the 2010 figure by 2011 and a 63% increase since 2003. Do you have those figures available? How do you collect them—by PCT area?
Anne Milton: Yes, quite.

Q436 Rosie Cooper: Or is it by city? If we were to ask for some of those disaggregated, could we find out? For example, Birmingham keeps being held up as a brilliant place, yet, when we spoke to them—and they were very good at brief interventions and had no waiting lists for anything—deaths from alcohol-related diseases was rising. I would be very interested to see these numbers because, again, we have this general myth that may not be underpinned by the actual facts about who is doing well and who is not. I find it all very worrying indeed.
Anne Milton: We are going to have to write to you on the specifics, if we may, but your point about digging slightly deeper into statistics is really important. I get enormously frustrated and have had discussions with officials about the way we use the term "alcohol-related admissions". It is widely misunderstood by the press who perceive that to be people coming into A and E. There is a published health question today which is going to ask about A and E admissions. There is no such thing as an A and E admission, of course, so they are widely misunderstood. You are right to talk about the source. It is why we are looking at how we define alcohol-related admissions. What we have to do, I think, is be much better at being very clear about what we are talking about.

Q437 Rosie Cooper: This is prescriptions.
Anne Milton: Yes, prescriptions and how they are collected.
Rosie Cooper: You cannot really mistake a—
Anne Milton: How they are collected, whether they are dispensed or prescribed—
Rosie Cooper:—prescription for the treatment of—
Anne Milton: As you will be well aware, there are lots of drugs prescribed and not nearly as many taken. It is about whether the prescriptions are written or whether they are actually dispensed and there will be a disparity.
Rosie Cooper: But if they are dispensed, whether they are taken or not, there is a perceived need by a clinician that they are required.
Anne Milton: Yes, there is.

Q438 Rosie Cooper: Therefore, the fact that the prescription is issued in the first place suggests a need. So I do not see the point you are making really.
Anne Milton: No, I do not want to get into detail here, but let us tell you how they were collected.

Q439 Chair: Unless any other Member of the Committee wants to come back to any point, or unless you have any concluding comment, Minister—
Anne Milton: No, other than to thank the Committee. I do mean that, actually.
Chair: Thanks from us to you for coming this morning.
Anne Milton: It is a pleasure.
Chair: We will ruminate on what you have told us. Thank you.

Written evidence

Written evidence from the Department of Health (GAS 01)

1. Our response below to the specific points in the terms of reference for the Committee's inquiry is supplemented by a background paper[1] which considers briefly:

- the nature and seriousness of harm from alcohol in England (and the UK in some instances) today, along with some issues on alcohol and wellbeing;
- trends in alcohol consumption and harm; and
- a brief summary of which policy interventions work to change which drinking behaviours.

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

2. Alcohol policy particularly affects or is affected by a large number of different policy areas, for which other Government Departments are responsible, for example, the Department for Education, HM Treasury, the Department for Business, Innovation and Skills, the Department for the Environment, Food and Rural Affairs, the Department for Culture, Media and Sport, the Ministry of Justice, the Department for Communities and Local Government, the Department for Work and Pensions, the Scotland Office, the Wales Office, and the Northern Ireland Office.

3. Cross-Government policy coordination is vital. The Cabinet Office has worked closely with other Departments in development of the new Alcohol Strategy. The Cabinet sub-Committee on Public Health has a role in considering key public health policy issues such as alcohol, where a coordinated approach is essential to achieving shared and interdependent outcomes.

4. This coordination is equally important at a local level, as is made clear in the White Paper *Healthy Lives Health People*, which sets out the Government's overall strategy for public health. Health and Wellbeing Boards will bring together councils, the NHS and local communities to understand local needs and priorities. The boards will be able to promote integration of health and social care services with health related services like criminal justice services, education or housing to meet these needs.

5. Within central Government, the Department of Health and the Home Office jointly have lead responsibility for alcohol policy within Government. This has been the case for a number of years and has not changed. We believe that joint responsibility by the two Departments is right, as alcohol misuse in the UK has major social impacts as well as major health impacts.

6. Responsibility for alcohol licensing policy was transferred from DCMS to the Home Office in June 2010. Because of this, the Home Office also has lead responsibility for policies impacting on the pricing of alcohol.

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

7. Health and education are devolved policy areas in Scotland, Wales, and Northern Ireland. Devolution in other policy areas varies, with criminal justice, policing, and licensing devolved in Scotland and Northern Ireland, but not in Wales.

8. Devolution recognises the value of devolved solutions for problems that differ from the average UK picture. Alcohol health and social harms are notably greater in Scotland than the UK average.[2] In both Wales and Northern Ireland, they are somewhat greater than the UK average.

9. It is important for the UK Government and the Devolved Administrations to work together on all areas of public policy—to share best practice in areas that are devolved; and to ensure policy in areas of reserved policy such as alcohol taxation and the regulation of broadcast advertising is taken forward in a way that benefits the whole of the UK.

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

10. Both the Alcohol Strategy and *Healthy Lives, Healthy People* make clear that everyone has a part to play in improving public health, including government, business, the third sector and individuals themselves. We have made clear from the start that the Responsibility Deal is just one strand of the Government's wide public health policy. It is part of our wider strategy to achieve responsible growth where economic development and businesses' role in improving health and wellbeing go hand in hand.

11. Priorities for action to improve public health are defined by Government; and informed by research, advice from scientists, health professionals and others. But this does not mean that Government is necessarily

[1] Annex B.

[2] http://www.healthscotland.com/uploads/documents/15312-MESASsettingTheSceneReport.pdf

best placed to deliver them. *The Public Health Responsibility Deal* is a new mechanism to deliver on these priorities.

12. The Responsibility Deal taps into the potential for businesses to improve public health through their influence over food, physical activity, alcohol, and health in the workplace. These are areas where "doing nothing" simply isn't an option, but the "something" to be done is not necessarily best done by Government. However, that is not to say that Government does not have a role. The role of Government in this case is to facilitate action and to build the partnerships that will enable genuine advances to be made in a way that is consistent with the public health needs of the country.

13. A plenary group, chaired by the Secretary of State for Health, oversees the development the Public Health Responsibility Deal. This group includes senior representatives from the business community, the voluntary sector, non-governmental organisations and local government.

14. Alongside this, five networks—considering food, alcohol, physical activity, health at work and behaviour change—have been established to develop pledges for action that are the outputs of the Public Health Responsibility Deal. The networks are each supported by a Minister and industry and health NGO co-chairs. Their membership brings together a wide range of representatives from the business community, the voluntary sector, non-governmental organisations and local government.

15. Partners committing to pledges provide delivery plans, laying out how they intend to meet each of the pledges they have signed up to. They provide annual updates on their progress each year. A list of the alcohol pledges is included in Annex A.

16. The Responsibility Deal is already influencing what businesses are doing as well as peoples' choices towards a healthier lifestyle, eg calorie information on menus, significant reductions in salt and removing artificial trans fats; improved alcohol unit labelling and clear warnings for pregnant women; and simple practical actions by employers to improve staff health with a resulting benefit on productivity.

17. The successes so far clearly demonstrate the potential that this voluntary approach has and we are now looking to broaden the impact by focusing on areas that will make the biggest difference such as the new pledge to remove one billion units of alcohol from the market by 2015.[3]

18. Companies signing up to this pledge are committing to reducing the number of units of alcohol that people drink, without necessarily reducing the number of drinks that they buy.

19. For example, Accolade Wines, the biggest wine company in the UK, is already leading the way in the drive towards lower alcohol wines—both through product innovation of new lighter wines and an incremental reduction in alcohol by volume (ABV) strength across large sections of their existing portfolio.

20. Their new 5.5% ABV wines are forerunners for a style that they are committed to extending across their portfolio and they have already gained listings in the major supermarkets. In addition to their commitment to lighter wines, they are also exploring ways to reduce the ABV on many of their different wine styles, whether by picking grapes earlier in the harvest or by other methods.

21. Modelling suggests that in a decade, removing one billion units from sales (from the current total of 52 billion units) is estimated to result in around 1,000 fewer alcohol related deaths per year; many thousands of fewer hospital admissions and alcohol related crimes, as well as substantial savings to health services and crime costs each year.

22. Reducing the amount of alcohol that people consume, without necessarily changing the number of drinks that they purchase has the benefit of both helping to reduce their chances of suffering an alcohol-related illness and also providing industry with a meaningful way to benefit public health without damaging the viability of their business.

23. Consumers will benefit from a greater range of choice of lower alcohol products and more easily available smaller measures, so that those looking to reduce their alcohol intake will find it easier to do so.

24. Achievement of the pledge will be measured on an industry-wide basis including using HMRC clearance data and sales data and ultimately assessed by the Alcohol Network's monitoring and evaluation sub-group.

25. They will determine if the 1 billion units reduction can be identified as resulting from actions taken as part of this pledge ie that consumers drink the same products but which now contain less alcohol by volume, consumers switch to lower alcohol products, the actions that companies take increases the market share of lower alcohol products at the expense of those with higher alcohol content and consumers switch to smaller measures.

26. *Drinkaware* is an independent, UK-wide charity funded by donations from the alcohol industry and not from the public purse. Current funders include nearly all major retailers, pub companies and producers, who have pledged approximately £5.2 million per year through to 2012.

[3] "As part of action to reduce the number of people drinking above the guidelines, we have already signed up to a core commitment to 'foster a culture of responsible drinking which will help people drink within guidelines'. To support this we will remove 1 billion units of alcohol sold annually from the market by December 2015 principally through improving consumer choice of lower alcohol products."

27. Drinkaware aims to change the UK's drinking habits for the better. For those who choose to drink, they promote drinking within the lower-risk guidelines and look for innovative ways to challenge the national drinking culture.

28. One of the Responsibility Deal alcohol pledges is about support for Drinkaware: "We commit to maintaining the levels of financial support and in-kind funding for Drinkaware and the 'Why let the Good times go bad?'" campaign as set out in the Memoranda of Understanding between Industry, Government and Drinkaware.

29. In addition, through the Responsibility Deal, Drinkaware has addressed unit awareness among adults and young adults through the development of two complementary initiatives with the British Beer and Pub Association and the Wine and Spirits Trade Association. The "2–2–2–1" creative, rolled out in pubs across the UK and in the off-trade, will provide consumers with a mnemonic device to help them remember unit guidelines.

30. As a market provider, Drinkaware is well placed to deliver some key messages, such as how strong drinks are (how many units are in each drink) and can reach environments (eg pubs) that no current Government brand can.

31. Their campaigns target those drinking above the lower-risk guidelines who are 30–45 year olds, employed, at-home and who drink to relax and unwind. This audience typically drinks wine and consumes alcohol above the lower-risk guidelines most days of the week.

32. The 2009 Addendum to the Drinkaware Memorandum of Understanding, requires a strategic review of their activities in 2012.

33. Under the aegis of a Steering Committee of stakeholders, the review will audit the effectiveness of Drinkaware's performance against its objectives. It will require a review of the policy context, an analysis of Board papers and a wide range of other documents, possible interviews with industry, government and public health community representatives.

34. The results will inform Drinkaware's 2013–2020 business planning and resources model.

35. *The Portman Group* was established in 1989 as a not for profit organisation funded by nine member companies who represent every sector of drinks production and collectively account for about 40% of the UK alcohol market.

36. It introduced a Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks in 1996. All alcohol products sold or marketed in the UK are subject to the rules of the Code, which prevent alcohol being marketed to children or in a way that would encourage excessive or irresponsible consumption. This is a self-regulatory approach with enforcement—if a product is found to have infringed the Code, the Portman Group can issue a Retailer Alert Bulletin notifying retailers not to stock the product. The Code does not have legal status but is referenced in the statutory guidance that supports the Licensing Act.[4] Licensing authorities can attach conditions that require premises to comply with these bulletins.

37. Portman Group members introduced a number of initiatives to help educate the public about responsible drinking. These include improved labelling, the widespread promotion of responsible drinking messages and contributing to the creation of Drinkaware. Portman Group members continue to provide significant funding for Drinkaware's education and campaigning work.

38. The Portman Group has a direct interest in marketing, non-paid advertising and labelling; and regulates industry activity in these areas, working in partnership with the Advertising Standards Authority, which regulates paid advertising.

39. As part of the Responsibility Deal they have an interest in five of the eight collective pledges (labelling, funding for Drinkaware, on-trade information, under-age sales "Challenge" programs and advertising and marketing) and in some of the individual pledges that their members have made.

40. They have also published guidelines to businesses looking to implement the Responsibility Deal collective pledge on alcohol labelling and will report on the delivery of this pledge through an independent market survey.

41. A public consultation on the Portman Group Code of Practice on the Naming, Packaging and Promotion of Alcohol Drinks (as part of the Responsibility Deal pledge on marketing) closed in January 2012. This considers, among other things, the introduction of a code on sports sponsorship.

42. We will work with the Portman Group to make sure that the Code is robust and that it actively encourages marketing, which builds more positive associations.

[4] Guidance issued under section 182 of the Licensing Act 2003.

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

Government approach

43. Currently, there is no minimum price threshold in place to prevent alcohol retailers from selling very cheap alcohol. As a consequence, alcohol has been so heavily discounted that it is now possible to purchase a can of lager for as little as 20p and a two litre bottle of cider for £1.69 with £42.1 billion being spent on alcohol in England and Wales in 2010 alone. The availability of such cheap alcohol has contributed to a culture of "binge-drinking"[5] and excessive drinking, with significant impacts on health and crime.

44. As the Alcohol Strategy sets out, the availability of cheap alcohol in supermarkets and off-licences has resulted in practices such as "pre-loading" at home prior to a night out. In a recent study, 66% of 17–30 year olds arrested in a city in England claimed to have "pre-loaded"[6] before a night out, with pre-loaders two and half times more likely to be involved in violence than other drinkers. This has contributed to a fifth of all violent incidents occurring in, or around, a pub or club. Responsible retailers, particularly those in the on-trade that typically offer a more controlled drinking environment, are less able to address the issues that take place on or around their premises without Government intervention to reduce the availability of cheap alcohol in supermarkets and off-licences.

45. The Government has therefore committed to introducing a minimum unit price for alcohol, but will consult on the level to be set.

46. Government analysts have carried out an initial estimation of the potential impacts of a 40p minimum unit price on health and crime considering a range of evidence and data including the Sheffield University study. However, these are only initial estimates and further research will be carried out through the Government's Impact Assessment and forthcoming public consultation.

Evidence base for a 40p MUP

47. A large number of studies (including by the World Health Organisation and many academic reviews) agree that there is a close link between alcohol price changes and levels of consumption.

48. The expected impact of minimum unit pricing is borne out by experience in Canadian provinces that have implemented a similar policy: social reference pricing.[7] Looking at Canada, there is a correlation between provinces that have introduced minimum pricing and those that have experienced sustained reduction in violent crime.

49. Government analysts have estimated that a 40p minimum unit price would lead to an estimated 30,000 fewer alcohol-related hospital admissions per year after 10 years, and approximately 50,600 fewer total crimes per year. This is expected to lead to an annual saving of £140 million in health and crime costs after 10 years.

50. Minimum unit pricing could also bring wider benefits, for example to productivity, as suggested by the Sheffield University study. Further work will be required to understand the magnitude of these effects in more detail.

Economic impact of a 40p MUP

51. A minimum unit price set at 40p per unit is unlikely to affect the on-trade as there is a significant price disparity between the off-trade and on-trade. The level of the minimum unit price will need to take into account the impact on alcohol duty receipts. We will take forward further work on the economic impact of minimum unit pricing as part of the Government's Impact Assessment.

Impact on moderate and harmful drinkers

52. There is substantial evidence to suggest that cheap alcohol is targeted by those who consume the most alcohol overall and by under 18s who drink alcohol. Furthermore, those who consume the most alcohol are known to "shop around" for the cheapest form of alcohol.

53. ONS data from 2010 suggests that 22% of people say they drink regularly at levels above alcohol guidelines and academic research[8] suggests that alcohol drunk as part of a binge drinking occasion accounts for over 50% of alcohol consumed.

54. The aim of minimum unit pricing is to end the sale of very cheap alcohol, drunk disproportionately by hazardous and harmful drinkers. Therefore, it is important that the minimum unit price is set at a level which

[5] Binge drinking in the population is measured as the number who self-report drinking on their heaviest drinking day in the previous week more than eight units per day for men and more than six units per day for women.

[6] Barton, A and Husk, K (forthcoming) Controlling pre-loaders: alcohol related violence in an English night time economy. Drugs and alcohol today.

[7] Does minimum pricing reduce consumption? The experience of a Canadian province. Addiction (February 2012). T Stockwell *et al*.

[8] Baumberg (2009), Alcohol & Alcoholism 44(5):523–528.

affects an appropriate proportion of the market. If the level is set too low then it might not have any substantial impact and if it is set too high then it may begin to affect the majority of consumers who drink responsibly (moderate drinkers).

55. Specifically, the Sheffield study found that those who buy more alcohol are most affected by the price of alcohol, and changes in spending affect mostly harmful drinkers, with hazardous drinkers somewhat affected and spending for moderate drinkers affected very little (in terms of their consumption and spending). This issue will be further assessed in the Government's Impact Assessment of minimum unit pricing.

Evidence/arguments for setting a different unit price

56. The Sheffield study found that general price increases lead to reductions in mean alcohol consumption with increasing benefits as the price per unit increases. This is partly due to limited scope for switching between products (because prices increase across the board) and partly because all consumer groups are targeted equally.

57. Sheffield University found that higher minimum unit prices will reduce switching effects. The study estimated overall changes in consumption for 20p, 25p, 30p, 35p, 40p, 45p, 50p, 60p, 70p, and showed that increasing levels of minimum pricing lead to steep reductions in alcohol consumption. Specifically, Sheffield estimates that a 40p minimum unit price will reduce alcohol consumption by 2.4%.

58. The estimated effect of setting a minimum price of 35p or below is that only the very cheapest alcohol products in the off-trade are likely to be affected. This is likely to affect only a limited amount of "loss-leading" products and is therefore unlikely to have a significant impact on reducing alcohol consumption and health and crime harms.

59. The estimated effect of setting a minimum price of 50p per unit or above is that products in the on-trade are more likely to be affected. This would have a more significant impact on health and crime harms, but may begin to affect moderate consumers disproportionately.

60. The Government is committed to reducing excessive alcohol consumption without unfairly penalising moderate drinkers. Therefore, the Government will consult on the level to be set for a minimum unit price and will consider the impact on moderate drinkers in its Impact Assessment.

The legal issues

61. There are number of issues to consider when implementing minimum unit pricing. The Government continues to take legal advice and will consider any potential legal implications as we take forward this proposal and consult on a proposed level of minimum unit price.

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

62. The Government continues to work closely with the independent and industry media regulators to ensure that any emerging concerns about the possible impact of advertising and marketing have been fully examined and that the latest evidence on the effects of marketing on alcohol consumption is properly reflected in the regulatory codes.

63. The most extensive recent systematic review of research undertaken in this area was the University of Sheffield's, School of Health and Related Research review, commissioned by the Department of Health and published in 2008.[9]

64. The Sheffield review indicated that there was consistent evidence from longitudinal studies that exposure to TV and other broadcast media is associated with inception of and levels of drinking by young people. It noted that much of the evidence came in the form of cohort studies from the USA, New Zealand and otherwise outside the UK, but found there was sufficient consistency of effect across a wide range of advertising media to suggest the need for preventive measures, particularly as many of those affected are young people who are not legally able to purchase alcohol.

65. The Science Group of the European Alcohol and Health Forum published a review of longitudinal studies of the impact of alcohol advertising on young people in 2009, which came to similar conclusions.

66. We are also aware of a more recent study from the UK that has suggested exposure to alcohol marketing has an impact on both the likelihood of young people drinking and the frequency with which they drink, however, the authors note that further research exploring levels of exposure to alcohol marketing and association with youth drinking in the UK would be helpful.[10]

67. The Sheffield review found that there was substantial uncertainty in the evidence on the potential impact of advertising restrictions, including the effect of complete bans on alcohol advertising.

[9] Independent Review of the Effects of Alcohol Pricing and Promotion, Part A: Systematic Reviews, University of Sheffield, 2008.

[10] Gordon R *et al* (2010): The Impact of Alcohol Marketing on Youth Drinking Behaviour: A Two-stage Cohort Study, Alcohol and Alcoholism 45 (5): 470–480.

68. The Sheffield research also highlighted the on-going methodological debate on how advertising effects can and should be investigated and the inherent difficulties of evaluating the relationship between expenditure on advertising, restrictions on advertising, and alcohol consumption.

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

69. The long term trend of UK alcohol consumption has been to follow growth in GDP and we are now at around the EU average for consumption and harm, with a tendency above the average to drink in binge patterns resulting in a high level of crime and social impacts.

70. Long term illness caused by alcohol tends for the most part to be the result of many years of sustained heavy drinking. For some illnesses, such as oesophageal cancer, research has shown that risks to an individual heavy drinker would continue to grow for two years after stopping drinking. The risks would then begin to fall, taking more than 20 years to fall to the level of a non-drinker.[11]

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

Alcohol treatment and prevention

71. While there has been some improvement in provision for treatment of people dependent on alcohol, it is very likely that there is still significant under-provision overall. We estimate that numbers of people in England mildly or severely dependent on alcohol rose by 24% between 2000 and 2007.[12] Without the decisive steps we are taking through our strategy to end the availability of cheap alcohol and to strengthen local powers to prevent the growth of alcohol misuse, it is likely that needs for treatment would grow in the future.

72. Levels of need vary greatly from place to place. It is right that plans for investment in alcohol treatment and prevention are for decision at local level. Our reforms to the NHS and Public Health will ensure a greater focus on commissioning of alcohol services to meet local needs.

73. The Department—and in future Public Health England—will support better local commissioning of alcohol treatment:

- — Through Payment by Results (PbR) programmes. The tools and learning from these programmes will be made available for local areas to incorporate into their local commissioning and service delivery systems.
- — By developing an evidence-based model to enable local areas to estimate needs for specialist alcohol treatment.
- — Through sharing best practice, including via the on-line Alcohol Learning Centre.

Liver disease

74. Alcohol is currently the single largest cause of liver disease. Approximately 60% of people with liver disease in England have alcoholic liver disease, which, in turn, accounts for 84% of liver deaths.

75. Around 9% of the male population and 4% of the female population of England are thought to be drinking at harmful levels, which means they are consuming more than 50 units and 35 units of alcohol per week, respectively. More than 90% of people who sustain drinking at these levels will go on to develop excessive fat accumulation in their livers—this is reversible if drinking is reduced, but, if not, 15–30% of those will develop more serious inflammation as a result and up to 10% could develop cirrhosis.[13]

76. The Department estimated that in 2006–07 liver disease was costing secondary and tertiary care in the NHS around £460 million per year. Based on a projected increase from Hospital Episode Statistics of 10% per annum, this would mean the cost of liver disease to the NHS would exceed £1 billion by 2015–16. This takes no account of the costs of GP visits for liver disease.

77. The Government believes that such severe financial pressure on the NHS from liver disease, as this is a preventable illness, is unacceptable. We expect the new Strategy to ameliorate this pressure.

78. The Liver Disease Strategy, to be published in due course, will set out our vision for how the NHS and local areas need to tackle liver disease better.

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

79. The Government's reforms to public health and the NHS will empower local communities to shape their own responses to local issues. Preventing and responding to alcohol-related harm cannot be achieved by one agency or service alone. Effective partnership is essential.

[11] Rehm *et al* International Journal of Cancer 121, 1132–1137 (2007).
[12] Data from the Adult Psychiatric Morbidity Survey, 2000 and 2007.
[13] Unpublished report for the Department of Health, "Unmasking Liver Disease: the forgotten killer", Bell Pottinger, 2009.

80. Local authorities have a wide role covering such services as housing, benefits, and child care, a broad interest in the wellbeing of their communities, and a reach to all sections of the community, including deprived groups, which should enable them to carry out their new public health responsibilities effectively.

81. Local Authorities' new public health responsibilities will mean they take on the main responsibility for commissioning alcohol prevention and treatment services, as we have described in the Strategy. For the first time, they will receive a ring fenced public health grant.

82. Alongside LA commissioned services the NHS will continue to have a vital contribution to preventing and treating health harm from alcohol.

83. It is the role of the Health and Wellbeing Boards to bring the whole system together to enable key local agencies to agree a strategic approach. They will maximise opportunities for integration between the NHS, public health and social care in promoting joint commissioning. This will also help to address properly the needs of specific groups, such as offenders.

84. Health and Wellbeing Boards are responsible for understanding local needs and priorities through the joint strategic needs assessment (JSNA) and are responsible for developing a joint Health and Wellbeing Strategy, which will provide the basis for both NHS and Public Health commissioning decisions.

85. We have retained the power for the Secretary of State to issue guidance on the preparation of JSNAs, and under the Health and Social Care Act 2012 we have a new power to issue guidance on the preparation of Joint Health and Wellbeing Strategies (JHWSs). New guidance to support Health and Wellbeing Boards in discharging their duties regarding JSNAs and JHWSs is currently under development and we will consult on this shortly. This guidance will not prescribe form or content of JSNAs and JHWSs as they are local strategic planning processes and need to be sensitive to local circumstances. The guidance will, however emphasise the need to consider a wide variety of needs and how they impact upon health and wellbeing outcomes, including drug and alcohol misuse.

86. The current JSNA support packs for local areas include an overview of the local population using alcohol treatment services. In the future, Public Health England will have the key role in support local areas to have an understanding of how this impacts on the health and wellbeing of their local communities.

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

- *public health interventions such as education and information;*
- *reducing the strength of alcoholic beverages;*
- *raising the legal drinking age; and*
- *plain packaging and marketing bans*

Public health interventions such as education and information

87. In 2005, the Department of Health and the Home Office commissioned a review of international evidence on the effectiveness of alcohol harm reduction communications and related campaigns.[14] It found no clear cut evidence that mass media campaigns alone can achieve behavioural change, although clearly they have a role to play. It found that many evaluations do not measure behaviour change, but changes in awareness. It can also be difficult to separate the impact of a campaign from that of other interventions.

88. The review did find useful evidence about how to understand and analyse the behaviour of different target groups and how to segment groups according to their attitudes and beliefs, how to use the right mix of media for each target group, and how to seek to use other influences such as social norms. Crucially, it was clear that mass communications need to be supported by other interventions, if they are to be effective.

89. Social marketing campaigns however, remain an important strand within any alcohol strategy. The evaluation of the integrated marketing campaigns focused on alcohol related health harms in 2010 and 2012 demonstrate the effectiveness of recent campaigns in encouraging self-identification amongst at risk drinkers, acceptance of the potential health risks and reframing the "norms" around moderate drinking. These are important initial stages in the behaviour change journey.

90. A number of other international evidence reviews and studies have considered the effectiveness of education and information more broadly.[15] Their findings are broadly consistent with those of the review we commissioned in 2005. The Department's background paper considers further evidence from research we have commissioned.

[14] Edcoms (2005): Review of the evidence base around effective alcohol harm reduction, prepared for COI on behalf of DH and Home Office.

[15] Anderson P, Baumberg B, Alcohol in Europe: a public health perspective: report to the European Commission, Institute of Alcohol Studies, 2006; WHO Expert Committee on Problems related to Alcohol Consumption, 2nd Report, World Health Organisation, 2007.

91. There will be a UK-wide review of the alcohol guidelines, lead by Dame Sally Davies, the UK Government's Chief Medical Officer, so that people at all stages of the life can make more informed choices about their drinking.

Reducing the strength of alcoholic beverages

92. The following international examples are taken from a rapid literature review by the Centre for Public Health, Liverpool John Moores University.

93. In Australia in the early 1980s differential tax rates for low (<3%abv) and full strength beers were introduced to promote consumption of lower-alcohol beer. Between 1980 and 2002, per capita consumption fell by 24% and lower strength beers now make up more than 20% of the total beer market.[16]

94. 50% of beer sales in the USA are now made up by <4.5% products and between 1999 and 2005 beer shipments increased by 8% but volume of pure alcohol rose by only 6%, suggesting that consumers were substituting lower strength products for regular/higher strength beers. A number of States have also introduced restrictions on the sale of beer eg Oklahoma and Utah only permit the sale of beer below 4% abv from supermarkets, petrol stations and convenience stores. In Oklahoma, full strength beers can only be sold from off-licences and by 2003 98% of beer sold was under 4% abv.[17]

95. A further study in the USA among university students found that substituting lower alcohol beers for regular beers did not result in a higher number of drinks being consumed when the students were unaware of the alcoholic content of the drink. It also recorded lower Blood Alcohol Concentration (BAC) levels when the lower-alcohol beers were consumed. A more recent study replicated these results.[18]

96. Studies conducted in Sweden found no significant additive trend among purchasing patterns following the introduction of a lower alcohol beer, although they also found no significant substitution effect as well. There was some evidence of both substitution and addition (consumers choosing the lower alcohol product over higher strength beers plus an increase in consumption of the lower alcohol beer in situations where no alcohol was previously consumed), but some of this was attributed to the relatively lower price of the lower alcohol beers compared to regular strength drinks.[19] However, abolition of the sale of higher strength beers in grocery stores is credited with an overall reduction in alcohol consumption and alcohol-related harm amongst young people.[20]

97. Conversely, Finland found that allowing medium strength beers to be sold in grocery stores resulted in an increase in consumption. This is attributed to people switching up from lower strength beers rather than switching down from other higher strength drinks.[21]

Raising the legal drinking age

98. We are not aware of any international studies comparing the effectiveness of different minimum purchase ages in different countries, for example 18 or 21, although there is evidence that raising a minimum purchase age reduces harm.[22] Minimum purchase ages vary between countries, although 18 is the most common legal limit within Europe.

99. We believe that a minimum purchase age should be set with reference to the evidence of harm to adolescents from drinking alcohol. The Chief Medical Officer for England published guidance on the consumption of alcohol by young people in December 2009. The report provides a comprehensive review of the scientific evidence on the links between alcohol-related harm and children and young people. It details key studies from an epidemiological review of the harms associated with adolescent alcohol consumption, upon which the guidance is based. It also draws on findings from a review of the associations between alcohol use and teenage pregnancy and consultation with the public, including parents and young people. The new advice was that:

- An alcohol-free childhood is the healthiest and best option.
- If children do drink alcohol, they should not do so until at least 15 years old.
- If 15 to 17 year olds drink alcohol, it should be rarely, and never more than once a week. They should always be supervised by a parent or carer.
- If 15 to 17 year olds drink alcohol, they should never exceed the recommended adult daily limits (3–4 units of alcohol for men and 2–3 units for women).

[16] AC Neilsen (2006).
[17] International Centre for Alcohol Policies (2007).
[18] Geller *et al* (1991), Segal and Stockwell (2009).
[19] Skog (1988) and Whitehead and Szandrowska (1977).
[20] Ramstedt (2002).
[21] Mustonen and Sund (2002) and Osterberg (2012).
[22] Anderson P, Baumberg B, Alcohol in Europe: a public health perspective: report to the European Commission, Institute of Alcohol Studies, 2006.

100. There is substantial evidence that introducing or raising a minimum purchase age reduces harm to young people from alcohol, including road casualties, alcohol-related injury admissions to hospital, and deaths from alcohol-related injury.

101. There is good evidence on the importance of enforcement and that low and inconsistent levels of enforcement can make it easy to purchase alcohol under age, especially when there is little community support for under age enforcement.[23]

102. The Government believes its actions set out in the Strategy to improve enforcement and increase penalties for businesses selling to under 18s are consistent with the evidence base and that this should be a priority for action in local communities. We very much welcome extended industry support for Community Alcohol Partnerships, which mobilise community support for better enforcement on under age purchase. We would wish to see this go further in the future.

Plain packaging and marketing bans

103. We have noted in the Strategy that some countries, such as Norway, have banned alcohol advertising altogether. France has banned TV and cinema advertising of alcohol, with controls on the content of advertising in other media. As we have noted already, evidence on the impact of such restrictions is very limited and it is very hard to show that they are proportionate.

104. Where there has been evidence of likely harm sufficient to justify action, UK regulators have acted robustly. In 2005, the advertising regulators, Ofcom and the Advertising Standards Authority (ASA) significantly strengthened the alcohol advertising rules in response to evidence which suggested that advertising has some influence on young viewers' attitudes to drinking.

105. The current rules are designed to protect young people and vulnerable groups. In particular, the rules ensure that alcohol ads do not reflect or encourage any antisocial or undesirable behaviours associated with alcohol misuse. There are also extensive scheduling restrictions to protect young people.

106. As part of their most recent review of the advertising codes, the ASA's code writing bodies, CAP and BCAP, undertook a comprehensive analysis of the latest research in this area, which included assessment of the Sheffield review. The advertising regulators' analysis of the existing research highlighted uncertainty in relation to the evidence on the potential impact of alcohol advertising and on the merits of more extensive restrictions. CAP and BCAP took the view that there was insufficient evidence to suggest the already robust alcohol advertising rules needed to be strengthened further. However, as set out in the Government's Alcohol Strategy, we will work with the ASA and Ofcom to examine ways to ensure that adverts promoting alcohol are not shown during programmes of high appeal to young people. We will also work with them to ensure the full and vigorous application of ASA powers to online and social media.

107. In addition to the advertising codes the Portman Group's Code of Practice, supported throughout the alcohol industry, applies to the naming, packaging and promotion of alcoholic drinks. We look to the Portman Group to ensure that the UK drinks industry continues to promote its products in a socially responsible way, reflecting the best evidence. In broad terms, the Portman Group's Code rules reflect the restrictions in the CAP and BCAP codes for advertising, for example, in prohibiting any encouragement of immoderate drinking, any association of drinking with sexual or social success, or inclusion of images of people aged under 25.

108. Plain packaging is not an intervention widely used for alcohol and we are not aware of any research on this.

109. We will continue to monitor the effectiveness of the UK's advertising and marketing regulatory regimes to ensure the rules implemented by the regulators continue to be based on best evidence and sufficient to protect the public—children and young people in particular.

May 2012

Annex A

RESPONSIBILITY DEAL ALCOHOL NETWORK—ALCOHOL PLEDGES

A1—Alcohol Labelling

We will ensure that over 80% of products on shelf (by December 2013) will have labels with clear unit content, NHS guidelines and a warning about drinking when pregnant.

A2—Awareness of Alcohol Units in the On—trade

We will provide simple and consistent information in the on-trade (eg pubs and clubs), to raise awareness of the unit content of alcoholic drinks, and we will also explore together with health bodies how messages around drinking guidelines and the associated health harms might be communicated.

[23] Wagenaar, A C and Wolfson, M (1994): Enforcement of the legal minimum drinking age in the United States, *Journal of Public Health Policy* 15: 37–53; Wagenaar A C and Wolfson, M (1995): Deterring sales and provision of alcohol to minors: A study of enforcement in 295 counties in four states, *Public Health Reports* 110: 419–7.

A3—Awareness of Alcohol Units etc in the Off—trade

We will provide simple and consistent information as appropriate in the off-trade (supermarkets and off-licences) as well as other marketing channels (eg in-store magazines), to raise awareness of the units, calorie content of alcoholic drinks, NHS drinking guidelines, and the health harms associated with exceeding guidelines.

A4—Tackling Under—Age Alcohol Sales

We will provide simple and consistent information as appropriate in the off-trade (supermarkets and off-licences) as well as other marketing channels (eg in-store magazines), to raise awareness of the units, calorie content of alcoholic drinks, NHS drinking guidelines, and the health harms associated with exceeding guidelines.

A5—Support for Drinkaware

We commit to maintaining the levels of financial support and in-kind funding for Drinkaware and the "Why let the Good times go bad?" campaign as set out in the Memoranda of Understanding between Industry (MoU), Government and Drinkaware.

A6—Advertising & Marketing Alcohol

We commit to further action on advertising and marketing, namely the development of a new sponsorship code requiring the promotion of responsible drinking, not putting alcohol adverts on outdoor poster sites within 100m of schools, and adhering to the Drinkaware brand guidelines to ensure clear and consistent usage.

A7—Community Actions to Tackle Alcohol Harms

In local communities we will provide support for schemes appropriate for local areas that wish to use them to address issues around social and health harms, and will act together to improve joined up working between such schemes operating in local areas as:

- Best Bar None and Pubwatch, which set standards for on-trade premises;
- Purple Flag which make awards to safe, consumer friendly areas;
- Community Alcohol Partnerships, which currently support local partnership working to address local issues, such as under-age sales and alcohol related crime, are to be extended to work with health and education partners in local Government; and
- Business Improvement Districts, which can improve the local commercial environment.

A8—Unit Reduction

As part of action to reduce the number of people drinking above the guidelines, we have already signed up to a core commitment to "foster a culture of responsible drinking which will help people drink within guidelines".

To support this we will remove 1bn units of alcohol sold annually from the market by Dec 2015 principally through improving consumer choice of lower alcohol products.

Individual Pledges

—	Asda	By 30 April 2011 we will no longer display alcohol in the foyers of any our stores.
—	Asda	We will provide an additional £1 million to tackle alcohol misuse by young people.
—	Heineken	We will aim to remove 100 million units of alcohol from the UK market each year through lowering the strength of a major brand by 2013.
—	Heineken	We will distribute 11 million branded glasses into the UK on trade showing alcohol unit information by end of 2011.
—	Diageo	Three year project to extend the NOFAS-UK "What Do You Tell A Pregnant Woman About Alcohol" programme across England & Wales to inform over 1 million pregnant women of what they need to know about alcohol in pregnancy.
—	Diageo Molson Coors, Heineken & Bacardi Brown Forman.	We; Bacardi Brown-Forman Brands, Diageo, Heineken and Molson Coors commit to working with the BII (British Institute of Innkeeping) and The Home Office to support the continuation and further development of the Best Bar None scheme for at least the next three years. We will invest at least £500,000 (commencing May 2011) and add a further 20 schemes in that time.

—	Wine & Spirits Trade Association	Community Alcohol Partnerships (WSTA & supporting partners) We will expand the reach of Community Alcohol Partnerships (CAPs) in the UK through an investment of at least £800,000 by alcohol retailers and producers over the next three years. This will allow us to significantly increase the number of CAP schemes in local communities and extend the remit of CAPs beyond tackling under-age sales to wider alcohol-related harm and in particular.

Annex B

The Evidence on Alcohol Misuse and Harm in England Today

1. This evidence paper has been written in support of the Government's alcohol strategy and as part of the Department's evidence to the Health Committee's inquiry. It considers briefly:

- the nature and seriousness of harm from alcohol in England today, along with some issues on alcohol and wellbeing;
- trends in alcohol consumption and harm; and
- our view of which policy interventions work to change which drinking behaviours.

The Nature and Seriousness of Harm From Alcohol

The costs of alcohol misuse

2. We estimate the costs of alcohol misuse in England as follows:

- NHS costs, at about £3.5 billion per year at 2009–10 costs.[24]
- Alcohol-related crime, at £11 billion per year at 2010–11 costs.[25]
- Lost productivity due to alcohol, at about £7.3 billion per year at 2009–10 costs (UK estimate).[26]

We estimate total costs at about £21 billion per year. This does not include any estimate for the economic costs of alcohol misuse to families and social networks.

Levels of alcohol consumption

3. People who drink alcohol vary enormously in how much they drink and how often, where and what they drink.

- Over half (57%) of the population in 2009 said that they had not drunk alcohol, or drank alcohol only once in the previous week. 16% of the population were classified as non-drinkers.[27]
- Around a quarter of adult men (26%) and a fifth of women (18%) reported drinking at levels which are above the NHS guidelines. 2.2m people (7% of men and 4% of women) said they drank more than twice the NHS guidelines, putting themselves at most risk of illness and death from alcohol.
- While public concern has tended to focus on binge drinking by young people and young adults, it is worth noting that heavy drinking is not just a problem for the young. Particularly for men, drinking above the NHS guidelines in 2009 was greater for the age 45–64 group (31%) than for 16–24s (23%). The pattern was different for women with more 16–24s (23%) drinking above the guidelines than 45–64s (20%).

4. Self-reported data from surveys tend to underestimate true consumption levels. HM Revenue & Customs data show alcohol sold in the UK that is 67% more than the total that people report to surveys, eg those from the Office of National Statistics.

5. Taking account of under-reporting, we estimate that the highest consuming 10% of the population are drinking more than 40% of all alcohol consumed in the UK.

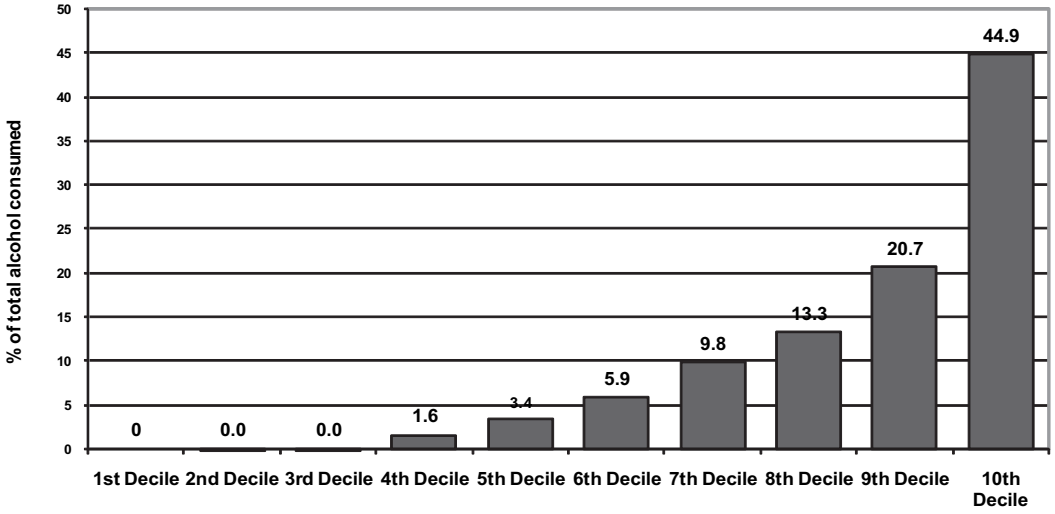
[24] The Department of Health has updated the previous estimate of around £2.7 billion at 2006–07 prices, using the same methodology.

[25] The Home Office has recently updated the estimate of the cost of alcohol-related crime: £11 billion in 2010–11 prices. This figure includes the cost of general offences (like violent crime) that are alcohol-related, the cost to the Criminal Justice System of alcohol specific offences (like drink driving) and the cost of issuing Penalty Notices for Disorder. This estimate was arrived at using the same methodology as that which lay behind the widely quoted figure of £8–13 billion in 2006–07 prices. The previous estimate was presented as a range due to a methodological uncertainty, which has now been resolved. Further information is available on request from the Home Office.

[26] The Department of Health has updated the previous estimate of around £6.4 billion at 2006–07 prices, using the same methodology.

[27] Statistics on Alcohol, England 2011, Table 2.1 (Information Centre for Health and Social Care).

More than 40% of alcohol consumption is concentrated in 10% of the population[28]



Binge drinking

6. Some drinkers in England drink to drunkenness, a pattern known as "binge drinking". In England, this is measured imperfectly in population surveys by reference to those who say they drank more than double the NHS guideline limits for men (ie more than eight units) and women (ie more than six units) on their heaviest drinking day in the previous week. This is not a perfect measure, as people vary a great deal in how drunk they become from the same amount of alcohol.

7. Several comparative studies within Europe show most northern European countries reporting more binge drinking compared with southern European countries, with the UK among those showing most weekly or monthly binge drinking.[29]

8. The UK has compared poorly with other European countries for drinking by 15–16 year old students in regular ESPAD[30] surveys. The UK is consistently in the top five European countries for binge drinking and drunkenness among school children.[31] Compared with other countries, young people in the UK are more likely to report that they drink alcohol at least weekly.[32]

[28] Policy options for alcohol price regulation: the importance of modelling population heterogeneity, Meier *et al*, Addiction 105, 383–393, 2009.

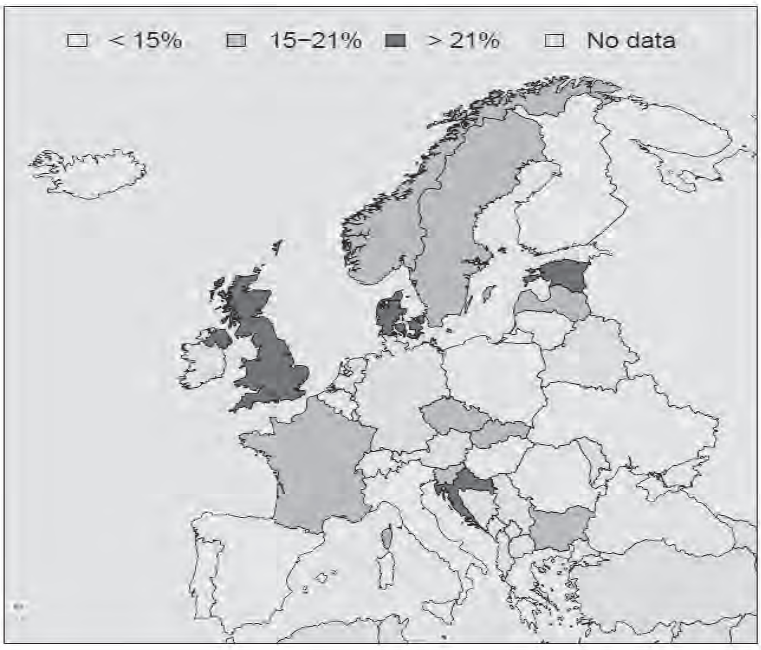
[29] Anderson P, Baumberg B, Alcohol in Europe: a public health perspective: report to the European Commission, Institute of Alcohol Studies, 2006—this considers a range of comparative studies and methodological issues.

[30] European School Survey Project on Alcohol and other Drugs, www.espad.org

[31] ESPAD, 2007, Figure 29b.

[32] Currie C, Gabhainn S N, Godeau E, *et al* (eds) (2008): Inequalities in young people's health: Health behaviour in school aged children. International report from the 2005/23006 survey, WHO policy series: Health policy for children and adolescents, Issue 5.

9. Studies from the UK have shown that exposure to alcohol marketing has an impact on both the likelihood of young people drinking and the frequency with which they drink.[33] These findings are consistent with the evidence of a number of longitudinal studies from other countries.[34,35] The Government's Alcohol Strategy proposes further work in the UK to minimise the harmful effects of alcohol advertising for young people.



Binge drinking in 15–16 year old students in Europe, defined as five+ drinks on a single occasion, three or more times in 30 days Source: ESPAD 2007 (Hibbell et al 2009). The data for Denmark and Spain has limited comparability.

Harms to health and social impacts from alcohol

10. Over 60 diseases or conditions can be caused by drinking alcohol.[36] Alcohol can impact on health through three linked mechanisms:

11. *Direct biochemical effects on the body*: through long term consumption. The four biggest disease groups are heart disease, stroke, liver disease, and cancer.

12. In pregnancy, alcohol can cause a range of harms to the foetus, including miscarriage, low birth weight, cognitive deficiencies, and fetal alcohol spectrum disorders (FASD).

13. Like any food, alcohol contributes to calorific intake. We estimate that for adults who drink 9% of energy intake on average comes from alcohol.[37] This is in a context where six in ten adults are overweight or obese.[38]

14. Risks of these diseases, broadly, rise in line with levels of consumption, with a main exception—there is a "J-shaped curve" for heart disease, meaning that low levels of drinking are associated with reduced risks for men over 40 and women post-menopause.[39] This effect lessens for people over 70.[40]

[33] Gordon R *et al* (2010): The Impact of Alcohol Marketing on Youth Drinking Behaviour: A Two-stage Cohort Study, Alcohol and Alcoholism 45 (5): 470–480.

[34] Anderson *et al* (2009): Impact of Alcohol Advertising and Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies. Alcohol and Alcoholism 44 (3): 229–243.

[35] Booth *et al* (2008): Independent review of the effects of alcohol pricing and promotion.

[36] Corrao et al. (2004): A meta-analysis of alcohol consumption and the risk of 15 diseases. *Preventive Medicine* 38, 613–9.

[37] National Diet and Nutrition Survey 2008–09 to 2009–10.

[38] Health Survey for England 2009.

[39] Gunzerath *et al* (2004): National Institute on Alcohol Abuse and Alcoholism Report on moderate drinking: *Alcoholism: Clinical and Experimental Research* 28, 829–47. Corrao *et al* (2000): Alcohol and Coronary Heart Disease: a meta-analysis. *Addiction*, 95(10), 1505–23.

[40] Groenbaek *et al* (1998): Alcohol and mortality: Is there a U-shaped relation in elderly people? Age and Ageing 1998, 27, 739–44.

15. *Drunkenness*, due to single, heavy drinking episodes ("binge drinking") has been shown to have a number of health and social consequences on the drinker and/or on other people, such as:

- Injuries, for example from falls.
- Violence and aggression, including alcohol-related crime and disorder and domestic violence[41] increase with drunkenness and with heavier drinking in general. If the heavy drinker is a parent, this can contribute to a variety of childhood mental and behavioural disorders.[42] Systematic reviews have suggested that alcohol is a contributory factor in 16% of child abuse cases.[43]
- Increased risk of stroke,[44] heart arrhythmias, and sudden coronary death, even in people with no evidence of pre-existing heart disease[45]—any protective effect of regular, moderate consumption may be lost through binge drinking, even if this is infrequent.
- Harming home life or marriage.[46]
- Damaging work performance.[47]
- Limiting young people's educational attainment.[48]

16. The risk of alcohol *dependence* rises with both the volume of alcohol consumption[49] and a pattern of binge drinking.[50] The risk of dependence is increased by starting drinking at a young age.[51] Alcohol dependence is most common among young adults. In 2007, there were an estimated 1.6 million moderately or

[41] Wells S, *et al* (2005): Drinking patterns, drinking contexts and alcohol-related aggression among late adolescent and young adult drinkers. *Addiction* 100, 933–944. Wechsler *et al* (1994): Health and behavioural consequences of binge drinking in college: a national survey of students at 140 campuses, *JAMA*, 272, 1672–1677 Wechsler *et al* (1995): Correlates of college student binge drinking. *American Journal of public health*, 85, 921–6. Wechsler *et al* (1998): Changes in binge drinking and related problems among American college students between 1993 and 1997: results of the Harvard School of Public Health College Alcohol Study. *Journal of American College Health*, 47, 57–68. Komro *et al* (1999): The relationship between adolescent alcohol use and delinquent behaviours. *Journal of Child and Adolescent Substance Abuse*, 9, 13–28. Bonomo *et al* (2001): Adverse outcomes of alcohol use in adolescents. *Addiction*, 96, 1485–96. Swahn (2001): Risk factors for physical fighting among adolescent drinkers. *American Journal of Epidemiology*, 153, S72. Richardson and Budd (2003): Alcohol, Crime and Disorder: a study of young adults. Home Office Research Study, 263. London, *Home Office Research, Development and Statistics Directorate*. Swahn and Donovan (2004): Correlates and predictors of violent behaviour among adolescent drinkers. *Journal of Adolescent Health*, 34, 480–92. Wells et al (2005): Drinking patterns, drinking contexts and alcohol-related aggression among late adolescent and young adult drinkers. *Addiction*, 100, 933–944. Mirrlees-Black (1999): Domestic violence: Findings from a new British Crime Survey self-completion questionnaire. *Home Office Research Study* No 191. London, Home Office. Abbey *et al* (2001): Alcohol and Sexual Assault. *Alcohol Health and Research World*, 25(1), 43–51. Brecklin and Ullman (2002): The roles of victim and offender alcohol use in sexual assaults: results from the National Violence Against Women Survey. *Journal of Studies on Alcohol*, 63(1), 57–63. White and Chen (2002): Problem drinking and intimate partner violence. *Journal of Studies on Alcohol*, 63, 205–214. Lipsey *et al* (1997): Is there a causal relationship between alcohol use and violence? A synthesis of evidence. In: Galanter, M ed. Alcohol and Violence: Epidemiology, Neurobiology, Psychology, Family Issues. Recent Developments in Alcoholism, Vol 13, New York, Plenum Press, pp 245–282. Greenfeld (1998): Alcohol and Crime: An analysis of national data on the prevalence of alcohol involvement in crime. Report prepared for the Assistant Attorney General's National Symposium on Alcohol Abuse and Crime. Washington DC, US Department of Justice. Heinz A. *et al* (2011): Cognitive and neurobiological mechanisms of alcohol-related aggression. *Nature*, Vol 12, 400–413. McKinney, CM. *et al* (2010): Does Alcohol Involvement Increase the Severity of Intimate Partner Violence? *Alcohol Clinical and Experimental Research*, Vol 34, No 4 655–8. Foran H M. and O'Leary D (2008): Alcohol and Intimate Partner Violence: A meta-analytic review. Clinical Psychology Review, 28, 1222–34. Klostermann K C. and Fals-Stewart W. Intimate partner violence and alcohol use: Exploring the role of drinking in partner violence and its implications for intervention. *Aggression and Violent Behaviour*, 11, 587–97.

[42] Gmel, G Rehm, J (2003): Harmful alcohol use. *Alcohol Research and Health* 27, 52–62. Rossow, I (2000): Suicide, violence and child abuse: review of the impact of alcohol consumption on social problems. *Contemporary drug problems* 27, 397–434

[43] English D R, *et al*, (1995): The quantification of drug caused morbidity and mortality in Australia. Canberra: Commonwealth Department of Human Services and Health. Ridolfo B, Stevenson C, (2001): The quantification of drug caused mortality and morbidity in Australia, 1998. Canberra, Australian Institute of Health and Welfare.

[44] Hillbom, M and Kaste, M (1982): Alcohol intoxication: a risk factor for primary subarachnoid hemorrhage, *Neurology*, 32, 706–11.

[45] Robinette *et al* (1979): Chronic alcoholism and subsequent mortality in World War II veterans, *American Journal of Epidemiology*, 109, 687–700. Suhonen *et al* (1987): Alcohol consumption and sudden coronary death in middle-aged Finnish men. *Acta Medica Scandinavica*, 221, 335–341. Wannamathee and Shaper (1992): Alcohol and sudden cardiac death, *British Heart Journal*, 68, 443–8. Mukamal *et al* (2005): (i) Drinking frequency , mediating biomarkers, and risk of myocardial infarction in women and men. *Circulation*. 112(10): 1406–13. (ii) Alcohol consumption and risk of atrial frbrillation in men and women: the Copenhagen City Heart Study. *Circulation*, 112(12), 1736–42.

[46] Leonard and Rothbard (1999): Alcohol and the Marriage Effect. *Journal of Studies on Alcohol* (Suppl 13) 139–146S. Fu and Goodman (2000): Association between health-related behaviours and the risk of divorce in the USA, *Journal of Biosocial Science*, 32, 63–88.

[47] Marmot *et al* (1993): Alcohol consumption and sickness absence: From the Whitehall II Study. Addiction, 88, 369–82. Rehm and Rossow (2001): The impact of alcohol consumption on work and education. In Klingemann H, Gmel G eds. Mapping the Social Consequences of Alcohol Consumption, pp 67–77, Dordrecht: Kluwer Academic Publishers. Gmel and Rehm (2003): Harmful Alcohol Use, *Alcohol Research and Health*, 27, 52–62. Mangione *et al* (1999): Employee Drinking Practices and Work Performance. *Journal of Studies on Alcohol*, 60, 261–270. Other studies are summarised and assessed in *Alcohol, Work and Productivity, Scientific Opinion of the Science Group of the European Alcohol and Health Forum*, September 2011.

[48] A number of studies are summarised in the Chief Medical Officer for England's, Guidance on the consumption of alcohol by children and young people: Supplementary Report, 2009.

[49] UK Adult Psychiatric Morbidity Survey, 2000. A number of other studies are summarised in the Chief Medical Officer for England's, *Guidance on the consumption of alcohol by children and young people: Supplementary Report*, 2009.

[50] Caetano *et al*: DSM-IV alcohol dependence and drinking in the US population: a risk analysis, Annals of Epidemiology, 7, 542–549. Bonomo *et al* (2004): Teenage drinking and the onset of alcohol dependence: A cohort study over seven years. *Addiction*, 99, 1520–8. A number of other studies are summarised in the Chief Medical Officer for England's, *Guidance on the consumption of alcohol by children and young people: Supplementary Report*, 2009.

[51] De Wit *et al* (2000): Age at first alcohol use: a risk factor for the development of alcohol disorders. *American Journal of Psychiatry*, 157: 745–50.

severely dependent on alcohol in England. We estimate that, on a like for like basis, the numbers dependent rose by 24% between the 2000 and 2007 UK Adult Psychiatric Morbidity Surveys.

17. A clear association exists between mental ill heath and alcohol misuse. Alcohol psychoses and dependence account for a major part of the burden of ill health from alcohol, though a small proportion of deaths. Symptoms of depression and anxiety have been shown to increase with alcohol consumption.[52] People with depression and mood disorders are at increased risk of alcohol dependence and vice versa.[53] Many depressive syndromes improve markedly within a short period (days or weeks) of abstinence.[54]

Alcohol and violence

18. Research suggests:

- a substantial proportion of incidents of aggression and violent crime involves one or more participants who have been drinking alcohol;[55]
- increased risks of involvement in violence, including homicide, among heavy drinkers, with the risks stronger for intoxication than for overall consumption;[56]
- an overall association between greater alcohol use and criminal and domestic violence, with particularly strong evidence from studies of domestic and sexual violence;[57] the relationship is moderated by other factors such as culture, gender, and social class;
- personality has also been found to be a mediating factor in the link between aggression and alcohol consumption. Studies have demonstrated that people who have high trait levels of aggression are more likely to behave aggressively under the influence of alcohol, but not necessarily when they are sober;[58]
- a review of experimental studies has found that we are also affected by how we expect to behave when drunk. Studies have shown that when people believe they are consuming alcohol, they are more likely to be aggressive (even if they have not actually drunk any alcohol at all) than if they believe that they are consuming non-alcoholic drinks. However, the effect on aggression of drinking alcohol is greater than drinking a placebo;[59] and
- studies have found that the belief that alcohol is linked with aggressive behaviour is stronger in some cultures than others. However, there is little evidence showing cultural variations in the link between alcohol and observed aggressive behaviour (rather than the belief that alcohol and aggression are linked).[60, 61]

Alcohol and crime

19. There is a strong link between alcohol and crime, disorder and anti-social behaviour, particularly violent crime. In 2010–11, according to the British Crime Survey, the victim believed the offender to be under the influence of alcohol in 44% of violent incidents (around 930,000), a significant reduction since 2009/10. This was the case in over a half (58%) of incidents of stranger violence and just under a third (31%) of domestic

[52] Alati *et al* (2005): Is there really a J-shaped curve in the association between alcohol consumption and symptoms of depression and anxiety? Findings from the Mater University Study of pregnancy and its outcomes. *Addiction* 100, 643–651.

[53] Regier *et al* (1990): Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) study. *Journal of the American Medical Association*, 264: 2511–2518 Merikangas *et al* (1998): Comorbidity of substance use disorders with mood and anxiety disorders: Results of the International Consortium in Psychiatric Epidemiology. *Addictive Behaviours: An International Journal*, 23(6): 893–907 Pirkola *et al* (2005): DSM-IV mood- anxiety- and alcohol use disorders and their comorbidity in the Finnish general population. *Soc Psychiatry psychitar epidemiol* 40, 1–10.

[54] Brown and Schuckit (1988): Changes in depression among abstinent alcoholics. *Journal of Studies on Alcohol*, 49: 412–7 Dackis *et al* (1986): Evaluating Depression in Alcoholics. *Psychiatry Research*, 17(2): 105–9 Willenbring (1986): Measurement of Depression in Alcoholics. *Journal of Studies on Alcohol*, 49: 412–7 Davidson K M (1995): Diagnosis of depression in alcohol dependence: changes in prevalence with drinking status. *British Journal of Psychiatry*, 166: 199–204.

[55] Murdoch, Pihl and Ross (1990): Alcohol and crimes of violence: present issues *International Journal of the Addictions*, 25, 1065–81. Budd (2003): Alcohol-related assault: findings from the British Crime Survey. Home Office on-line report 35/03 http://www.homeoffice.gov.uk/rds/pdfs2/rdsolr3503.pdf

[56] Rossow (2000): Suicide, violence and child abuse: review of the impact of alcohol consumption on social problems. *Contemporary drug problems*, 27, 397–434. Wells *et al* (2000): Alcohol-related aggression in the general population. *Journal of Studies on Alcohol*, 61, 626–632.

[57] Mirrlees-Black (1999): Domestic violence: findings from a new British Crime Survey self-completion questionnaire. Home Office research study No 191, London, Home Office. Abbey et al. (2001): Alcohol and sexual assault, *Alcohol Health and Research World*, 25(1), 43–51. Caetano *et al* (2001): Alcohol-related intimate partner violence among white, Black and Hispanic couples in the United States, *Alcohol Research and Health*, 25, 58–65. Brecklin and Ullman (2002): The roles of victim and offender alcohol use in sexual assaults: results from the National Violence Against Women Survey, *Journal of Studies on Alcohol*, 63(1), 57–63.

[58] Miller, C, D Parrott, and P Giancola, *Agreeableness and Alcohol-Related Aggression: The Mediating Effect of Trait Aggressivity.* Experimental Clinical Psychopharmacology, 2010. 17(6): p 445–455.

[59] Bushman, B and H Cooper, *Effects of Alcohol on Human Aggression: An Integrative Research Review.* Psychological Bulletin, 1990. **107**(3): p. 341–354. These studies focus on male reactions to alcohol and there is evidence that this is not applicable in females. For further information, see Gussler-Burkhardt, N and P Giancola, *A Further Examination of Gender Differences in Alcohol Related Aggression.* Journal of Studies on Alcohol and Drugs, 2005. **66**(3): p 413–422.

[60] MacAndrew, C and R B Edgerton, *Drunken Comportment: A Social Explanation*1969: Aldine.

[61] Lindman, R and A R Lang, *The Alcohol-Aggression Stereotype: A Cross Cultural comparison of beliefs.* International Journal of Addictions, 1994. **29**(1): p 1–13.

violence incidents. Nearly a quarter (24%) of BCS respondents in 2010–11 considered people being drunk or rowdy in public places to be a very or fairly big problem in their local area.

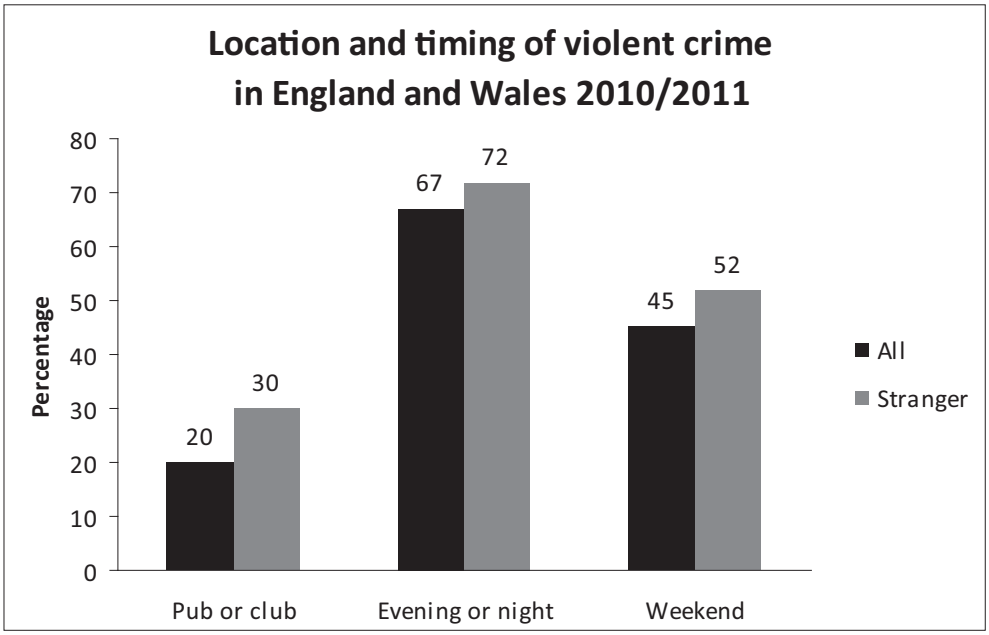
20. There is a link between the amounts of alcohol an individual drinks and increased offending. According to analysis of the Offending Crime and Justice survey,[62] adult binge drinkers (18 to 65) were significantly more likely to have offended in the past 12 months than any other drinking group. Nearly a fifth (19%) of all adult binge drinkers reported committing an offence in the previous year compared with 6% of other regular drinkers and 3% of those who occasionally or never drank alcohol. There is also some evidence that people who "pre-load" before going out for further drinking are more likely to become involved in violent crime. A small scale local study found that those pre-loading were 2.5 times more likely to have been in a fight.[63]

21. Many of those are not long-term or repeat offenders, but acting up on alcohol. A recent evaluation of Alcohol Arrest Referral schemes found that around six out of 10 individuals participating in the schemes had no previous arrest history in the previous six months.[64] This finding is consistent with a study of arrests around licensed premises in the West Midlands, which found that around 40% of those arrested for one or two violent offences had no other criminal involvement over a period of several years.

22. A significant amount of violence is linked to the night-time economy.[65] As Figure 11 shows, a fifth (20%) of all violent incidents in 2010–11 took place in or around a pub or club. This rises to 30% for stranger violence. More than two thirds (67%) of violent offences occur in the evening or at night and 45% at the weekend.[66]

Figure 11

LOCATION AND TIMING OF VIOLENT OFFENCE



Source: British Crime Survey 2010/11

The burden of disease and death from alcohol

23. Disability adjusted life years (DALY) are a measure of combined ill health (adjusted for severity) and premature death. Alcohol is 10% of the UK burden of disease and death, as measured by DALYs lost-smoking is 15%.[67] By this measure, alcohol is one of the three biggest lifestyle risk factors for disease and death in the UK, after smoking and obesity. This takes account of the net benefit from a reduced risk of heart disease for moderate consumption.

[62] Matthews S and Richardson A (2005): The 2003 Offending Crime and Justice Survey: alcohol-related crime and disorder. *Home Office Research Findings 261.*

[63] Hughes K, Anderson Z, Morleo M and Bellis M A (2008): Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes, *Addiction*, 103(1), 60–65.

[64] Blakeborough L, and Richardson A (2012) Summary of findings from two evaluations of Home Office Alcohol Arrest Referral pilot schemes. *Home Office Research Report 60.* Home Office: London.

[65] Crime in England and Wales, 2010–11.

[66] Chaplin R, Flatley J and Smith K (2011): Crime in England and Wales 2010–11, Home Office Statistical Bulletin 10/11, Home Office, London—Tables 7: http://www.homeoffice.gov.uk/science-research/research-statistics/crime/crime-statistics/bcs-supplementary-tabs/

[67] Balakrishnan R *et al* (2009): The burden of alcohol-related ill health in the United Kingdom, *Journal of Public Health*, Vol 31, No 3, 366–373.

24. It is important to note that DALYs take account of long term health damage and loss of life, short term accidents and injuries, which account for a high proportion of early deaths, and the burden of ill health linked to dependence. It is all of these together that account for alcohol's importance as a risk factor.

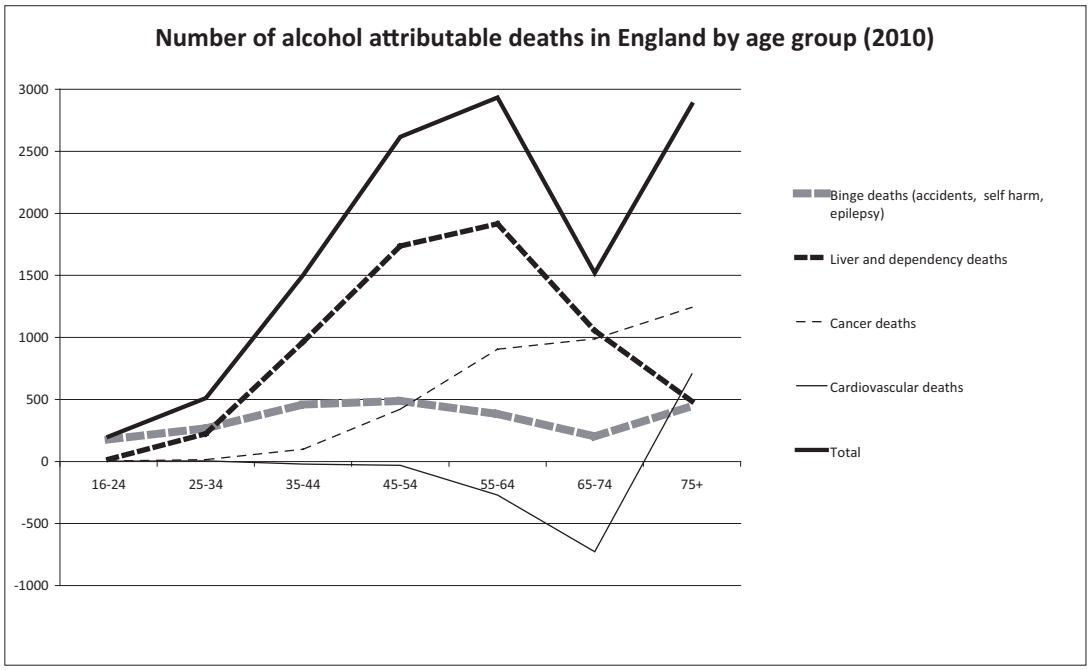
Alcohol and health inequalities

25. ONS data suggests lower than average consumption among those with the lowest weekly incomes.[68] Health harm from alcohol appears to be highest among these groups. Over the years 2001–2005, alcohol-specific mortality in the most deprived quintile of local authorities in England was 5.5 times the rate of the least deprived.[69]

26. We need to understand more about why our current measures of drinking patterns do not account for the higher levels of alcohol related harms falling on more deprived communities. However, some of the disproportionate impact of alcohol on deprived communities may be due to under-reporting by higher risk drinkers in these groups—a recent study in Greater Manchester[70] found that under-reporting was most evident with higher risk drinkers. Other possible reasons could include combinations of apparently lower risk levels of regular drinking with binge drinking, combinations of problematic drinking with smoking and unhealthy diets, and better access to social and financial support and to treatment and care by better off individuals.

Alcohol harm and the life course

27. Risks to health from alcohol occur at every age of life. This graph shows how the biggest net risks affect different adult age groups in England.[71] The relatively young ages of those suffering deaths due to alcohol is apparent.



28. In England, the average years of life lost for men and women dying from alcohol-attributable conditions during 2003–05 was 20 years and 15 years respectively.[72]

Harm to young people from alcohol

29. The Chief Medical Officer for England's 2009 guidance that young people under 15 should not drink alcohol at all is based on the fact that young people who start drinking alcohol at an early age drink more

[68] Information Centre for Health and Social Care: Statistics on Alcohol: England, 2011, Table 2.11.

[69] Indications of Public Health in the English Regions, 2008, Table 10.

[70] Centre for Public Health (Liverpool John Moores University): Improving accuracy in recording alcohol consumption: a survey in Greater Manchester, May 2011.

[71] North West Public Health Observatory: Analysis based on Jones L, Bellis M A, Dedman D, Sumnall H, Tocque K. 2008. Alcohol-attributable fractions for England. Alcohol-attributable mortality and hospital admissions. North West Public Health Observatory, Centre for Public Health, Liverpool John Moores University. ISBN: 978–1-906591–34–2 (data updated to 2010 mortality; NWPHO, March 2012).

[72] Indications of Public Health in the English Regions, 2007, Association of Public Health Observatories.

frequently and more than those who delay drinking; as a result, they are more likely to develop alcohol problems in adolescence and adulthood. Beginning to drink before age 15 is associated with:[73]

- increased health risks, including alcohol-related injuries;
- truancy, exclusion, and lower educational attainment;
- involvement in violence;
- suicidal thoughts and attempts;
- having more sexual partners;
- pregnancy and sexually transmitted infections;
- using drugs; and
- employment problems.

30. Young people who binge drink in adolescence (ie under 18) are more likely to be binge drinkers as adults and have an increased risk of developing alcohol dependence in young adulthood. They are also more likely to experience drug use and dependence, be involved in crime and be a victim of crime, and to achieve lower educational attainment by the time they are adults.

31. Research undertaken by North West Public Health Observatory[74] found there was an association between alcohol-related hospital admissions and teenage pregnancy, in both males and females. This was true even after controlling for the effect of deprivation. The same was true of the more common sexually transmitted infections. There is evidence that alcohol consumption and being drunk can result in lower inhibitions and poor judgements regarding sexual activity and risky sexual behaviour. Early alcohol consumption means that young people have an increased likelihood of having sex at a younger age. Alcohol misuse is linked to a greater number of sexual partners, regretted or coerced sex. There is also a strong relationship between hazardous alcohol consumption and non-consensual sex.[75]

Impact on productivity of alcohol misuse

32. Work for the Prime Minister's Strategy Unit published in 2003[76] summarised damage to productivity as:

- increased sickness absence;
- unemployment and early retirement from inability to work; and
- premature deaths among economically active people of working age.

33. Our updated estimate (above) using the same methodology suggests a loss from all three factors of up to £7.3bn per year in 2009–10.

34. Research suggests additionally that heavy drinking and binge drinking episodes increase the risks of poor work performance and that the costs are likely to be considerable.

Fire and alcohol

35. The Department for Communities and Local Government (DCLG) carried out a study in 2011 into fires that occurred in people's homes. This showed that alcohol resulted in 2,656 fires, resulting in 60 deaths and 1,267 injuries. The remaining 27,502 fires resulted in 85 deaths and 4,512 injuries.[77] Where alcohol was a contributory factor, 49% of fire incidents resulted in casualties, compared to 14% for other fire incidents.

36. The estimated cost of fires where alcohol was suspected to be a contributing factor was almost £131 million. This compares to just over £286 million for other fires in the study.

Attitudes of the public—how good is the public's understanding?

37. There is good evidence that the public in general underestimates the risks of excessive alcohol consumption. This is not unique to the UK.[78]

38. ONS surveys show that in 2009 only 13% of the public said they keep a check on the number of units they drink. This was the same figure in 1997. 90% of people had heard of units of alcohol (up from 79% in 1997), and the more people drank the more likely they were to have heard of units. Knowledge of the actual

[73] Chief Medical Officer for England, Guidance on the consumption of alcohol by children and young people: Supplementary Report, 2009.

[74] Bellis M *et al* (2009): Contributions of Alcohol to Teenage Pregnancy: An initial examination of geographical and evidence based associations. North West Public Health Observatory.

[75] Gunby *et al* Gender differences in alcohol-related non-consensual sex; cross-sectional analysis of a student population, *BMC Public Health* 2012, 12: 216.

[76] Strategy Unit Alcohol Harm Reduction Project, Interim Analytical Report, 2003.

[77] Although the DCLG Incident Recording System return does not distinguish between alcohol or drugs related fires, it is possible to separate out casualties that were under the influence of either substance. The study concluded that while there will be a few only drugs related fires, the *vast majority* of fires were where alcohol was a contributing factor, or at least alcohol or alcohol and drugs related.

[78] The World Health Report, 2002, Reducing Risks, Promoting Healthy Life, World Health Organisation.

number of units in a particular drink was lower, but for frequent beer drinkers 69% know the correct number of units and 83% of frequent wine drinkers similarly.

39. Monitoring by Drinkaware suggests that (a) accurate understanding of the daily guidelines can be improved through social marketing and (b) this can easily be lost again, if social marketing campaigns are not sustained.[79]

40. After the Department of Health's *Alcohol Effects* campaign in February 2010, awareness of the link with mouth cancer moved from 5% to 24%.

41. Individual long term health risks from alcohol can be difficult to grasp, in the same way as long term risks from over-eating and obesity.

Alcohol and Wellbeing

42. The Government's wellbeing agenda seeks to give policy a broader focus than just economic growth. It sees quality of life as equally important.

43. Some drivers of wellbeing are those commonly considered in Government policy, for example, individuals' own and their family's health and the experience of crime in their local community.

44. Other drivers relate to issues like social relationships, social trust, and the opportunities for people to control or influence their situations.

45. The main positive impact of moderate alcohol consumption on adults' wellbeing seems to relate to social forms of alcohol consumption, although research in this area is limited.[80] Recent research in the North West of England shows a complex picture.[81]

46. While, clearly, alcohol consumption also happens in social settings in people's own homes, there may be a particular value in the ways in which well run pubs provide opportunities for social interaction as part of an experience involving moderate drinking and sometimes eating.

47. However, an approach which does not favour "normalising" alcohol consumption at the expense of alternatives could be important for young people, given the evidence of the harm alcohol can do to their wellbeing, and for young adults, given that many still choose not to drink alcohol, or to drink it infrequently.[82]

48. There is good evidence, from what people themselves tell researchers, that *excessive* alcohol consumption is bad for individuals' own wellbeing, not just for their health. It can also be damaging to the wellbeing of families and others close to heavy drinkers.[83]

Trends in alcohol consumption and harm

49. Trends in consumption have broadly followed growth in Gross Domestic Product (GDP), with gradual, but sustained, *long term* growth—UK consumption per head doubled between 1950 and the peak in 2004. Consumption fell by 12% from 2004 to 2009, of which 9% occurred in the two years 2008 and 2009. There was no further fall in 2010. The recent fall should also be viewed in the context of the long term rise of 91% in consumption per head since 1960.

[79] Ability to state the guidelines correctly for women fell from 36% to 31% and for men from 34% to 30% between 2009 and 2010 (Drinkaware Trust).

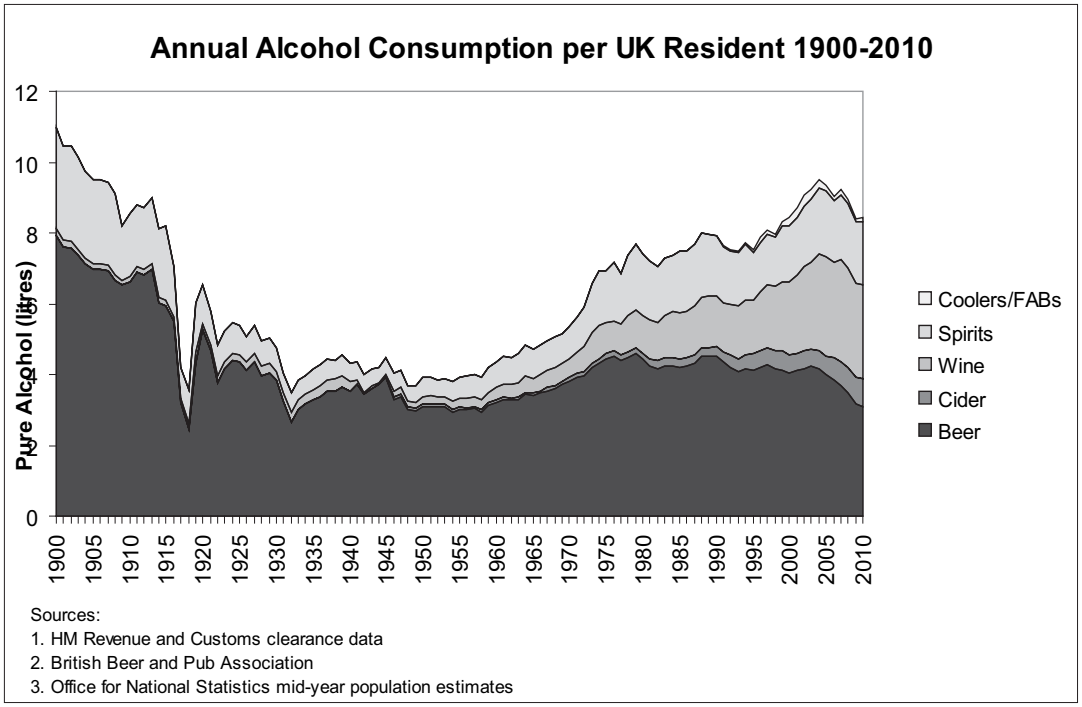
[80] Molnar *et al* (2009): A longitudinal examination of alcohol use and subjective wellbeing in an undergraduate sample. *Journal of Studies on Alcohol and Drugs*, Vol 70(5).

[81] Bellis *et al* (2012): Variations in risk and protective factors for life satisfaction and mental wellbeing with deprivation: a cross-sectional study, *North West Public Health Observatory (Centre for Public Health)*.

[82] In 2009 62% of 16–17 year olds and 39% of 18–24 year olds said they drank no alcohol in the week before the survey. DH analysis of ONS General Lifestyle Survey.

[83] Alcohol's harm to others: reduced wellbeing and health status for those with heavy drinkers in their lives, by Sally Casswell, Ru Quan You and Taisia Huckle, Addiction 106, 1087–1094, 2011.

50. The rising level of abstainers from alcohol is a trend of longstanding. 9% of the population were non-drinkers in 1992 and 16% in 2009.[84] HMRC data on trends in consumption per head therefore understates the growth in consumption per drinker over that period.



51. UK average consumption is now at about the EU average, having been much below it. The average long term trend in EU countries was an increase to the mid-1970s, followed by a long term decline from about 15 litres pure alcohol per head to 11 litres per head.[85] Countries such as France or Italy have shown much bigger declines in consumption per head since 1961 and are now very close to and below the UK level respectively.[86]

52. Binge drinking is measured imperfectly in population surveys in England by reference to those who say they drank more than double the NHS guideline limits for men (ie more than eight units) and women (ie more than six units) on their heaviest drinking day in the previous week. This is not a perfect measure, as people vary a great deal in how drunk they become from the same amount of alcohol. Recent trends in self-reported data used as a measure of binge drinking were as follows. Data before 2006 are not directly comparable, due to a change of methodology.[87]

— A decline from 23% in 2006 to 19% in 2010 for men drinking more than eight units on at least one day.

— A decline from 15% in 2006 to 12% in 2010 for women drinking more than six units on at least one day.

53. The decline between 2006 and 2010 was most marked for men and women aged 16–24—from 30% to 24% for men and from 27% to 17% for women,[88] suggesting a possible link to economic weakness over that period.

Trends in alcohol consumption by young people

54. Survey data on drinking by 11–15 year olds[89] suggests some reasons for encouragement, but with continuing concerns. While fewer young people are drinking, those who drink do have not reduced how much they drink. Data on units drunk before 2007 are not directly comparable, due to a change of methodology:

— The proportion of 11–15 year old pupils who reported they had drunk alcohol in the last week fell from 18% in 2009 to 13% in 2010. The level has fallen in most years since 2001, when it was 26%.

— In 2010, average alcohol consumed by pupils who had drunk in the last week was 13 units.

[84] Statistics on Alcohol, England: 2004 and 2011.

[85] Figure 4.1 in Anderson P, Baumberg B, Alcohol in Europe: a public health perspective: report to the European Commission, Institute of Alcohol Studies, 2006.

[86] WHO, European Status Report on Alcohol and Health, 2010.

[87] Smoking and Drinking among Adults, 2009, a report on the 2009 General Lifestyle Survey, ONS; and: General Lifestyle Survey Overview: A report on the 2010 General Lifestyle Survey, ONS.

[88] Smoking and Drinking among adults, 2009, ONS.

[89] Smoking, drinking and drug use among young people in England in 2010, Information Centre for Health and Social Care, July 2011.

— Alcohol consumed by those pupils who do drink was 12.7 units in 2007 (when the methodology changed) and 12.9 units in 2010.

The changing market dynamics

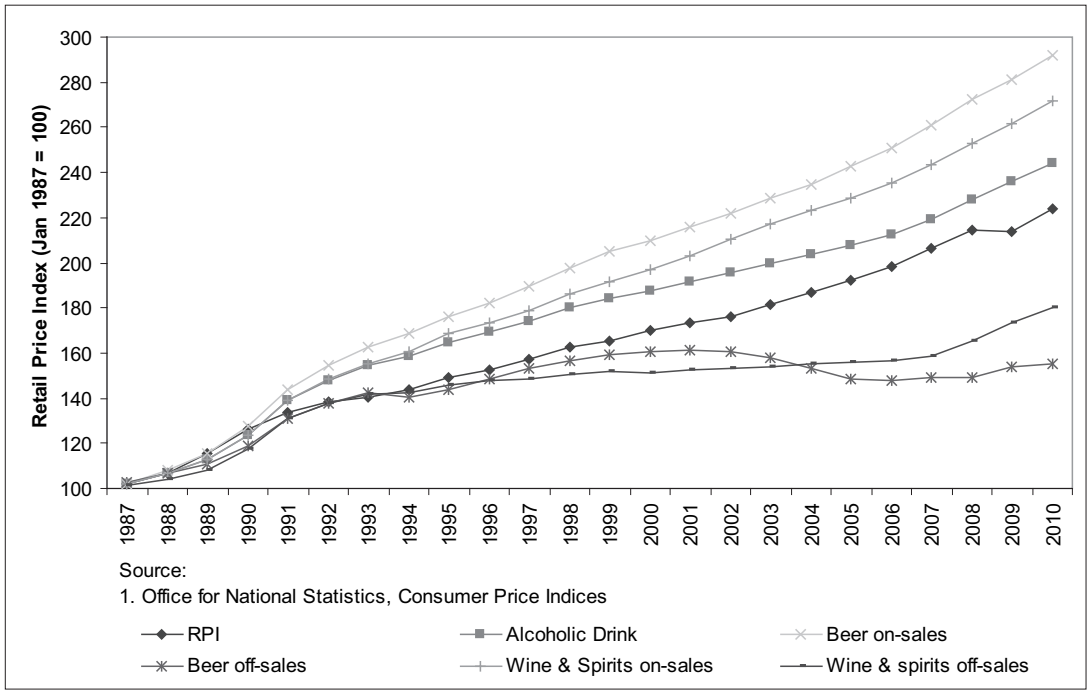
55. Since 2000, off-trade sales (eg. supermarkets, off-licences) of alcohol have come to be dominant over on-trade sales (eg. pubs, clubs). By 2009, the off-trade share had advanced to 65%.[90]

Year *1.*	*Litres per head of 100% alcohol consumed* *2. On Trade*	*Litres per head of 100% alcohol consumed* *3. Off Trade*	*Litres per head of 100% alcohol consumed* *4. Total Trade*
2000	3.9	4.5	8.4
2001	3.9	4.8	8.7
2002	4.0	5.1	9.1
2003	3.9	5.3	9.2
2004	3.7	5.8	9.5
2005	3.5	5.8	9.4
2006	3.4	5.7	9.0
2007	3.2	6.0	9.2
2008	3.0	6.0	8.9
2009	2.9	5.5	8.4

56. The off-trade's dominance of alcohol sales is the culmination of a long term trend to liberalise alcohol retailing. For example, in 1978 only one third of supermarkets had a licence to sell alcohol.[91] Until the Licensing Act 2003 came into force (in late 2005), there were effective quantity limits on individual purchases from the off-trade—no more than 12 bottles of wine, for example.

57. The price of off-trade alcohol has fallen in real terms and this is probably a major factor in the off-trade's increasing market share. Off-trade prices of wine and beer were broadly stable in cash terms and so well below Retail Price Inflation (RPI) from 1998 to 2006. On-trade prices have risen faster than RPI.

PRICE TRENDS IN THE ON-TRADE AND OFF-TRADE



58. The following table suggests that a higher proportion of moderate drinkers than excessive drinkers choose to drink in the on-trade, but that young adult binge drinkers and many under 18s (many of whom will be 16–17 year olds) have tended to choose the on-trade as a preferred venue for drinking. This would tend to support the Government's policies set out in our Strategy for tougher penalties and better enforcement on under-age sales of alcohol and to restrict the availability of cheap alcohol, particularly in the off-trade.

[90] BBPA Statistical Handbook, 2010.

[91] Central Policy Review Staff report on alcohol, 1979.

DRINKING PATTERNS IN THE ON- AND OFF-TRADES (2007)[92]

	Average units per drinker per week	*% consumption in the on-trade*	*% consumption in the off-trade*
11–17 year old drinkers	12.5	77%	23%
18–24 year old binge drinkers	27.2	64%	36%
Age 25+ moderate drinkers	5.8	45%	55%
Age 25+ increasing risk drinkers	27.4	36%	64%
Age 25+ higher risk drinkers	69.9	32%	68%
Average for all drinkers	15.8	37%	63%

Promotional offers on alcohol

59. It is well established that people like offers and buy more when products are on offer, there is lots of evidence that when there are volume offers people buy more. The influence of multiple unit price promotions (volume offers) on sales was first evidenced by a field study by Blattberg and Neslin (1990).[93]

60. The decision about whether to consume the additional alcohol requires a trade-off between the pleasure derived from consumption today with the possible health harm in the future as a result of drinking too much today. Empirical studies have shown that the standard economic assumption that people will have the same preferences in the future as they have today, that is they will be able to balance today's enjoyment with their desire for a healthy future, is incorrect and in fact people tend to overvalue the pleasure derived from consumption today.[94]

61. It is not unreasonable to expect that when people buy a bigger portion (because alcohol is on a volume based discount) they will tend to consume more. This is confirmed by research in other product areas such as food[95] and would be consistent with clear findings on the effects of discounted alcohol promotions on increased drinking,[96] as many such promotions are volume-based promotions.

Trends in alcohol-related harm

62. Over the last 10 years, health harms have continued to grow. Alcohol-attributable deaths in England rose by 7%, from 14,406 in 2001 to 15,479 in 2010. Over the same period, alcohol-specific deaths, ie from conditions wholly caused by alcohol, rose by 30%. In contrast, total deaths in England fell by 7%.[97] The rate of liver deaths in the UK has nearly quadrupled over 40 years, a very different trend from most other European countries. Chronic liver disease can be driven by factors other than alcohol, notably obesity, although alcohol remains the main driver in the UK.

63. The rate of alcohol-related hospital admissions has also continued to rise by an average of 4% each year over the eight years 2002–03 to 2010–11. (Alcohol-related admissions are defined in the Public Health Outcomes Framework by reference to admissions where the primary diagnostic code is for an alcohol-related condition.)

[92] Independent /review of the Effects of Alcohol Pricing and Promotion, University of Sheffield, 2008, from Table 28.

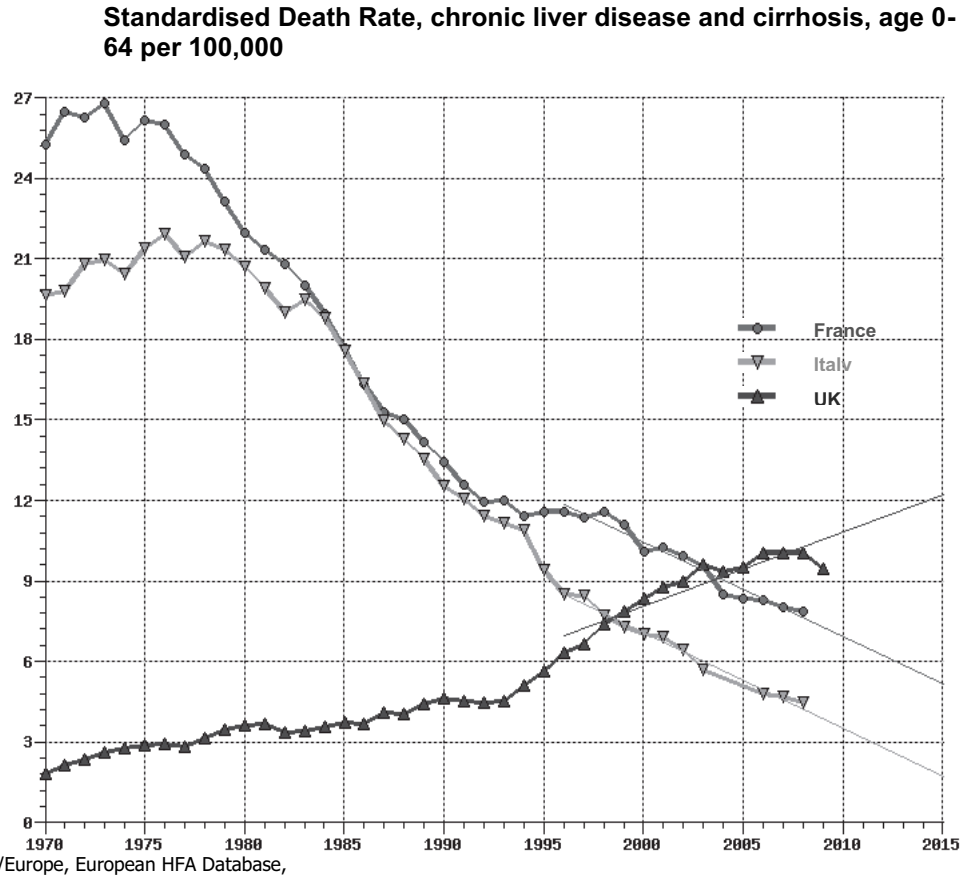
[93] Blattberg, R C & Neslin, S A (1990). *Sales Promotion: Concepts, Methods, and Strategies*. Englewood Cliffs, NJ: Prentice-Hall, Inc.

[94] See for example: Loewenstein, G (1987). Anticipation on the valuation of delayed consumption. *Economic Journal, 87,* 666–84.

[95] Just, D R (2006), Behavioral Economics, Food Assistance, and Obesity *Agricultural and Resource Economics Review* 35/2 (October 2006) 209–220.

[96] Independent Review of the Effects of Alcohol Pricing and Promotion, Part B, University of Sheffield, 2008.

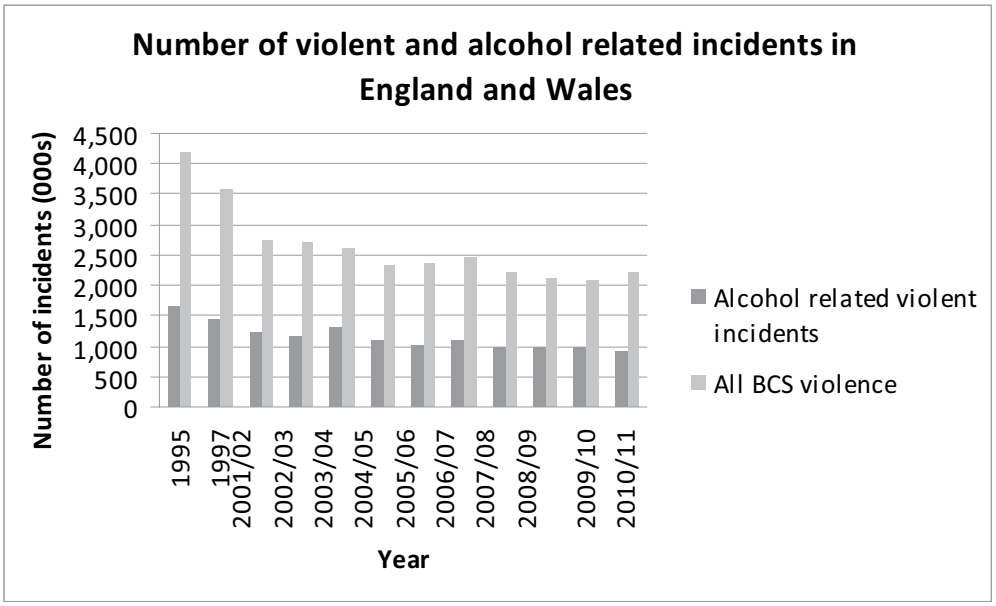
[97] Jones L, Bellis M A, Dedman D, Sumnall H, Tocque K. 2008. Alcohol-attributable fractions for England. Alcohol-attributable mortality and hospital admissions. North West Public Health Observatory, Centre for Public Health, Liverpool John Moores University. ISBN: 978–1-906591–34–2.



Source: WHO/Europe, European HFA Database, January 2012

64. There have been significant decreases since 1995 in the number of violent incidents believed by victims to involve offender(s) under the influence of alcohol. This is in the context of the overall fall in the number of violent crimes in which the proportion of alcohol-related incidents has remained similar over this period—41% in 1995 and 44% in 2010/11.[98]

ALCOHOL-RELATED VIOLENT CRIME IN ENGLAND AND WALES



Source: Adapted from British Crime Survey 2010–11[99]

[98] Chaplin R, Flatley J and Smith K (2011): Crime in England and Wales 2010–11. *Home Office Statistical Bulletin 10/11,* Home Office, London.

[99] Chaplin R, Flatley J and Smith K (2011): Crime in England and Wales 2010–11. *Home Office Statistical Bulletin 10/11,* Home Office, London.

Drink driving

65. Drink driving remains a significant cause of death and injury, even though drink drive casualties fell by more than 75% between 1979 and 2009. Deaths in Great Britain fell from 560 in 2006 to 380 in 2009.

66. Alcohol-related deaths are the third highest cause of deaths among under 25s, with drink drive deaths nearly half of these.

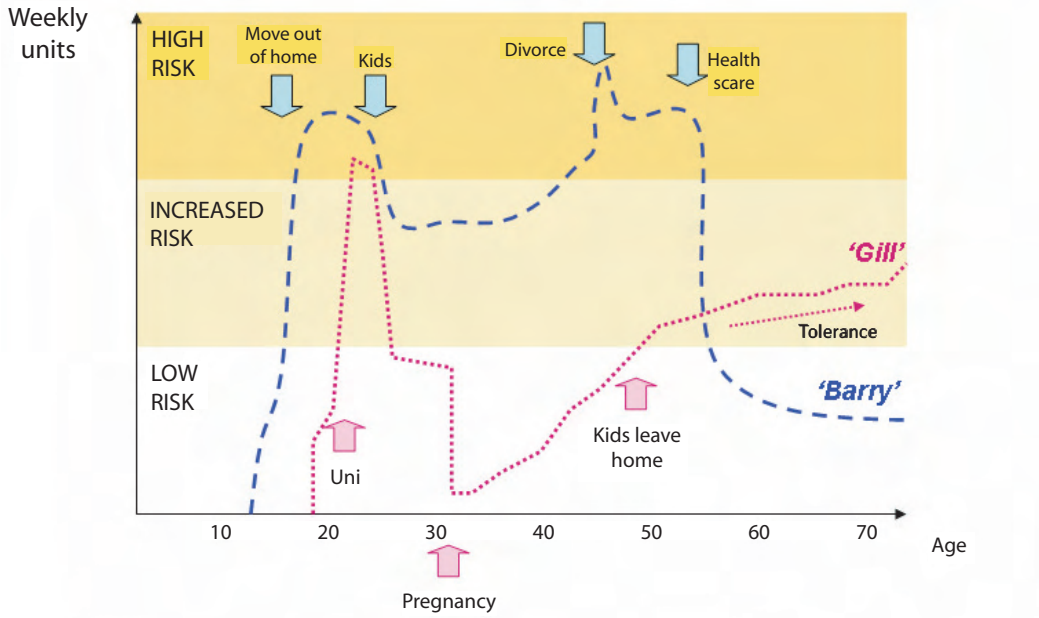
Policy Interventions

What kinds of interventions work to change drinking behaviour—and for whom?

67. Research shows that, typically, drinking patterns evolve as individuals grow and move through life, in response to changing social groups, partners, family, or work pressures. Life events such as becoming a parent, divorce, bereavement, or a health scare, may influence drinking—the same life events may trigger more drinking in one person, less in another.

68. Many people who drink heavily later cut down, without consciously being motivated—for example, they may feel they "have to" for work reasons, or feel less desire to drink with family responsibilities. In one study, only one third of a high risk cohort maintained higher risk drinking levels for as long as 8 years.[100]

MANY PEOPLE DIP IN AND OUT OF DIFFERENT DRINKING PATTERNS THROUGHOUT THEIR LIFETIME IN RESPONSE TO LIFE EVENTS[101]



69. Cutting down drinking with no direct intervention is most common among former binge drinkers,[102] particularly in early adulthood.[103] It is less common among those who are living alone, unemployed, or unavailable for work.[104]

70. Key points are:

- "At risk" drinkers are not a static group. Many will dip in and out of risky drinking patterns throughout their lifetime.
- Anyone drinking to excess may be at risk over time—at risk of health harm or at risk of dependence on alcohol. It is not currently possible to predict an individual who is most at risk.
- Changing behaviour across a lifetime indicates broad reaching interventions, sustained over the long-term.[105]
- There are some key stages in the lifecourse:
  - young people drinking too early and too much increase their risks of drinking problems and dependence later in life; and

[100] Birmingham Untreated Heavy Drinkers study.
[101] Source: COI, created from Birmingham Untreated Heavy Drinkers study, wave 5 (2007) *please note, typical example, does not reflect specific individuals.*
[102] Know Your Limits campaign tracking data, 2008: Females aged 25–40 claimed most success.
[103] Jefferis *et al* (2005): Adolescent drinking level and adult binge drinking in a national birth cohort. *Addiction*, 100: 543–9.
[104] Birmingham Untreated Heavy Drinkers study.
[105] Babor T *et al* Alcohol: no ordinary commodity. Research and public policy. Oxford University Press, 2003 provides broad ranging discussion of evidence on harm from alcohol and effective policy interventions.

— young adults who drink heavily are also at particular risk of alcohol dependence, which may increase in severity and later become entrenched for a minority.

— Yet, because many people change drinking patterns throughout their lifetime, all stages of life including adulthood and old age matter; typically, chronic diseases from long term heavy drinking will be incurred in middle age, resulting in early death.

Price Interventions

71. The strongest evidence for reducing population consumption is through increasing the price of alcohol.

72. A large body of evidence from extensive research on alcohol price also confirms that lower alcohol prices, or increasing affordability of alcohol, increase both consumption and harm.[106] Lower prices or increasing affordability over a period of time may be likely, therefore, to reduce the impact of other interventions. While raising price is effective for reducing a population's consumption, the evidence shows that this is no less effective for regular heavy drinkers and is particularly effective for young drinkers under 18.[107]

73. The aim of minimum unit pricing is to end the sale of very cheap alcohol, drunk disproportionately by the heaviest drinkers. There is substantial evidence (IFS, Sheffield University study and other academic reviews) to suggest that cheap alcohol is targeted by those who consume the most alcohol overall and by under 18s who drink alcohol. The expected impact of minimum unit pricing is borne out by experience in Canadian provinces that have implemented a similar policy: social reference pricing.[108] There is a correlation between Canadian provinces that have introduced social reference pricing and those that have experienced a sustained reduction in violent crime.

Limiting Availability

74. Limiting availability is also well evidenced to reduce harm. Limiting availability through:

— Reduced premises density.

— Enforcing refusal to serve customers when drunk.

— Restricting late night trading.

— Enforcing the law on age of purchase.

is most effective in reducing binge drinking and alcohol-related crime[109] and drinking by young people.[110]

Brief Interventions

75. Brief intervention (IBA) by health care workers is well evidenced and a cost-effective route to reduce consumption and harm among at risk drinkers.

76. A short interview with a trained health care professional at a "teachable moment", such as a time of concern about the individual's health, or after an accident, can change both attitudes and drinking behaviour.

77. This is effective for at risk drinkers, for those drinking above NHS guidelines. Dependent drinkers will usually need specialist treatment.

78. At least one in eight at risk drinkers reduce their drinking and experience improved health as a result—an even better outcome than for smoking cessation services.

79. Initial summary findings (March 2012) from the Alcohol Screening and Brief Intervention Research (SIPS) project may be found at: http://www.sips.iop.kcl.ac.uk/. These cover primary care, hospital emergency departments, and probation. Later summaries are expected to report on impacts on health and re-offending.

80. Brief interventions were not found to be effective in a pilot scheme aiming to reduce offending in those individuals arrested for an alcohol-related offence.[111]

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[106] *Independent Review of the Effects of Alcohol Pricing and Promotion, Part A: Systematic Reviews*, University of Sheffield, 2008.

[107] *Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol-attributable harm in England using the Sheffield Alcohol Policy Model version 2.0,* Report to the NICE Public Health Programme Development Group, 2009; *Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People,* University of Sheffield review for the NICE Public Health Programme Development Group, 2009.

[108] Does minimum pricing reduce consumption? The experience of a Canadian province. Addiction (February 2012). T Stockwell *et al*.

[109] *Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People,* University of Sheffield review for the NICE Public Health Programme Development Group, 2009.

[110] Anderson P, Baumberg B. Alcohol in Europe: a public health perspective: report to the European Commission, Institute of Alcohol Studies, 2006.

[111] Blakeborough L and Richardson A (2012): Summary of findings from two evaluations of Home Office Arrest Referral pilot schemes, *Home Office Research Report 60*, Home Office, London.

Specialist Treatment and Support

81. Specialist treatment and support is effective in treating severe alcohol dependence, but is usually accessed only in response to harm being experienced.

82. Alcohol dependence is a long-term condition, which may involve recurring relapses even after good quality treatment. Sufferers typically also experience multiple health problems and are heavy users of health services. Treating alcohol dependence, where successful, has been shown to prevent future illnesses and reduce health service use.

83. The Royal College of Physicians have long advocated the appointment of dedicated Alcohol Liaison Nurses in major acute hospitals to provide an in-reach service including staff training; advice on management of alcohol withdrawal and referral to specialist alcohol services in the community.[112, 113] Over an 18-month period, an Alcohol Liaison Nurse service in the Royal Liverpool Hospital had prevented about 15 admissions or re-admissions per month.

84. The UK Alcohol Treatment Trial (UKATT) found that £1 invested in treatment would save £5 in future costs across the public sector.[114] These include reduced costs of health care and in the criminal justice system. 25% of patients involved in the UKATT study had a successful outcome, reporting no continuing alcohol-related problems and 40% of patients reported being much improved, reducing their alcohol problems by two thirds.[115]

85. NICE has reviewed the clinical evidence and cost-effectiveness information and released guidance on alcohol dependence and harmful alcohol use http://www.nice.org.uk/guidance/CG115. This guidance outlines the need to provide a comprehensive package of treatment for dependent drinkers that include assessment and engagement; care co-ordination; withdrawal management; psychosocial interventions; pharmacotherapy; and recovery services.

86. The High Impact Changes promoted by DH advocate the increase in treatment and support for dependent drinkers.[116]

Education and Information

87. Evidence for changing drinking behaviour through education or information alone is limited. But information can change attitudes and reinforce motivation among some groups.

88. A review of international evidence has shown limited evidence for mass media campaigns changing drinking behaviour, but some evidence that they can change attitudes.[117]

89. The evidence from research commissioned by the Department of Health is that the impact of communicating health risks is greater for less entrenched drinkers and those more motivated by long term health, such as people aged 35–54, those in ABC1 social groups, and many women. Younger adults tend not to see long term health risks as compelling.[118]

90. Research for previous Department of Health and Home Office campaigns suggests that most heavy drinkers in particular are not motivated to change their drinking behaviour by information alone. For them to change drinking behaviour consciously would require, inter alia:

- A change in the balance of risks and consequences against the perceived benefits and enjoyment from their drinking.
- Willingness to take personal responsibility and self-belief in the ability to change—even after cutting down as part of our research, many heavy drinkers did not believe they would sustain this.
- A positive social and physical environment, a supportive network of friends or family and limited drinking triggers or temptations.

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[112] *Alcohol—can the NHS afford it?* London: Royal college of Physicians, (2001).

[113] Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care (arms.evidence.nhs.uk/resources/qipp/29420/attachment).

[114] UKATT Research Team (2005b). cost-effectiveness of treatment for alcohol problems: Findings of the UK alcohol Treatment Trial. British Medical Journal, 331, 544–547.

[115] UKATT Research Team (2005a). Effectiveness of treatment for alcohol problems: Findings of the randomised UK alcohol Treatment Trial (UKaTT). British Medical Journal, 311, 541–544.

[116] Signs for improvement—commissioning interventions to reduce alcohol-related harm (2009). Department of Health. London.

[117] Edcoms (2005): Review of the evidence base around effective alcohol harm reduction, prepared for COI on behalf of DH and Home Office; BMA Board of Science (2008): Alcohol Misuse: Tackling the UK Epidemic.

[118] 2CV (2008) Insight and action to help reduce levels of hazardous and harmful drinking, Qualitative research debrief.

Supplementary written evidence from the Department of Health (GAS 01A)

I promised to send you further information to assist in your Inquiry into the Government Alcohol Strategy.

Your Committee asked about the collection of the data on prescription items dispensed to treat people for alcohol dependency.

This is available through the Health and Social Care Information Centre at general practice level: http://www.ic.nhs.uk/services/transparency/prescribing-by-gp-practice.

Information at Primary Care Trust level is also available on request from the Health and Social Care Information Centre. Other alcohol-related heath data is available at a PCT and local authority level in the NWPHO Local Alcohol Profiles (http://www.lape.org.uk).

We also discussed the impact of a minimum unit price (MUP) for alcohol, including the figures for a 50p MUP.

The Committee will have seen the impacts for a range of prices in the report by Sheffield University (the ScHARR model—http://guidance.nice.org.uk/PHG/21/EconomicModellingReport/pdf/English)

The impacts of pricing polices are set out in section 3.2 and summarised in the tables on pages 110 and 111.

The Government is updating the analysis for a number of minimum unit price levels, which will be published in the impact assessment for the consultation on the level of minimum unit pricing later this year.

Anne Milton MP

19 June 2012

Written evidence from the British Beer & Pub Association (GAS 07)

The BBPA is the leading trade association for the brewing and pub sector. Our members represent around 95% of all beer brewed in the UK, and own over half the country's pubs.

Introduction

1. Alcohol consumption and most measures of problem drinking have been in decline over the last five or six years.

2. Health outcomes have not responded to changes in consumption, questioning the effectiveness of population-level policy interventions.

3. Government policy should focus on tackling alcohol-related harm, rather than aiming to reduce total alcohol consumption.

4. The brewing and pub sectors take responsibility extremely seriously.

5. Brewers and pub owners have fully engaged with the Public Health Responsibility Deal (PHRD), leading to tangible and immediate benefits for consumers.

6. Brewers and pub owners have demonstrated leadership in many areas, in particular alcohol labelling, innovation in lower-strength products and reducing product strengths, supporting consumer information campaigns and providing unit information in pubs.

7. Our members have differing views on minimum pricing. The evidence to suggest that minimum pricing will improve public health or reduce binge drinking is inconclusive at best.

8. The marketing of alcohol in the UK is covered by a very strong self-regulatory system, and further regulation in this area would not be a necessary or proportionate response.

9. Voluntary measures, with Government and industry working together, have proved successful and should be continued and enhanced.

10. The brewing and pub industries contribute significantly to the UK economy, adding nearly £20 billion to the UK economy. The sector contributes over £11 billion in taxation to the Treasury and support almost one million jobs.[119]

11. The sector employs 1 in 12 of all working, young adults.

Alcohol Consumption and Harm in the UK

12. Based on HMRC alcohol "clearances", consumption per capita has fallen by 13% since 2004. Alcohol consumption in the UK is currently just below the European average, with Britons drinking less than the French, Germans and Spanish, amongst others.[120]

[119] Oxford Economics, Local impact of the beer and pub sector.
[120] HM Revenue & Customs & BBPA.

13. However, many commentators observe that the pattern of alcohol consumption is key to addressing alcohol-related harm. The trends in those consuming more than double the recommended "regular" daily intake[121] have been downwards for a number of years. Since 2005, the proportion of men drinking more than eight units on their heaviest drinking day in a week fell from 23% to 19% in 2010. The percentage of women drinking more than six units on their heaviest drinking day was 15% in 2005 and 13% in 2010.[122]

14. Drinking at "harmful" levels has also fallen significantly. The proportion of men drinking more than 50 units a week fell from 9% in 2005 to 6% in 2010. For women the proportion drinking more than 35 units a week has fallen from 5% in 2005 to 3% in 2010.[123]

15. The decline in 16 to 24 year olds consuming double the daily guidelines within the last week has been even more significant. Since 2005, for young men this has fallen from 32 to 24% and for young women from 27 to 17%.[124]

16. The proportion of young people (11 to 15 year olds) who have tried alcohol has fallen from 59% in 2004, to 45 in 2010 (England only).[125]

17. The review in the methodology for has reduced the headline figure quoted for alcohol-related admissions. The primary diagnosis method shows that the number of hospital admissions attributed to alcohol consumption increased faster than total admissions between 2002–03 and 2005–06 (23% vs 11%), but has increased at a slower rate in the last four years (12% vs 15%) (England only). Alcohol-related admissions make up just over one% of all hospital admissions.[126]

18. The primary diagnosis method is a more realistic way to measure alcohol-related admissions.

19. Alcohol-related violent crime has fallen by 40% since 1995, and by 11% since 2004–05.[127]

Responsibility for Alcohol Policy Across Government(s)

20. There is little co-ordinated policy for beer and pubs across Government departments. Beer is predominantly brewed from UK-produced agricultural produce and therefore responsible to DEFRA. Pubs are a central part of the country's tourism offering and responsible to DCMS, whilst licensing is the responsibility of the Home Office. The Department of Health clearly has a major role to play in alcohol policy, particularly as the service provider for those who suffer from alcohol-related harm. More support for the industry from BIS would be welcome.

21. The BBPA respects the democratic and legal rights of the devolved Parliaments to implement policies that suit the needs of their populations. We therefore appreciate that in certain circumstances policies will vary across jurisdictions. However, where possible, policy should be consistent, particularly around product labelling.

The Role of the Alcohol Industry in Addressing Alcohol-Related Health Problems

22. BBPA believes the industry has a key role in addressing alcohol-related harms. Our members have an inherent interest in the responsible consumption of their products and believe that beer is there to be enjoyed and pubs are the home of sociable and responsible drinking. Industry expertise can be harnessed, as is being demonstrated through the PHRD and campaigns such as "Why Let The Good Times Go Bad?" to ensure the right consumer reach to raise awareness, encourage a responsible attitude to alcohol and provide the information to make informed decisions.

23. The brewing and pub industry has been fully engaged in the Department of Health's PHRD throughout. The largest members of the Association have signed up to all relevant pledges.

24. Approximately 90% of packaged beer now produced carries the core alcohol messaging.[128] Pubs display unit awareness literature in premises, on websites and through social media. These are examples of voluntary agreements which are implemented quickly and are far more effective than legislation.

25. The brewing industry has embraced the opportunity offered by the Treasury's decision to cut excise duty on beers of 2.8% abv or below. In excess of 20 new brands have been brought to market, supported by significant innovation and investment in marketing. The industry believes this threshold could be increased to 3.5% abv through negotiation with the European Union.

26. Brewers and pub owners have also invested significant resources into Drinkaware as part of a programme to "increase awareness and understanding of the role of alcohol in society, encouraging individuals to make

[121] Sometimes used as a proxy for "binge drinking".
[122] ONS, General Lifestyle Survey 2010, Table 2.4.
[123] *Ibid*, Table 2.2.
[124] *Ibid*, Table 2.4.
[125] Smoking, Drinking and Drug Use Among Young People in England, Table 3.1.
[126] NHS Information Centre, Statistics on Alcohol, England, 2011, Table 4.5.
[127] Home Office, Crime in England & Wales, 2009–10, Table 3.20.
[128] Unit content, Chief Medical Officers' daily drinking guidelines and drinking while pregnant advice.

informed choices about their drinking." BBPA members contribute over £2 million per year to Drinkaware and significantly more through in-kind contributions.

27. BBPA's biggest producer members are also members of the Portman Group, which has played a leading role in developing industry self-regulation. Their Code of Practice places restrictions on the marketing of alcohol products, and provides an advisory service. The Portman Group was also one of the first organisations to recognise the need for self-regulation through digital media and introduced comprehensive digital marketing guidelines in 2009. They have been regulating online marketing in the UK since 2003.

28. This combines with the Advertising Standards Authority rules on paid-for advertising. This regime is regarded as one of the strictest anywhere in the world.

The Evidence Base For, and Economic Impact Of, Introducing a Fixed Price Per Unit of Alcohol of 40p

29. The BBPA's membership has a range of views on the subject of minimum pricing.

30. Whilst there is clearly a relationship between alcohol pricing and alcohol consumption, evidence of a link between pricing and harmful consumption is less well established. Are the heaviest drinkers affected by increased prices? The Sheffield study, in line with most international evidence, found that the heaviest drinkers are least responsive to changes in price.[129]

31. The BBPA believes that it is important that alcohol should be retailed in a manner that is socially responsible and supports a ban on below-cost selling. BBPA supports measures targeted to help those who misuse alcohol, alongside education, awareness, and a tax system that encourages consumers towards lower-strength drinks like beer. Whilst minimum pricing might cut the differential between the price of beer in a supermarket or pub, it must not be seen as the answer to pub closures which are clearly down to high taxation. Minimum pricing is, by definition, a blunt tool and clearly the higher the minimum price the greater the impact on the vast majority who enjoy alcohol responsibly; particularly those on the lowest incomes.

32. Minimum pricing may be a breach of European competition law. BBPA has a real concern that a minimum price would ultimately be achieved through, or result in, higher beer taxation. Beer taxation would have to rise by 80% to achieve the same effect as minimum pricing, damaging both brewers and community pubs, costing tens of thousands of jobs. UK consumers already endure the second highest beer tax rate in Europe, paying 40% of the total tax bill, with a rate that is an astonishing 11 times higher than in the largest beer market, Germany.

33. The key piece of research, from Sheffield University (ScHARR),[130] on which the policy of minimum pricing is based is inconclusive on the impact it would have on alcohol-related harm. For example, the latest research suggests that harmful drinkers consume over 70 units per week on average, which will be reduced by less than 3 units per week[131] (based on a 45p minimum price).

34. The reduction in health harms claimed in the ScHARR research at 40 pence per unit is based on reductions in consumption. For example, ScHARR suggests a minimum price would lead to a 2.4% fall in consumption in alcohol, and therefore 7,481 fewer alcohol admissions in the first year. Alcohol consumption actually fell by more than double that amount (–6.1%), but alcohol-related hospital admissions increased by 9,000 in 2009.[132]

35. The level of the minimum unit price will be consulted upon and as well as considering the proportionality and effectiveness, Government needs to consider any unintended consequences.

36. If minimum unit pricing is to be introduced, the Government needs to ensure that it is implemented in a fair and reasonable method, minimising the impact on pubs.

The Effects of Marketing on Alcohol Consumption, in Particular in Relation to Children and Young People

37. The UK has some of the tightest restrictions on the marketing of alcohol in the world, particularly designed to avoid exposing children and young people to alcohol advertising. The large decline in youth consumption over the period that self-regulation has been in place serves as proof that alcohol advertising is not encouraging children to consume alcohol.

38. Research into the link between advertising and alcohol consumption remains inconclusive, and many studies have found no correlation. For example, a study by Gerard Hastings at the University of Stirling found no association between awareness of alcohol marketing at age 13 and either the onset of drinking, or the volume of alcohol consumed two years later.

[129] University of Sheffield, Modelling alcohol pricing and promotion effects on consumption and harm, p 51.
[130] From the School of Health and Related Research (ScHARR).
[131] http://www.sheffield.ac.uk/polopoly_fs/1.150021!/file/scotlandupdatejan2012.pdf
[132] http://www.nice.org.uk/guidance/index.jsp?action=download&o=45668

39. Research has consistently shown that the key influence on consumption by young people is parents and peers. Young people (11 to 15 year olds) are more than twice as likely to have tried alcohol if one or more of the people they live with consume alcohol.[133]

40. Alcohol advertising bans are in place in France and Norway. Neither appears to have been successful in reducing alcohol-related harm. A review of the French ban, conducted by Dr. Alain Rigaud, President of the French National Association for the Prevention of Addiction and Alcoholism concluded that "no effect on alcohol consumption could be established" from it. In Norway, alcohol consumption increased by nearly 30% in a decade after the ban was introduced.

The Impact that Current Levels of Alcohol Consumption will have on the Public's Health in the Longer Term

41. Most indicators of harmful consumption are in decline. Furthermore total consumption in the UK remains at or below the levels of our European neighbours.

42. There is also no direct correlation between per capita alcohol consumption and levels of alcohol-related harm across Europe. There are clearly other factors at play, such as patterns of consumption, income levels and wider socio-economic factors, dietary habits, prevalence of smoking, culture, etc.

43. The WHO points out that "the relatively small proportion of deaths in western European countries, in spite of the high level of alcohol consumption in these countries, can be explained by the drinking patterns, the age structure, and the beneficial impact of low-risk drinking in these countries".[134]

44. There is a need to understand that total population consumption does not necessarily correlate with total population harm.

45. In the UK in recent decades there has been a growth in sales of stronger drinks. Whilst all drinks can be abused, we firmly believe that Government policy should be encouraging the consumption of lower-strength beverages. The ability to become intoxicated quickly and to dangerous levels from drinking average-strength beers is constrained by volume and capacity. This is recognised by the WHO Global Alcohol Strategy.[135]

Public Health Interventions such as Education and Information

46. Education and information campaigns in the UK, and in other countries, have led to a much greater knowledge amongst consumers. In the UK, the proportion of people who are aware of measuring alcohol consumption in units has increased from 75% in 1998 to 90% in 2009 as a result of education campaigns. This is much higher amongst regular drinkers.[136]

Reducing the Strength of Alcoholic Beverages

47. The international evidence for the impact of this policy is limited. However this is a policy approved by the WHO in their Global Alcohol Strategy. The pledge under the PHRD to remove one billion units through the reduction of alcohol strengths and promoting lower-strength alternatives was (as far as we are aware) a world first. Other nations, particularly Spain and Australia, have seen considerable growth in their lower-alcohol beer categories when given the appropriate level of support from Government and industry. This market is still constrained by barriers to advertising lower-strength beers. Of course, beer is already relatively lower in strength than other alcohol products, and should therefore be supported by Government policy.

Raising the Legal Drinking Age

48. The age at which individuals are allowed to purchase alcohol in the UK is 18.[137] This is broadly consistent with the rest of Europe, and much of the world. Indeed, many countries have a lower legal age of purchase. The BBPA is unaware of any evidence that suggests increasing the legal purchasing age would be a proportionate or effective measure.

Plain Packaging and Marketing Bans

49. There is very little international evidence on the effectiveness of plain packaging on alcohol products, with no examples of this being implemented in any other country. As packaging of alcohol products is unlikely to be a key determinant as to whether, and how much, alcohol is consumed, we do not believe this should be considered as a realistic policy option. This would also be completely disproportionate for alcohol which, unlike tobacco, has potential health benefits when consumed in moderation.

May 2012

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[133] Smoking, Drinking and Drug Use among Young People, 2010.
[134] WHO Global Alcohol Report.
[135] http://www.who.int/substance_abuse/activities/gsrhua/en/
[136] NHS Information Centre, Statistics on Alcohol: England, 2011, Table 3.1.
[137] With the exception of having alcohol bought for you as an accompaniment to food, in the presence of an adult, where the legal age is 16 for the purchase of beer and wine.

Written evidence from Drinkaware (GAS 16)

1. About Drinkaware

1.1 Drinkaware provides consumers with information to make informed decisions about the effects of alcohol on their lives and lifestyles. Our public education programmes, grants, expert information, and resources help create awareness and effect positive change. An independent charity established in 2007, Drinkaware works alongside the medical profession, the alcohol industry and government to achieve its goals.

1.2 Drinkaware is entirely funded by voluntary donations from across the drinks industry, but operates completely independently from it. Our board is made up of five members of the health community, five members of the drinks industry and three independents. This structure enables the organisation to act independently whilst being fully funded through voluntary donations from industry.

1.3 Our behaviour change campaigns are designed using an evidence-based approach. Drinkaware provides consumers with best evidenced information and facts about alcohol. Our independent medical advisory panel checks all information, web, and printed materials to ensure their accuracy and that it reflects the most current evidence.

1.4 We promote responsible drinking and find innovative ways to challenge the national drinking culture to help reduce alcohol misuse and minimise alcohol-related harm. One example is our five-year £100 million "Why let good times go bad?" campaign which is already delivering measurable results.[138]

1.5 Drinkaware was established following a Memorandum of Understanding between the Portman Group, the Department of Health, the Home Office, Scottish Executive, Welsh Assembly Government and Northern Ireland Office. This enabled the Portman Group's former campaigning arm—called the Drinkaware Trust—to be transformed into an independent charity in 2007.

1.6 We provide accessible, free-of-charge, evidence-based information about alcohol and its effects on employers, young people, teachers, parents and community workers. Using a range of media, such as interactive educational resources, film, social media, multimedia and outdoor advertising, we help dispel myths and present the best evidenced facts about alcohol.

1.7 Our campaigns focus on specific demographics as our evidence suggests that this targeted approach yields results.

2. Declaration of Interest

2.1 Drinkaware welcomes the opportunity to submit evidence to this inquiry. As the leading source of alcohol information for consumers in the UK, with more than 320,000 unique visitors coming to its website every month, Drinkaware is one of the primary resources consumers turn to for evidence-based advice.

2.2 Our brand is displayed on at least 5 billion drinks containers every year and independent research shows that 44% of consumers questioned believe that the Drinkaware logo is a prompt to consume alcoholic drinks responsibly.[139]

2.3 This submission, following the publication of the Government's Alcohol Strategy, responds to a number of the Committee's key terms of reference. It provides a detailed response to subject areas where Drinkaware is able to supply clear evidence and where it does not conflict with our Memorandum of Understanding which precludes us from commenting directly on policy matters.

3. Summary of our Views

3.1 Our views can be summarised as follows:

- Evidence suggests that the Alcohol Strategy's emphasis on a "long-term and sustained action by local agencies, industry, communities and Government" is appropriate.
- The strategy makes positive reference to two of our current programmes. The first is a campaign to make information more easily available to 18–24 year olds, entitled "Why let good times go bad?" and the second is the research project we are facilitating in Wales on the use of "social norms".
- Whilst irresponsible and harmful drinking amongst young people remains problematic, levels of this activity have declined and it is important that young people know that the majority (55%) of 11–15 year olds have never drunk alcohol; a percentage that has increased in recent years.[140]
- Alcohol misuse among young adults remains an issue which needs to be tackled, but evidence suggests that we should not overlook other at-risk drinkers.

[138] For information on research and campaigns visit http://www.drinkaware.co.uk

[139] Base: All those who have definitely/probably seen the logo in the last nine months (417 Jul 11) among 1,000 adults 16+, Britain. Source: Charity Awareness Monitor, Jul 11, nfpSynergy.

[140] NHS Information Centre, Smoking, drinking and drug use among young people in England in 2009, 2010. P 10.

— Tackling alcohol misuse among under-18s is a key area for Drinkaware. Parents are the biggest influence on their child's attitudes to drinking. Drinkaware research[141] highlights that 72% of the 10–17 year olds questioned say their parents are the first people they would approach with questions about alcohol, yet half (50%) of those who have had a drink report it was their parents who supplied them with the alcohol the last time they drank.[142]

— Drinkaware's Parents' campaign[143] seeks to give parents support and age appropriate advice on how to talk to their children about alcohol in the pre-teen years. It encourages parents to delay the age of their first drink to the UK Chief Medical Officers' guidance of 15 years old.[144]

— Educational public health interventions based on acquiring "life-skills" have a strong evidence base for reducing alcohol misuse among under-18s. Drinkaware has begun to roll out a life-skills based programme called In:tuition in UK schools.

— Another of Drinkaware's target groups is middle class working professionals (aged 25–44) who drink regularly (at least once a week). The proportion of this group who drink regularly is considerably higher than for the 18–24s age group (67% vs 47%).[145] evidence which was confirmed by recent ONS statistics.[146]

— In response to this problem, Drinkaware launched a drinks tracker in May 2011 called MyDrinkaware. The new tool is an easy-to-use multi-faceted tool, which supports people in their efforts to moderate their drinking and engages with wider lifestyle issues. It combines a drink diary, budget manager and diet programme into one online and mobile tool and delivers personalised feedback on the risk levels associated with a person's alcohol consumption.

— Evidence suggests that changing attitudes towards drinking is critical to reducing alcohol misuse in the UK. Drinkaware believes that, while it is highly valuable to provide information to consumers on the consequences of excessive drinking, this action should be balanced by simultaneously taking action to address the underlying foundations of popular attitudes towards alcohol.

4. Question 1: *Who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and to what extent should the Department of Health take a leading role?*

4.1 Drinkaware's Memorandum does not permit the organisation to comment on policy, this includes the extent to which individual Government departments take a leading role on alcohol policy. However, as a charity with a national perspective, we have evidence to suggest that the Alcohol Strategy is correct to highlight the importance of effective partnership working at both the local and national level.

4.2 Drinkaware has worked with the UK Government in communicating unit guidelines. This work has included coordinating campaigns and messages to reflect Government advice as well as practical partnerships including mail drops of a "unit and calorie calculator" to more than 2.3 million households in support of the Change4Life January 2011 campaign activity.

4.3 Drinkaware engages with all major departments involved in alcohol policy implementation to ensure that we are communicating the best evidenced information once it has been established by Government and to share our research findings. This includes the Department of Health, the Home Office, the Department for Education and the Department for Transport.

5. Question 2: *How well does the coordination of policy across the UK with the devolved administrations work, and what is the impact of pursuing different approaches to alcohol?*

5.1 Drinkaware's Memorandum does not permit the organisation to comment on policy, this includes the coordination of policy. However we do know that the success of alcohol education, both through Drinkaware and other bodies, is predicated on credibility amongst consumers.

5.2 Drinkaware is one of the primary resources consumers turn to for evidence-based advice on low-risk drinking. It is essential that its advice is trusted and seen as credible by consumers, including the 320,000 unique users who come to our website every month looking for information about alcohol and the 175,000 who have accessed MyDrinkaware to understand more about their drinking and its impact on their body. Whilst Drinkaware has extensive experience of working with the UK and devolved Governments on specific initiatives,

[141] Drinkaware KPI and Insight Research—Young People aged 10–17 and their Parents, Ipsos Mori, 2012.

[142] *Ibid* When asked about the last time they were drinking, 50% of 10–17 year olds who have had a drink say their parents gave them the alcohol.

[143] Drinkaware.co.uk/parents.

[144] The UK Chief Medical Officers recommend an alcohol-free childhood is the healthiest and best option.
England and Northern Ireland
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110258
Scotland
http://www.scotland.gov.uk/Topics/Health/health/Alcohol
Wales
http://wales.gov.uk/topics/health/ocmo/publications/position/alcohol/?lang=en

[145] Base: 25–44 year old ABC1 (723). Source: Ipsos MORI Social Research Institute. November 2011.

[146] General Lifestyle Survey: A report on the 2010 General Lifestyle Survey.

maintaining a reasonable level of convergence on any unit guidelines is necessary to achieve acceptance by consumers and ultimately shape their behaviour.

5.3 However, Drinkaware also acknowledges that consumers are not a homogenous group and that targeted communication based on nationally accepted guidelines can be highly effective. For this reason, Drinkaware runs campaigns aimed at young people (18–14), adults (30–45) and parents, and has launched a life-skills education programme, In:tuition, for use in schools.

5.4 As the Government's Alcohol Strategy highlights, the factors contributing to harmful alcohol use are complicated and any effective response should also be adapted for local circumstances. As an example, in 2010 Drinkaware joined forces with the Newquay Safe Partnership providing strategic guidance, a national perspective and an alcohol-free café offering advice and support for 16 and 17 year olds visiting the area.

5.5 Cornwall PCT were active members of the Newquay Safe Partnership and multi-agency specialists offered support and assistance for people with minor injuries or other issues. This lead to a much reduced demand on front line services—in particular the ambulance service.

5.6 In its first year (2009–10), the Newquay Safe Partnership's headline achievements were:

- No deaths or serious alcohol-related injuries in the area.
- Anti-social behaviour down 19%.
- Rowdy/nuisance behaviour down 22%.
- Violence against the person down 7%.
- Alcohol-related violence down 9%.
- Sexual offences down 7%.
- Drug offences down 14%.
- Theft down 15%.

5.7 Drinkaware has also successfully worked with each of the devolved Governments of the UK to assist the delivery of alcohol related messaging and the execution of research.

5.8 Drinkaware has worked with the Scottish Government, supporting its Alcohol Awareness Week activities in 2008, 2009 and 2010. Drinkaware provided almost 400,000 unit measure cups to help consumers in Scotland easily identify the number of units of alcohol in wine, beer and spirits and assist them in moderating their drinking behaviour.

5.9 We also fund Scottish Sports Future's Jump2it programme, an activity-based schools programme that addresses healthy lifestyles, which is delivered to primary school aged children through a mixture of information provision and physical activity via Glasgow Rocks basketball players and qualified coaches.

5.10 Over a seven month period, researchers utilised a range of evaluation methods primarily across 10 selected case study schools with the aim of gaining an indication of the impact on pupils of the Jump2it programme.

5.11 The resulting survey of 666 pupils shows that, following a six to eight week period, pupils demonstrated a significant increase in knowledge of diet, alcohol, smoking and exercise. This was the case for both those pupils who received the standard programme and those who participated in the extended version.

5.12 In 2009–10 the Welsh Government funded Drinkaware to research social norming in relation to drinking practices amongst the student population across universities in Wales.

5.13 The project takes a multi-component approach, including a toolkit and a social norming intervention. The toolkit and social norming intervention materials were provided to universities during the summer of 2011 and the intervention took place in the first two terms of the 2011–12 academic year.

5.14 Measures of success will include observed changes in student consumption rates, observed student drinking patterns and the use and engagement of the toolkit by university staff. The results of the evaluation will be published in August 2012.

5.15 In Northern Ireland Drinkaware is supporting "My Name is Katie" an early intervention project funded by the Department of Justice Community Safety Unit Project and set to educate parents on how to talk to children about alcohol. The project will be operating initially in the Coleraine Borough Council area before being run out in Limavady, Ballymoney and Moyle.

5.16 The programme is based on the evidence that although parents might be tempted to delay speaking to their children about alcohol until they are older and more mature, opening a dialogue in their pre-teen years is crucial to delaying the age of first drink.[147]

[147] Spoth R L., Lopez Reyes M., Redmond C, Shin L, 1999. Assessing a public health approach to delay onset and progression of adolescent substance use: latent transition and log-linear analyses of longitudinal family preventative intervention outcomes. *Journal of Consulting and Clinical Psychology*, 67: 619–630.

6. Question 3: *What is the role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group?*

6.1 Drinkaware is currently undergoing an audit and review, the result of which will determine the effectiveness of activity to date and priorities for the organisation from 2013 onwards, including its campaigns, funding and structure.

6.2 As part of a process established between Government, industry and the public health community this follows from the 2009 review which led to a higher level of funding for Drinkaware and the involvement of more industry partners.

6.3 One of the key pledges of the Responsibility Deal is the continuation of industry support for Drinkaware. This currently takes the form of around £5.2 million in financial support and a target has been set for £50 million of in-kind support across all three campaigns in 2012.

6.4 A major example of the impact of this support is our "Why let good times go bad?" campaign which was launched in 2009. "Why let good times go bad?" is a five-year £100 million project to challenge the social acceptability of drunkenness among young UK adults, and operates in partnership with more than 40 drinks industry companies and the UK Government.

6.5 The "Why let good times go bad?" target is to achieve £20 million in support, of which £5 million is from media buy (rate-card valued advertising) and £15 million from in-kind support from partners. In 2011, industry support achieved a significantly higher value of £27 million, thus exceeding the target for this campaign.

6.6 Targeted at 18–24 year olds, the campaign warns of the risks of binge drinking and encourages drinkers to adopt smarter drinking tips. These include eating before drinking, alternating alcoholic drinks with water or soft drinks, and looking after friends when consuming alcohol.

6.7 An independent evaluation among a representative sample of 18–24 year olds, conducted by Millward Brown, following the 2011 "Why let good times go bad?" campaign activity found that:

- 27% recalled seeing the campaign—double that of industry norms.
- 8 out of 10 claimed to be adopting at least one of the campaign tips.
- 56% claimed it made them consider drinking differently.
- 82% agreed "They could personally relate to it".
- 72% agreed "It was the sort of advertising they would talk about with friends".
- 66% agreed "The advertising clearly communicated that 'drinking too much alcohol can ruin a good night out'".

6.8 In 2011 Drinkaware and the British Beer and Pub Association (BBPA) developed a new "2–2–2–1" unit campaign providing a simple and quick way to gauge the number of units in the four most popular drinks—a pint of beer, a 175ml glass of wine, a 330ml bottle of 5% beer, and a 25ml pour of spirits.

6.9 Through a partnership with the Wine and Spirits Trade Association (WSTA), Drinkaware has helped develop a similar "2–2–2–1" campaign for use in the off-trade sector, which replaces a pint of beer with a 440ml can of 4% beer and a 330 ml bottle of 5% lager with a 330ml bottle of ready to drink (RTD) lager. When approved, it is anticipated that the campaign will be rolled out in the majority of retail outlets across the UK.

7. Question 4: *Do you think the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm?*

7.1 As a national charity our resources are completely free and will be available for all new bodies established through the Health and Social Care Act reforms. We have successfully worked with a wide range of bodies and will continue to help administrations deliver well-evidenced and targeted campaigns.

8. Question 5: *What evidence exists of the most effective international interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking, such as:*

- *public health interventions such as education and information;*
- *reducing the strength of alcoholic beverages;*
- *raising the legal drinking age; and*
- *plain packaging and marketing bans*

8.1 Drinkaware has considerable insight into public health interventions and has recently built on European evidence of success in reducing harmful behaviour choices to develop a UK-specific initiative called In:tuition.

8.2 In:tuition is a life-skills resource aimed at providing teachers with the tools required to equip learners with the knowledge and skills to make lifelong healthy decisions, develop greater self-esteem and self-confidence and enhance cognitive and behavioural competency to reduce and prevent a variety of health risk

behaviours. Across the UK, 38 schools are taking part in the In:tuition pilot and 459 schools have registered to use the programme.

8.3 In:tuition was informed by international examples of rigorously evaluated, best-evidenced life-skills based education programmes, which have been shown to be effective in preventing alcohol and other substance misuse—reducing alcohol misuse by 28–31%.[148]

8.4 Evidence such as the EU-Dap trial, UNPLUGGED, a multi-centre study implemented by nine partners from seven different European countries with funding from the European Commission formed a key basis in the development of the In:tuition programme.

8.5 UNPLUGGED aimed "both to develop a theory-based school programme for the prevention of use of tobacco, drugs and alcohol, and to assess its effectiveness by mean of a rigorous experimental design."

8.6 The UNPLUGGED programme was developed by the EU-Dap Intervention Planning Group and evaluated roughly 7,000 12–14 year old students during the 2004–05 school year. The contents of the programme were dedicated to decreasing drug initiation and/or delaying the switch from experimental to repeated drug consumption.

8.7 UNPLUGGED focused on a "life-skills" programme where intra- and interpersonal skills, enhancing young people's self-discipline, were used to increase learners' understanding of self-respect, respect for others and their trustfulness, feelings, individuality and privacy.

8.8 According to the EU-Dap trial, "results have shown that comprehensive social influence programmes do help prevent the use of alcohol, tobacco and other drugs." The UNPLUGGED programme was found to be effective in preventing the onset of alcohol, tobacco and other drug use. Results from an 18 month follow-up study found that "persisting beneficial program effects were found for episodes of drunkenness ... in the past 30 days."[149]

8.9 After one year the evaluation showed that pupils who participated in the UNPLUGGED school curriculum had a 30% lower probability to have smoked cigarettes (daily), to have experienced drinking to intoxication, and a 23% lower probability to have used cannabis in the past month, compared to students who followed the usual educational curricula.[150]

8.10 Adapted for the UK context, Drinkaware's cross-curricular programme builds the esteem, confidence and decision-making skills of learners aged 9 to 14, so they can make more informed decisions about a range of issues—including alcohol, sex and relationships, personal finance, health and civic responsibility. Research, such as the 2011 Foxcroft and Tsertsvadze Cochrane collaboration[151], suggests that a "life-skills" based approach to teaching, encompassing current guidance, is one of the best ways to achieve these outcomes.

May 2012

Written evidence from Alcohol Health Alliance UK (GAS 27)

About the Alcohol Health Alliance UK

The Alcohol Health Alliance UK (AHA) is a group of 31 organisations whose mission is to reduce the damage caused to health by alcohol misuse. The Alcohol Health Alliance works together to:

- Highlight the rising levels of alcohol-related health harm.
- Propose evidence-based solutions to reduce this harm.
- Influence decision makers to take positive action to address the damage caused by alcohol misuse.

While coalitions have previously been formed on specific topics in the medical field, notably tobacco control, this is the first time a group has existed specifically to co-ordinate campaigning on alcohol, which brings together medical bodies, patient representatives and alcohol health campaigners.

Members of the Alliance

Academy of Medical Royal Colleges, Action on Addiction, Alcohol and Health Research Trust, Alcohol Concern, Alcohol Focus Scotland, Balance North East, British Association for the Study of the Liver, British Liver Trust, British Medical Association, British Society of Gastroenterology, College of Emergency Medicine, Drink Wise North West, Faculty of Dental Surgery, Faculty of Occupational Medicine, Faculty of Public Health, Institute of Alcohol Studies, Medical Council on Alcohol, National Addiction Centre, National Heart

[148] Base: 25–44 year old ABC1 (723). Source: Ipsos MORI Social Research Institute. November 2011.

[149] Faggiano *et al* (2010). The effectiveness of a school-based substance abuse prevention program: 18-Month follow-up of the EU-Dap cluster randomized controlled trial.

[150] Faggiano *et al* (2008). The effectiveness of a school-based substance abuse prevention program: EU-Dap cluster randomised controlled trial.

[151] Foxcroft and Tsertsvadze (2011), Universal school-based prevention programs for alcohol misuse in young people: The Cochrane Library.

Forum, National Organisation for Foetal Alcohol Syndrome, Royal College of Anaesthetists, Royal College of General Practitioners, Royal College of Nursing, Royal College of Physicians Edinburgh, Royal College of Physicians London, Royal College of Physicians and Surgeons, Glasgow, Royal College of Psychiatrists, Royal College of Surgeons of England, Royal Pharmaceutical Society, Royal Society for Public Health, Scottish Health Action on Alcohol Problems, Scottish Intercollegiate Group on Alcohol.

1. Summary

The AHA welcomes The Government's Alcohol Strategy (2012) and its acknowledgement of the harms associated with current levels of alcohol consumption in England.

A number of issues need to be addressed at the same time to successfully reduce the negative health and social impacts of alcohol. The most effective interventions address price, availability and marketing of alcohol, and should be coupled with efforts in early identification and ongoing treatment of both acute and chronic alcohol-attributable health harms.

The strategy makes clear commitments to address areas such as pricing and licensing. The AHA particularly applauds the proposal of a minimum unit price for alcohol, and the recognition that affordability is a major factor in driving levels of excessive consumption and associated health harms.

However the strategy's commitments in other areas are weaker, particularly in relation to restricting alcohol marketing and investing in a range of patient-focused treatment services. The ongoing involvement of the alcohol industry in public health campaigns is also an area of concern. A lack of action in these areas will hinder the government's capacity to ensure widespread changes to consumption and its health and social consequences.

The strategy proposes interventions for specific groups within the English population, including offenders and young people who binge drink. While the AHA welcomes these measures, we are concerned about the lack of actions and investment to address the significant proportion of the population who regularly drink at or above published guidelines over a sustained period of time, which can lead or contribute to a range of chronic illnesses.

A strong national framework, underpinned by effective governance, quality research and evaluation, will be essential in supporting local authorities and clinical commissioning groups to deliver effective services for their communities in the new public health system.

2. Overall response to The Government's Alcohol Strategy

2.1 The growing costs to individuals and society of excessive alcohol consumption are well documented. Alcohol is a factor in over 40 serious medical conditions, is a contributing factor in accidents, violence, self-harm and sexual assault, and recent analysis indicated 3% of all deaths in the UK in 2005 were attributed to alcohol consumption.[(1)] In 200910 there were 1.1 million alcohol related admissions to hospital in England, more than twice as many as in 2002–03.[(2)] 2003 estimates indicated that the annual cost of health, crime and employment problems caused by alcohol consumption at around £20 billion a year, and there strong evidence that these costs are continuing to rise.[(3)]

2.2 The AHA welcomes *The Government's Alcohol Strategy* ("the strategy") as an important step forward in addressing the negative impacts of alcohol consumption in England. For the first time we are seeing clear government acknowledgement that there is a need to reduce consumption in order to tackle the negative impacts of alcohol on public health and social disorder.

2.3 While we welcome the intent of the strategy, the AHA is concerned about the absence of specific targets and timeframes for achieving changes in consumption, violent crime and incidence of alcohol-related chronic conditions.

2.4 The strategy focuses on the effects of young people binge drinking, and the social disorder caused by excessive alcohol consumption. The AHA would like to see this focus to be equitably balanced to better acknowledge the long term health harms, including chronic disease and alcohol dependence. There is a large section of the population that is consuming well over the recommended limits, often in their own homes, and storing up problems (and demand for services) for the future.[(4), (5)]

2.5 Quality research and evaluation will be essential to implementing the strategy's actions. The AHA welcomes the recent launch of the NIHR School for Public Health Research, and would like to see further commitments to ensure alcohol-related interventions and initiatives have the longitudinal, large-scale and rigorous monitoring and evaluation processes, as well as commissioning independent research, required for national and local bodies to make informed decisions about the most effective ways to allocate resources.

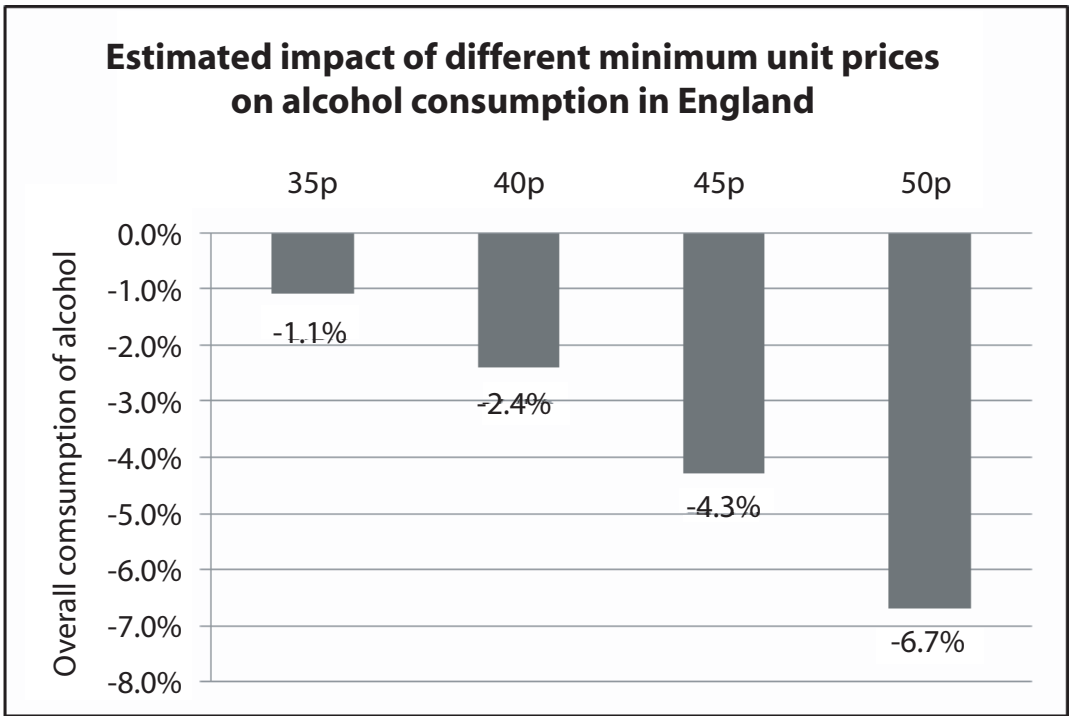
3. Establishing a Minimum Unit Price

3.1 The AHA strongly supports the Government's commitment to introduce a minimum price on alcohol in England and Wales. This step acknowledges the clear relationship between price and the consumption of alcohol and associated harms, which is supported by substantial and robust evidence and modelling.[(4), (6), (7), (8), (9)]

3.2 Minimum unit pricing is particularly important in helping to address alcohol consumption's contribution to chronic disease and will primarily target harmful and hazardous drinkers, with comparatively little impact on the spending of moderate drinkers.[8] Evidence shows that it is the cheapest alcohol that is causing high levels of harm—in the UK on average, harmful drinkers buy 15 times more alcohol than moderate drinkers, yet pay 40% less per unit. [10]

3.3 Modelling conducted by the University of Sheffield found that increasing levels of minimum pricing show substantial increases in effectiveness (see Figure 1 below). The AHA supports the introduction of a minimum unit price of at least 50p per unit, which the modelling suggests would reduce total alcohol consumption by 6.7%, saving around 20,000 hospital admissions in the first year and 97,000 a year once the policy has been in place for 10 years. This would result in direct costs saved in relation to health, crime and workplace impacts in England of £7.6 billion over 10 years.[8]

Figure 1



Data taken from University of Sheffield 2009 [8]

3.4 Once it has been implemented it will be essential to establish an effective mechanism for reviewing and adjusting the minimum unit price over time to account for inflation and rising disposable incomes. The AHA recommends this occurs on an annual basis as a minimum. Robust independent evaluation of the impact of the minimum unit price will be essential.

3.5 Further consultation should also be taken on how best to use the additional profits generated by retailers through a minimum unit price, which are estimated at several hundred million pounds. Given the limited investment in alcohol treatment services as previously identified by the Health Select Committee[9] and National Audit Office,[11] the AHA would like the government to explore introducing a levy that would see the funds reinvested in specialist alcohol treatment services.

Banning multi-buy discounts

3.6 The strategy also commits to consulting on a ban of multi-buy promotions in the off-trade. The AHA strongly supports this ban. The University of Sheffield modelling shows that increasing restrictions in off-trade discounting (ie through multibuys) does have increasing effects in a similar way to minimum pricing. Restrictions to 40%, 30%, 20% and 10% discounting give estimated consumption changes of –0.1%, –0.3%, –1.6%, –2.8% respectively. A 2.8% reduction in consumption is similar to the change estimated for a 40p minimum price (see Figure 1 above).[8]

3.7 The AHA argues that this ban should be expanded to include multi-buy discounts in the on-trade as well as the off-trade.

4. Addressing Marketing and Advertising

4.1 Evidence shows that exposure to alcohol marketing encourages children to drink at an earlier age and in greater quantities than they otherwise would. The Science Committee of the European Alcohol and Health

Forum concluded in 2009 that "alcohol marketing increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol."[12]

4.2 The Health Select Committee reported in 2010 that the current regulatory framework for alcohol marketing was inadequate. '9' Current controls are intended to limit the exposure of children to alcohol advertising, however clear failures with the controls can be identified. For example, an OFCOM audit of exposure showed that for approximately every five 24 year olds, four 10 year olds saw the same TV alcohol advert—this does not protect children.[13] A study funded by the Medical Research Council showed that in the UK 96% of 13 year olds were aware of alcohol advertising and had, on average, come across it in more than five different media.[9]

4.3 The OFCOM data shows that overall levels of TV advertising are declining, normal advertising comprises only around £250 million of the total £800 million spend—the remainder goes on other forms of marketing such as football sponsorship, promotions, musical festivals and viral and internet promotions where the potential exposure of children is even more problematic.[9]

4.4 While the government's strategy recognises the link between marketing and consumption, the actions outlined focus on working within the current structures and do not go far enough to curb children's exposure to alcohol advertising. The evidence above highlights that relying on the Advertising Standards Agency alone is insufficient.

4.5 AHA supports a UK adapted version of *Loi Evin.* The *Loi Evin* is a French framework that allows alcohol marketing and promotion in media that is used by adults, but not where a large proportion of children and young people make up the audience. The *Loi Evin* model provides a simple framework that can offer clarity on what marketing practices can and cannot be implemented whilst ensuring that children and young people are protected from an exposure that poses a risk to their health and wellbeing. It has been upheld in by the European Court of Justice, which found in 2004 that the measure is proportionate, effective, and consistent with the Treaty of Rome.[14]

4.6 Children and young people's exposure to alcohol marketing should be monitored by an independent body, with no representation within this body from the alcohol industry. This monitoring should be performed systematically and routinely to monitor trends over time. Particular attention should be paid to ensuring that marketing through digital, online and social media is adequately monitored and regulated.

5. The Role of the Alcohol Industry

5.1 The AHA welcomes the acknowledgement in the strategy that "industry needs and commercial advantages have too frequently been prioritised over community concerns".[15] However the AHA remains concerned that the strategy reinforces existing roles and structures for industry involvement. Evidence indicates that industry self-regulation is not an effective strategy due to industry's conflicts of interest.[16] The AHA would like to see an immediate commitment to an independent evaluation of the current responsibility deal initiatives.

5.2 The strategy restates the government's commitment to Drinkaware. While the AHA acknowledges that Drinkaware contributes to raising public awareness about the risks of excessive alcohol consumption, it is important to acknowledge that Drinkaware's reliance on alcohol industry funding means it has a very specific remit and limited role in a wide-ranging public health strategy.

5.3 In line with WHO recommendations, while we believe business must play a part and have the opportunity to engage with health issues, health experts must lead on setting policy priorities.[17] Although businesses have a role to play in protecting and promoting the health and wellbeing of their employees and the wider community, and implementing and supporting public health initiatives it is not the place or responsibility of business to define public health policy or to be responsible for public health information, as in many cases this is in direct conflict with their interests and responsibilities to their shareholders and employees.

5.4 To address this conflict of interest the AHA recommends that industry contributes to funding for public health initiatives via a truly independent charity or blind trust, constituted as a grant-giving foundation to support bodies operating for the public good with a track record of reducing alcohol harm, without involvement from industry representatives. All programmes and policies should be subject to proactive monitoring and independent evaluation, including those with private investment.

6. Greater Investment in Effective Interventions

6.1 There is a clear need to provide care for a large and growing group of patients with alcohol-related health problems. Presently a lack of coordinated action means that care is imperfect and spending is poorly targeted and ineffective, very few hospitals have dedicated alcohol services and only 5.7% of dependent or harmful drinkers access treatment, compared to 67% of dependent or harmful drug users.[19]

6.2 The strategy proposes interventions for specific groups within the English population, including offenders and young people who binge drink. While the AHA welcome these measures, we are concerned by the lack of actions and investment to address the significant proportion of the population who regularly drink at or above

published guidelines over a long period of time, which can lead to or contribute to a range of chronic health conditions.

6.3 The strategy raises a number of health risks such as foetal alcohol spectrum disorders and mental illness, along with highlighting the value of early identification and treatment of alcohol disorders. A comprehensive system of care is required to successfully address the wide spectrum of health harms, however the strategy fails to provide any specific actions or funding in these areas.

6.4 The AHA is calling for the full implementation of the NICE guidelines relating to alcohol dependence, which provide an excellent, evidenced-based guide to effective intervention, treatment and referral systems that involve a wide range of health professionals.[4], [5] In particular the AHA would like to see additional support and funding for:

Early diagnosis and treatment of alcohol use disorders

6.5 A wealth of evidence shows that early interventions are both effective and cost effective. '4,5,18,20' An extra £217 million invested in alcohol services—double the current level—would bring about an annual saving of £1.7 billion for the NHS in England.[21]

6.6 The NICE Guidance on alcohol use disorders states that primary prevention of alcohol-related harm at primary care level is both effective and cost effective.[4] This should be incentivised through including a measure in the Quality and Outcomes Framework for GPs to record the alcohol intake of their patients and to give brief advice where indicated. For patients who do not respond to simple advice there should be a stepped programme of further intervention.

6.7 Cost effective treatment interventions for alcohol dependence have been described in NICE guidelines[5] but are currently available only to a small proportion of those who could benefit from it. This will require sustained investment in specialist alcohol services to achieve parity for services for drug misusers.

Secondary care services

6.8 Healthcare modelling methodology suggests that if each district general hospital established a seven day Alcohol Specialist Nurse Service to care for patients admitted for less than one day and an Assertive Outreach Alcohol Service to care for frequent hospital attendees and long-stay patients, it could result in a 5% reduction in alcohol-related hospital admissions, with potential cost savings to its locality of £1.6 million per annum. This would equate to savings of £393 million per annum if rolled out nationally.[18]

6.9 The AHA recommends that there should be a multidisciplinary "Alcohol Care Team", a 7 day Alcohol Specialist Nurse Service and an "Assertive Outreach Alcohol Service" in every District Hospital. Transitions between teams and services should be quick and seamless in order to increase the efficiency and cost effectiveness of the service.[18]

7. The Changing Public Health System

7.1 The AHA believes there is potential to work more closely with local authorities to drive change and innovation, and deliver services targeted to the needs of local communities. However, with the changes to the public health system come risks that must be mitigated. These include: unjustifiable variation, piecemeal and fragmented service provision, an absence of quality evaluation metrics, and a lack of information sharing and best practice. The AHA are keen to work with central and local government to identify mechanisms that deliver on the localism agenda, whilst protecting the need for coordinated, integrated and evidence-based policy-making and service delivery.

7.2 A national service framework on alcohol, which could be adapted to local needs, would be an effective way of keeping costs down, sharing best practice and getting the best value for money. A framework could be led by a dedicated alcohol team within Public Health England, with established experts leading the research work at the highest level, setting out principles for action, rather than prescriptive plans. This allows for local areas to develop plans to meet local needs with the backing of expertise and knowledge provided by PHE.

7.3 Leaving it to each individual council to decide on priorities may result in some choosing to ignore alcohol harm, even where significant problems exist. There must be robust measures for holding local authorities accountable for these decisions. The AHA recommends that an expert, influential and independent Director of Public Health—supported by robust data analysis and outcome monitoring systems—will be essential.

7.4 Likewise, the NHS Commissioning Board should provide local commissioning groups with guidance on the best practice for commissioning comprehensive alcohol treatment services, based on the NICE guidance and the forthcoming quality standard on alcohol dependence. They must hold clinical commissioning groups to account on their performance against a set of indicators relating to alcohol treatment services, linking to the shared mortality improvement area to reduce the under 75 mortality rate for liver disease in the NHS Outcomes Framework.

8. Measures to Reduce Drink Driving

8.1 The AHA is concerned that there is no mention of measures to reduce drink driving in the strategy. Despite a substantial decline in levels of drinking and driving in Great Britain since the 1980s, drivers drinking alcohol still kill and injure scores of people each year. In 2009 there were 11,990 reported casualties involving drivers over the legal limit (5% of all road casualties) and an estimated 380 people killed in drink drive accidents (17% of all road fatalities).[22]

8.2 The AHA fully supports the recommendations of the 2010 North Review into the Drink and Drug Driving law. In particular, the AHA calls for the present drink drive blood alcohol content limit to be lowered from 80mg% to 50mg%, and giving police unrestricted power to require anyone driving a vehicle on the public highway to give a preliminary breath test.[23]

9. Coordination of Alcohol Policy

9.1 Policies relating to alcohol fall under a broad range of governmental departments, including the Home Office, the Department of Health, the Treasury, the Departments of Culture, Media and Sport, Transport, Communities and Local Government and the Ministry of Justice. There is therefore a particularly strong case for a cross-departmental unit on alcohol, and the AHA suggests that such a unit could be led by the Chief Medical Officer—reporting to the Home Affairs (Public Health) Cabinet Sub-committee. A cross governmental alcohol unit could maximise the impact of the different strands of the government's strategy and ensure there is rigorous evaluation applied to all aspects of the strategy.

9.2 A cross governmental alcohol unit would also be well placed to coordinate policy with the devolved administrations. Greater consistency around policies relating to the price, availability and promotion of alcohol will be important in ensuring success across the UK. In particular, efforts to introduce a minimum unit price on alcohol are already well underway in Scotland and under discussion in Northern Ireland—therefore it is important that the timeframes for introducing a minimum unit price in England and Wales aligns as closely as possible with the devolved administrations.

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May 2012

Written evidence from The Portman Group (GAS 54)

1. The Portman Group is the responsibility body for UK drinks producers. We regulate the promotion and packaging of alcoholic drinks sold or marketed in the UK; challenge and encourage the industry to market its products responsibly; and lead on best practice in corporate alcohol social responsibility.

Executive Summary

2. The vast majority of adults in the UK enjoy sociable drinking, with 78% drinking within Government guidelines.[152] Patterns of consumption are improving.

3. The Alcohol Strategy (the Strategy) recognises the value of effective self-regulation of alcohol marketing and the Portman Group's leadership role alongside Ofcom and the Advertising Standards Authority.

4. Drinks producers are effective, committed partners in tackling alcohol misuse and creating a responsible drinking culture. Profit and social responsibility are not mutually exclusive. The industry's sustainable future is linked to playing its part in reducing harms, alongside other stakeholders, such as parents and employers.

5. The Public Health Responsibility Deal (RD) works—partnership working has delivered unprecedented voluntary commitments since launch.

6. Industry-led innovation has resulted in fast, collective solutions to reducing harms: local partnerships combatting anti-social behaviour and underage purchasing; raising awareness of sensible drinking guidelines; and a wider range and availability of lower-alcohol drinks (resulting in a market reduction of 1 billion units).

7. Government policy should build on the RD partnership and be evidence-based. It must target the minority misusing alcohol and not penalise the majority drinking responsibly. Policy should not overburden responsible business partners.

8. We invite the Committee to consider two areas:

- The need for consistent Government-led alcohol statistics updated regularly, including both consumption patterns and harms.
- Widespread introduction of effective employee alcohol policies, such as those used by drinks companies.

Alcohol Trends in Context

9. *Alcohol is commonplace in society*—in 2010, 84% of the working-age population in England drank alcohol.[153]

10. *UK per capita consumption has fallen* from 9.5 to 8.3 litres per head[154] between 2004 and 2011. Consumption in the UK is equal to the European average and lower than many of our European neighbours, including Spain, Ireland and France.[155]

[152] Government's Alcohol Strategy 2012.
[153] Office for National Statistics, General Lifestyle Survey Overview 2010, Published 8 March 2012.
[154] HM Customs and Excise & British Beer & Pub Association, New figures show UK alcohol consumption down again in 2011, 11 March 2012.
[155] OECD Health Data ,2010; WHO, 2010.

11. *Majority drink within weekly guidelines*—in 2010, 74% of men drank less than 21 units p/w (2005: 69%) and 83% of women drank less than 14 units p/w (2005: 79%).[156]

12. *Drinking at harmful levels falling*—in 2010, 6% of men drank more than 50 units p/w (2005: 9%) with the equivalent for women down to 3% from 5%).[157]

13. *Binge drinking down*—in 2010, 19% of men drank more than 8 units on their heaviest drinking day (2005: 23%) and 13% of women drank over 6 units (down from 15% in 2005).[158]

14. *Young people binge-drinking at lowest recorded levels*—in 2010, only 17% of 16–24 year old women drank more than 6 units on their highest drinking day (2005: 27%) and 24% of young men drank more than 8 units (2005: 32%).[159]

15. *Fewer 11–15 year olds trying alcohol*—in 2010, 55% had never had an alcoholic drink (2001: 39%) with the percentage reporting past week drinking falling by over half from 26% to 13%.[160]

Alcohol-Related Harms

16. *The number of hospital admissions for which alcohol is the primary diagnosis* stood at just under 195,000 in England in 2009/10, up from 142,000 in 2002–03.[161]

17. There were 8,790 *alcohol-related deaths in the UK* in 2010, whilst doubling since the early 1990s, have remained broadly flat over the last five years.[162]

18. There were just under a million *alcohol-related incidents of violent crime* in 2010, accounting for 50% of all violent crime, with volumes having fallen from 1.6 million in 1995.[163]

19. *Drink-driving fatalities have fallen by 85% since 1979 to* 250 fatalities and 1,230 seriously-injured casualties in 2010.[164]

Detailed Responses

A. *Responsibility within Government*

20. Given the cross-cutting nature of alcohol policy, effective coordination across Government is vital. Policies should be evidence-based and consider the impact upon all sectors of society.

B. *Co-ordination of alcohol policy across the UK*

21. The UK is a single market, and consistent regulation (eg product labelling, marketing, and licensing law) provides clarity for consumers and businesses and prevents discriminatory regulatory burdens harming growth, investment or jobs.

22. However, alcohol misuse is particularly concentrated in a number of local areas, such as Blackpool, Salford, Liverpool, Manchester and North Tyneside, which consistently score in the top 20% of local authorities in England (and significantly above the national average) across a basket of measures of alcohol related harm, such as health, mortality, crime and binge drinking.

23. To counter this and avoid penalising the responsible drinking majority, we advocate a locally targeted partnership approach which involves bringing the weight of national organisations (alcohol producers, retailers, police, NHS, employers etc.) behind effective local schemes (such as Best Bar None, Purple flag, Pubwatch, and Community Alcohol Partnerships) in a co-ordinated way.

C. *Industry involvement—alcohol-related health problems*

24. The Alcohol Strategy recognises the need for effective self-regulation and the Portman Group's role in achieving this.

25. The Responsibility Deal is the right approach. It enables industry to deliver practical measures quickly to effect positive behaviour change. It encourages local partnerships to reduce anti-social activity and uses innovative consumer marketing and education programmes (eg the industry-funded Drinkaware) to communicate the Government's sensible drinking guidelines and promote responsible behaviour.

26. In the UK, alcohol marketing is subject to strict controls ensuring that alcohol promotion is socially responsible and targeted only at 18 and overs.

[156] *Ibid*, Table 2.2.
[157] *Ibid*, Table 2.2.
[158] *Ibid*, Table 2.4.
[159] *Ibid*, Table 2.4.
[160] NHS Information Centre, *Smoking, Drinking and drug use among young people in England 2010,* 28 July 2011, table 3.3b.
[161] NHS Information Centre, Statistics on alcohol: England 2011, table 4.1.
[162] Office for National Statistics, Alcohol-related deaths in the United Kingdom 2010, January 2012.
[163] Home Office Statistical Bulletin, Crime in England and Wales 2009–2010, July 2010.
[164] Department for Transport, *Reported Road Casualties in Great Britain, 2010* Annual Report.

27. Three regulatory bodies control standards of alcohol marketing; the Portman Group, the Advertising Standards Authority (ASA) and Ofcom, ensuring there are no regulatory gaps (see Appendix A).

28. The Portman Group Code (the Code)—introduced in 1996—covers the responsible naming, packaging and promotion of alcohol. It prohibits associations with social/sexual success or harmful or irresponsible consumption.

29. An alleged breach of the Code is referred to an Independent Complaints Panel. Where complaints are upheld, licensed retailers are instructed not to stock the product. The Code is commended to licensed retailers under the Licensing Act (see paragraph 38). A press release reporting the breach can inflict reputational damage on producers. Since 1996, over 80 products have been removed from the market.

30. Our aim is to prevent irresponsible products or promotions coming to market. Our free pre-launch Code Advisory Service received over 500 requests for advice in 2011. We also offer a comprehensive industry Code training programme.

31. We conduct third party audits; watch for problematic products/promotions; and monitor the Trade Marks Registry for new alcoholic products. Many producers have their own internal marketing codes which go over-and-above the minimum required by our Code.

32. The Code must reflect changing environments and marketing practices, so regular reviews have taken place. These ensure there is balance between protecting children and legitimately marketing products to adults.

33. Our RD pledge to review the Code is already underway. We are in the consultation phase and will develop a new edition of the Code during the summer and expect to launch it in autumn 2012.

D. *Minimum Unit Pricing (MUP)*

34. The Portman Group does not wish to comment on MUP. Our focus is on reducing harm by enforcing effective self-regulation through our Code of practice and the collective leadership actions of our member companies.

E. *Effects of marketing on alcohol consumption*

35. The UK has some of the most effective self-regulatory codes to ensure alcohol is marketed responsibly and not to children.

36. The Secretary of State's Guidance on the Licensing Act commends the Portman Group Code:

> "The Code is an important weapon in protecting children from harm because it addresses the naming, marketing and promotion of alcohol products sold in licensed premises in a manner which may appeal to or attract minors. The Secretary of State commends the Code to licensing authorities and recommends that they should commend it in their statements of licensing policy."

37. Critics believe alcohol marketing encourages people, particularly under 18s, to start drinking earlier or to drink more.[165] However, official statistics show fewer young people (16–24) and children (11–15) are drinking (see paras14, 15 above).

38. The influence of marketing on alcohol consumption is subject to various studies. Whilst there is longitudinal research showing a modest relationship between marketing exposure and drinking among young people; the strength of association varies between studies.[166]

39. The lack of evidence is recognised in the Strategy:

> "So far we have not seen evidence demonstrating that a ban is a proportionate response but we are determined to minimise the harmful effects of alcohol advertising."

40. Furthermore, the marketing impact on young peoples' drinking behaviours is likely to be outweighed by other factors (such as family environment, peer behaviour, socioeconomic status, and personal attitudes.[167, 168, 169]

41. The Strategy has asked us to look at other ways to tighten self-regulation around retail, sponsorship and marketing. These are being addressed in our Code review.[170]

[165] www.ias.org.uk/resources/factsheets/advertising.pdf

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

[167] Epstein, J A, Griffin, K W, & Botvin, G J (2008). A social Influence model of alcohol use for inner-city adolescents: Family drinking, perceived drinking norms, and perceived social benefits of drinking. *Journal of Studies on Alcohol and Drugs, 69,* 397–405.

[168] Scholte, R H J, Poelen, E A, Willemsen, G, Boomsma, D I, & Engels, R C (2008) Relative risks of adolescent and young adult alcohol use: The role of drinking fathers, mothers, siblings, and friends. *Addictive Behaviors, 33,* 1–14.

[169] Fisher, L B, Miles, I W, Austin, S B, Camargo, C A, & Colditz, G A (2007). Predictors of initiation of alcohol use among U.S. adolescents: Findings from a prospective cohort study. *Archives of Pediatrics & Adolescent Medicine, 161,* 959–966.

[170] http://www.portmangroup.org.uk/?pid=1003&level=1

42. The Strategy has also given a clear mandate to ASA and Portman Group to review any advertising rules which currently inhibit the promotion of lower strength alcohol products; this is being addressed by our Code review.

43. Whilst regulating social media is new territory for many, digital alcohol marketing has been subject to our Code rules since 2003.[171] The Portman Group led on introducing comprehensive digital guidelines for the industry in 2009. These are recognised as best practice and we share our experience with our European counterparts.

F. *Impact of current level of alcohol consumption*

44. We have some concern about the consistent use of alcohol trend data and invite the Committee to consider a call for Government-led statistics which are updated regularly.

45. For example, the Strategy reported that the number of hospital admissions in which alcohol related health conditions were present, but not necessarily the primary diagnosis, stood at 1.2 million in 2010–11 having more than doubled since 2002–03.

46. However DH announced a consultation in 2012 having previously expressed the view that the calculation used was inadequate as a public health indicator,[172] preferring a focus instead on primary diagnosis alone (for which admission levels are significantly lower at just under 200,000).

47. External commentators are also commenting on the shortcomings of alcohol trend data *Straight Statistics.*[173]

G. *Impact on future patterns of NHS services*

48. Not within PG remit.

H. *Proposed reforms of the NHS*

49. Not within PG remit.

I. *International evidence of the most effective interventions*

50. The UK is at European average for alcohol consumption per adult. However, it is drinking patterns not population-wide consumption that determine harms and these derive from differing cultural, societal and familial norms. Effective interventions may not transfer from one country to another and need to be evidence based in the country where they are applied (See also section M).

J. *Education and information*

51. We recognise that education, changing social norms and law enforcement are essential to change behaviour.

52. It is important to provide information and education programmes to help people make sensible choices about their drinking. In recent years, numerous awareness campaigns have been run by Government and the Drinkaware Trust. Evidence suggests that more people understand units and the Governments recommended drinking guidelines.[174]

53. More work is needed to help consumers understand how many units are in their drinks and the health impacts of drinking above the guidelines.

54. Drinks producers have committed to feature clear unit content, NHS guidelines and a warning about drinking when pregnant on over 80% of products on shelf by December 2013.[175]

K. *Reducing the strength of alcoholic beverages*

55. As part of the RD, the alcohol sector has launched a new pledge to introduce a wider range of lower-alcohol products.

[171] The ASA extended its remit to regulate the majority of online marketing in March 2011. Any alcohol marketing not within ASA remit is covered under our Code.

[172] DH: Improving outcomes and supporting transparency Part 2: Summary technical specifications of public health indicators, January 2012
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132558.pdf

[173] Nigel Hawkes, Straight Statistics—"Alcohol admissions set to tumble"
http://www.straightstatistics.org/article/alcohol-related-hospital-admissions-set-tumble

[174] Summary from Office for National Statistics (ONS) General Lifestyle Survey 2010, published March 2012 and Office for National Statistics (ONS), *Omnibus Survey Report: Drinking Adults' Behaviour and Knowledge in 2009,* 2010.

[175] http://responsibilitydeal.dh.gov.uk/2012/02/03/a1-factsheet/

56. This is an innovative initiative to grow a new lower-alcohol market, providing more consumer choice, helping to reduce the amount of pure alcohol they consume without affecting the number of drinks purchased. It will also remove 1 billion units of alcohol from the drinks market without penalising the responsible majority.

57. For example, a consumer who usually drinks a product at 5% ABV and substitutes it for a 4% ABV product will consume 20% less alcohol, if purchasing the same number of drinks. Evidence from other areas of behavioural science suggests they are unlikely to increase volume consumption.

L. *Raising the legal drinking*

58. Not within PG remit.

59. However, it is unlikely that there would be strong support for raising the legal purchasing age and we believe it would be harmful if under 21s were to seek alcohol from illicit or harmful sources.

60. If we want to create a healthier drinking culture, where alcohol is respected it should not be turned into a social taboo.

61. At 18, people are old enough to vote, drive and fight for their country and they should be trusted to drink alcohol.

62. Preventing underage sales is more effective. Industry innovations (eg age verification through Challenge 21, Challenge 25, and local partnerships such as Community Alcohol Partnerships and Best Bar None) have important roles to play.

63. Alongside this, there must be rigorous enforcement of existing laws to prevent underage sales and selling to those who are intoxicated.

M. *Plain packaging and marketing bans*

64. We note that plain packaging is not in the Strategy but is a policy being considered for tobacco products. Alcohol and tobacco are fundamentally different products.

65. Banning marketing risks commoditising alcohol to the point that it can only be marketed primarily on price or % ABV strength rather than brand position.

66. Much attention has been paid to the *Loi Evin*, which significantly restricts alcohol marketing and sponsorship in France. The Government's official evaluation report[176] in 1999 stated that the *Loi Evin* had been "ineffective" in reducing high-risk drinking patterns. The French anti-alcohol NGO ANPAA accepts that the effects of the law are "weak".

67. The UK Government's partnership with industry enables it to lead Europe in responsibility measures such as voluntary labelling and innovating lower-alcohol drinks.

Declaration of Interest

68. We are a not-for-profit organisation funded by nine member companies[177] who represent every sector of drinks production and collectively account for more than half the UK alcohol market.

May 2012

[176] *La loi relative à la lutte contre le tabagisme et l'alcoolisme: Rapport d'évaluation,* Octobre 1999. http://www.ladocumentationfrancaise.fr/var/storage/rapports-publics/004000708/0000.pdf

[177] Current member companies are: AB InBev; Bacardi Brown-Forman Brands; Beverage Brands; Carlsberg; C&C Group; Diageo; Heineken; Molson Coors; and Pernod Ricard.

APPENDIX A

ALCOHOL MARKETING REGULATION TABLE

Regulator	*Ofcom*	*Advertising Standards Authority*	*Portman Group*
Remit	Television programme sponsorship (Also broadcast editorial standards)	All advertising, eg: — television — radio — press — poster — cinema — direct mail — internet — mobile phones (SMS and Bluetooth)	All other alcohol producer marketing activities, eg: — naming — packaging — sponsorship (excluding TV programme sponsorship) — sampling — press releases — producer-generated point-of-sale materials — brand websites (except those areas covered by the ASA)
Nature of system	Statutory	Co-regulatory (broadcast) Self-regulatory (non-broadcast)	Self-regulatory (but consistent with and complementary to the entire co-regulatory system)
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

Supplementary written evidence from The Portman Group (GAS 54A)

REGIONAL DATA—Q156

Whilst it is encouraging that the overall national context around drinking patterns and harms is showing improvement across many indicators, some local areas have disproportionately high alcohol-related harms, with a particular concentration in the North West and North East. For example, data on the North West regional Health authority website[178] shows:

— Rates of alcohol specific mortality and liver disease in Blackpool are nearly 3 times the national average.

— Alcohol specific hospital admissions in Liverpool are nearly 2.5 times the National average.

— Binge drinking in North Tyneside, and indeed much of the North East, is 1.5 times the national average

The alcohol industry has developed a number of schemes to support local areas in promoting responsible drinking and combatting alcohol related harms, details of which can be found below.

The Portman Group will be working with local partners and the alcohol industry over the next year to ensure these, and similar schemes, are appropriately targeted where they would be of most benefit to effectively meet pressing local needs.

BEST BAR NONE

Best Bar None is a national award scheme supported by the Home Office and aimed at promoting responsible management and operation of alcohol licensed premises. It was piloted in Manchester in 2003 and found to improve standards in the night time economy, with premises now competing to participate. It has since been adopted by 100 towns and cities across the UK and is now being taken up internationally.

The aim of BBN is to reduce alcohol related crime and disorder in a town centre by building a positive relationship between the licensed trade, police and local authorities.

It reduces the harmful effects of binge drinking as well as improves the knowledge and skills of enforcement and regulation agencies, licensees and bar staff to help them responsibly manage licensed premises.

The process of becoming recognised by BBN includes meeting minimum standards and culminates with a high profile award night with category winners and an overall winner.

Responsible operators are recognised and able to share good practice with others. A scheme can also highlight how operating more responsibly can improve the profitability of an individual business and attractiveness of a general area.

The following areas currently operate the scheme:

ENGLAND & WALES

— Altrincham
— Aylesbury Vale
— Barnsley
— Bedford
— Birmingham
— Bishop Auckland
— Bournemouth
— Bradford
— Brent
— Bromley
— Calderdale
— Camden
— Carlisle & Eden
— Ceredigion—covering Aberystwyth, Cardigan, Lampeter, Averaeron, Llandysul, Tregaron
— Cheltenham
— Chester-le-Street
— City of York & Selby District
— Consett
— Conwy and Denbighshire
— Cornwall
— Croydon
— Darlington
— Derby City Centre
— Doncaster
— Leeds
— Leicester
— Lincoln
— Luton
— Manchester
— Middlesbrough
— Nationwide—NUSSL
— Newcastle City Centre
— Newcastle under Lyme
— Newport, South Wales
— Northamptonshire
— North Lincolnshire
— Norwich
— Nottingham
— Oldham
— Peterhead
— Plymouth
— Poole
— Portsmouth
— Reading
— Redbridge
— Rochdale
— Rhondda Cynon Taff
— Sefton
— Scarborough

[178] http://www.lape.org.uk/data.html

— Durham City Centre
— Ealing
— East Lindsey
— East Riding including Bridlington, Beverley, Driffield, Hornsea, Coltingham, Hessle, Goole, Howden & Pocklington
— Filey
— High Wycombe
— Hull
— Ipswich
— Isle of Wight
— Islington
— Jersey
— Kensington & Chelsea
— Kingston upon Thames
— Kingston upon Hull
— Kirklees
— Sheffield
— Shropshire
— Solihull
— Southampton
— Stafford
— Stockport
— Sunderland
— Sutton
— Swindon
— Thames Valley Area—covering Newbury
— Wakfield
— Walsall
— Watford
— Whitby
— Wigan
— Woking

SCOTLAND

— Aberdeen City Centre
— Aberdeenshire—covering Fraserburgh, Peterhead, Inverurie
— Angus—covering Forfar, Kirriemuir, Brechin, Montrose and Monifeith
— Central—covering Falkirk Town centre and Stirling City Centre
— East Lothian—covering Musselburgh
— Mid Lothian—covering Dalkeith and Aberlady
— Fife—covering Kircaldy, Dunfermline, Glenrothes, Leven, Cupar, Cowdenbeath and St Andrews
— Northern—covering Inverness City Centre
— Strathclyde—covering Glasgow City Centre
— Tayside—covering Dundee City Centre and Perth City Centre
— West Lothian—covering Livingston, Bathgate, Linlithgow, East Calder, Whitburn, Fauldhouse, Newton village, Broxburn, Seafield, Uphall and Armadale
— Scottish Borders—covering Galashiels Town centre

COMMUNITY ALCOHOL PARTNERSHIPS (CAPS)

Launched in 2007, Community Alcohol Partnerships were originally developed by the Retail of Alcohol Standards Group in an effort to tackle underage drinking and is now a standalone Community Interest Company.

Community Alcohol Partnerships are developed within individual communities to tackle underage drinking and related antisocial behaviour. CAPs are tailored to suit local needs and, depending on the nature and extent of the problem, different methods of best practice will be adopted in order to best tackle the issue. The range of measures that could be adopted includes:

Enforcement

— Joint Police & Trading Standards activity.
— Visible Trading Standards and Police coordinated operations in hot spot areas.

Education

— Retailers, Police and the Local Authority communicate agreed messages.
— Handouts developed for school and in store use.
— Local schools, sixth form colleges and youth clubs engaged.
— Engagement with parents as well as young people.
— Health Authority involvement.

Partnership Working

— Early intelligence sharing.
— Training for independent retailers.

— Buddying systems.
— Co-ordinated signage and leaflets.
— Regular meetings.

Community Alcohol Partnerships is funded with contributions from the some of the UKs largest drinks producers as well as large and small retailers.

The following areas currently have CAPs up and running:

— Bath (Midsomer Norton)
— Berkshire (Caversham)
— Cambridge (St Neots, South Cambs, Ely & Soham, Wisbech)
— Devon (Tiverton, Crediton, Cullompton)
— Durham (Stanley)
— Hampshire—(Gosport, Havant & Gosport)
— Islington
— Kent (Edenbridge, Maidstone, Whitstable, Margate, Cliftonville, Canterbury, Thanet, Swanley)
— Norfolk (Great Yarmouth)
— Powys (Brecon)
— Reading (Tilehurst, Caversham)
— Shropshire (Ludlow, Oswestry)
— South Yorkshire (Barnsley—Dearne, Peniston, Grimethorpe, Kendray&Worsbrough)
— Sussex East (Hastings)
— Scotland (Rosyth)
— Northern Ireland (Derry/Londonderry)

Purple Flag

Purple Flag has been designed as an objective assessment that will help improve town or city centres at night. Most significantly it is designed to provide recognition that areas are managing their night time experience, and thus help overcome any negative public perceptions that may exist. Purple Flag provides the opportunity for successful centres to present themselves in their true colours and in a positive light to town centre users, including operators, residents, tourists and visitors.

Purple Flag aims to raise the standard and broaden the appeal of centres between 1700 and 0600. The scheme is managed by the ATCM working alongside the Purple Flag Advisory Committee—a partnership of key stakeholder groups, including central and local government, police, business and consumers.

Areas that reach or surpass Purple Flag standards can fly the flag! Benefits include:

— A raised profile and an improved public image.
— Increased visitors.
— Increased expenditure.
— Lower crime and anti-social behaviour.
— A more successful mixed-use economy.

Purple Flag has been developed by ATCM from original research undertaken by the Civic Trust as part of the "NightVision" project. This showed that:

— More people would use centres at night if they were safer, more accessible and offered more choice.
— A good mix of clientele can lessen intimidation and improve perceptions.
— A wider range of attractions and consumers leads to longer term economic viability.

The following places have all achieved the purple flag standards:

Aylesbury
Bangor
Bath
Belfast
Birmingham
Bournemouth
Bristol
Canterbury
Clerkenwell, Islington, London
Covent Garden, Westminster
Derry—Londonderry
Enniskillen
Halifax
High Wycombe
Kingston Upon Thames
Leicester Square, Westminster
Liverpool
Manchester
Nottingham
Oxford
Preston
Stockton Heath—Warrington
Torquay
Victoria—Westminster
Winchester

PUBWATCH

Pubwatch is a scheme set up and run by licensees to reduce crime and disorder in pubs and clubs. Supported by the police, it is a national initiative, which is proved to reduce violence and other types of criminal acts such as drug dealing and vandalism.

The scheme works by creating links between licensees, allowing information—such as the identity of troublemakers—to be passed quickly between each other and police. It also provides a forum where licensees can share problems and solutions.

There are a number of advantages for licensees joining the scheme, including:

— membership of Pubwatch deters troublemakers;

— a reduced risk of licensees, staff and customers being assaulted or abused;

— less damage caused to property and smaller repair bills; and

— it is good for trade—Pubwatch helps create a pleasant environment to work and socialise in.

There are also advantages for the police, such as:

— officers know more about potential troublemakers and get better quality information which they can act upon;

— by receiving more precise details in calls for assistance, police can make the best response;

— violence in and around licensed premises reduce; and

— improving the working relationship between police and the licensed trade.

Nationally, police statistics show a significant decrease in violent offenders in those pubs where the scheme operates. The rapid growth of Pubwatch shows the scheme is valued by both the licensed trade and police.

A detailed map of Pubwatch areas can be found on the National Pubwatch website.[179]

June 2012

Written evidence from Alcohol Concern (GAS 62)

1. SUMMARY

— Drinking alcohol is a freedom that many enjoy, however this must be balanced with the need to avoid harm and improve health. Pricing is one of the most effective measures to address excessive consumption and alcohol-related harms.

— A minimum unit price (MUP) of at least 50p would result in lower consumption levels and a significant reduction in alcohol-related harms, whilst ensuring that alcohol remains affordable for moderate drinkers.

— In addition to price increases, the most effective strategies to reduce alcohol-related harm, include restrictions on the physical availability of alcohol, brief interventions with at-risk drinkers and treatment of drinkers with alcohol dependence.

— Children and young people are especially vulnerable to the effects of alcohol marketing. Consequently, such marketing should be firmly regulated and restricted to adult only audiences.

— Current health spending priorities need to be rebalanced, with much greater expenditure in areas such as alcohol treatment and advice services.

— Central guidance and support for the development of cohesive and comprehensive services to tackle alcohol problems should be provided via a specialist team within Public Health England.

2. ALCOHOL CONSUMPTION AND PUBLIC HEALTH

2.1 There is overwhelming scientific evidence that excessive consumption significantly increases risk to long-term health. Alcohol is a factor in more than 40 serious medical conditions, including liver disease and mouth, food pipe, bowel and breast cancer,[180] and one of the major preventable causes of death in England and Wales. Liver disease, in particular, to which alcohol is the key contributor, is the only major cause of death still increasing year-on-year.[181] UK deaths from liver cirrhosis increased more than five-fold between 1970 and 2006.[182] In contrast, in France, Italy and Spain, the number of deaths decreased by at least 50% and are now lower than those in the UK.[183]

[179] http://www.nationalpubwatch.org.uk/NPWMapping/

[180] Cancer Research UK (2008) *Alcohol and cancer*, online, available from http://www.cancerresearch.org.uk [Accessed 23/02/10].

[181] Office for National Statistics (2008) *Health statistics quarterly*, Winter 2008, No 40, Newport, ONS.

[182] House of Commons Health Select Committee (2010) *Alcohol: First report of session 2009–10*, Volume 1, London, The Stationery Office.

[183] *ibid*.

2.2 As the Government's alcohol strategy acknowledges, alcohol misuse also places a huge burden on the NHS. It is estimated to cost the NHS £2.7 billion every year. The number of hospital admissions due to alcohol misuse was 1.1 million in 2009–10, a 100% increase since 2002–03.[184] If the rise continues unchecked, by the end of the current Parliament 1.5 million will be admitted to hospital very year as a result of drinking.[185]

3. Minimum Unit Price

3.1 Alcohol Concern has been campaigning for a MUP for a number of years, and we are strongly welcome the Government's decision to commit to this measure.

3.2 A culture of alcohol overuse has developed. Recent qualitative research conducted on behalf of Alcohol Concern, found that heavy drinking is typically regarded by drinkers as an essential part of "a good night out", with drunkenness seen by some as not only acceptable, but as something to look forward to, even though it often led to regrettable incidents.[186] It is clear that changes to our drinking behaviour are needed, and an increasing body of evidence shows that the affordability of alcohol is a key driver in achieving this.[187]

3.3 A meta-analysis of the effects of alcohol prices and taxes on drinking, by Wagenaar *et al*, concluded that "price affects drinking of all types of beverages, and across the population of drinkers from light drinkers to heavy drinkers. We know of no other preventative intervention to reduce drinking that has the numbers of studies and consistency of effects seen in the literature on alcohol taxes and prices".[188]

3.4 There have been limited examples of minimum pricing policies which have been undertaken. A locally imposed minimum pricing restriction in Australia resulted in a 19.4% reduction in alcohol consumption, fewer hospital admissions for alcohol-related illnesses and fewer arrests.[189] A recent study of MUP in British Columbia, Canada, which has been in place for 20 years, found that a 10% increase in minimum prices reduced consumption of spirits and liqueurs by 6.8%, wine by 8.9%, alcoholic sodas and ciders by 13.9%, beer by 1.5%, and all alcoholic drinks by 3.4%.[190]

3.5 As part of a Sheffield University study in 2009, the potential effects of different minimum pricing levels were examined.[191] The study found that the more intensive the pricing policy, the greater the harm reduction. Low minimum prices were found to have little impact, but the effectiveness accelerates rapidly from a MUP of 40p up to 70p. A MUP of 40p would result in a reduction in consumption of 2.7%, 3,600 fewer hospital admissions and 1,100 fewer crimes per year. A MUP of 50p would see a 7.2% reduction in consumption, 8,900 fewer hospital admissions and 4,200 less crimes per year. This impact would be even greater if the policy is combined with an off-licence discount ban.

3.6 Using the same data sources as the Sheffield study, which indicate that 80% of alcohol is consumed by 30% of the population and that the bottom 30% consumes only 2% of alcohol, it has been shown that, based on a 50p MUP, the bottom 30% of consumers would spend 10p per week more on alcohol, the middle 40% £1.09 and the top 30% £4.16 (if consumption remained the same).[192] Alcohol Concern advocates at least 50p MUP, which would result in a significant reduction in alcohol-related harms whilst ensuring that alcohol remains affordable for moderate drinkers.

3.7 An effect of a MUP might also be to encourage alcohol producers to reduce the alcoholic content of their products.[193] Wine usually has an alcohol content of 12%, meaning that a standard bottle contains nine units of alcohol. A bottle selling at a price for three bottles for £10 would cost £3.33 and a MUP of 50p would increase this to £4.50; however, by reducing the alcohol content to 9%, the price could still be £3.38, thus facilitating a reduction in alcohol content.

4. The Effectiveness of Other Interventions

4.1 According to a recent review,[194] the most effective strategies to reduce alcohol-related harm from a public health perspective include, in rank order, price increases, restrictions on the physical availability of

[184] North West Public Health Observatory (2009) *Alcohol-Related Hospital Admissions*, North West Public Health Observatory and Centre for Public Health.

[185] Department of Health (2010) *Alcohol Ready Reckoner V.5.1*, London, Department of Health.

[186] Alcohol Concern (2010) *A drinking nation? Wales and alcohol*, London, Alcohol Concern.

[187] Bailey, J *et al* (2011) *Achieving Positive Change in the Drinking Culture of Wales*, Glyndŵr University Wrexham and Bangor University, London, Alcohol Concern.

[188] Wagenaar, A C, Salois, M J and Komro, K A (2008) *Effects of beverage alcohol price and tax levels on drinking: A meta-analysis of 1003 estimates from 112 studies, p187*, Presented at the 34th Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol, Vicotir, British Columbia, June 2–6, 2008.

[189] Gray, D *et al* (2000) *Beating the grog: An evaluation of the Tennant Creek liquor licensing restrictions*, Australian and New Zealand Journal of Public Health, 24(1), pp 39–44.

[190] Stockwell, T *et al* (2012) *Does minimum pricing reduce alcohol consumption? The experience of a Canadian province*, Addiction, online, available from http://onlinelibrary.wiley.com/doi/10.1111/j.1360–0443.2011.03763.x/full [Accessed 04/04/2012].

[191] School of Health and Related Research (2009) *Model-Based Appraisal of Alcohol Minimum Pricing and Off-Licensed Trade Discount Bans in Scotland: An Scottish Adaptation of the Sheffield Alcohol Policy Model version 2*, online, available from http://www.scotland.gov.uk/Publications/2009/09/24131201/0 [Accessed 04/04/2012].

[192] Record, C and Day, C (2009) *Britain's alcohol market: How minimum alcohol prices could stop moderate drinkers subsidising those drinking at hazardous and harmful levels*, Clinical Medicine, 9(5), pp421–425.

[193] ibid.

[194] *ibid*.

alcohol, drink-driving counter measures, brief interventions with at-risk drinkers, and treatment of drinkers with alcohol dependence. Another review concludes that regulatory approaches (including those that manage price, availability and marketing of alcohol) reduce the risk and the experience of alcohol-related harm, whereas educational approaches (including school-based education and public education programs) do not.[195]

4.2 Educational programmes and persuasion strategies, typically favoured by the drinks industry, are expensive and compared with other interventions appear to have little long-term effect on alcohol consumption levels and drinking-related problems, especially compared with £800m spent on promoting alcohol through advertising. Studies have shown that although they can increase knowledge and change attitudes, actual alcohol use amongst participants largely remain unaffected.[196] Other researchers argue that, even with adequate resources, strategies which try to use education to prevent alcohol-related harm are unlikely to deliver large or sustained benefits, and that "education alone is too weak a strategy to counteract other forces that pervade the environment".[197]

4.3 Conversely, there is evidence that introducing restrictions on physical availability can have a positive effect in reducing harm. Several international studies have identified a link between outlet density and physical violence. Limiting outlet density within a community may be effective because this may increase the time and convenience that a typical drinker encounters in obtaining alcohol; limiting competition between retailers and thereby reducing the likelihood of cut-price promotions and under-age sales; and avoiding high crowd density that frequently accompanies the bunching of outlets that may exacerbate incidences of violence.[198] We therefore welcome measures in the Government's Alcohol Strategy to strengthen licensing arrangements.

4.4 A combination of law enforcement and sustained publicity campaigns has substantially reduced the number of drink-drive accidents in recent years. Despite this, 17% of all road fatalities in 2009 were a result of drink-driving.[199] It is therefore surprising that there is no mention of specific measures to reduce drink-drive accidents in the new strategy. Alcohol Concern supports the recommendations of Sir Peter North,[200] in particular the need to lower the legal blood alcohol limit to 50mg of alcohol in 100ml of blood, which would bring the country in line with many other European countries, including France, Spain, Germany, Italy and the Netherlands.

4.5 Evaluations of the effects of alcohol warning labels on drinks products are limited to the US, which have shown improved awareness of safe drinking, but only slight evidence of any effects in changing actual drinking behaviour.[201] The tobacco labelling experience, however, offers strong evidence that warning labels can be effective in shifting behaviour. According to Ferrence et al,[202] unlike cigarette warnings, alcohol warning labels are often "vague and equivocal" and are not presented "in a vivid manner that evokes emotional reactions".

4.6 Plain packaging of cigarette products is gathering increasing support, with Australia set to become the first country to enforce this through legislation. To our knowledge, there are no studies of the potential effectiveness of plain packaging for alcohol products, and research in this area would be welcome. Labelling is clearly part of the alcohol marketing mix, illustrated by a leading drinks company's recent decision to include images of James Bond on packaging as part of its sponsorship deal with the movie franchise.[203]

5. Alcohol Marketing and the Drinks Industry

5.1 Children and young people are particularly vulnerable to the effects of alcohol marketing, especially those who are already showing signs of alcohol-related problems. Such marketing manipulates this vulnerability by shaping their attitudes, perceptions and expectancies about alcohol, which then influence their decision to drink.[204]

5.2 A number of recent studies have shown a clear association between alcohol marketing and youth drinking behaviour, and which conclude that the alcohol industry should not be involved in making alcohol policy.[205, 206]

[195] Anderson, P (2009) *Global alcohol policy and the alcohol industry*, Current Opinion in Psychiatry, 22(3), pp 253–257.

[196] *op cit* Babor, T *et al* (2010).

[197] *op cit* Bailey, J *et al*, p 31 (2011).

[198] Alcohol Concern (forthcoming) *Full to the brim? Explaining the relationship between outlet-density and alcohol-related harm*, London, Alcohol Concern.

[199] Department for Transport, online, http://webarchive.nationalarchives.gov.uk/20110503151558/http://dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesgbar/rrcgb2009 [Accessed 23/04/2012].

[200] Sir Peter North (2010) *Report of the Review of the Drink and Drug Driving Law*, online, available from http://webarchive.nationalarchives.gov.uk/20100921035225/http://northreview.independent.gov.uk/docs/NorthReview-Report.pdf [Accessed 23/04/2012].

[201] Wilkinson, C and Room, R (2009) *Warnings on alcohol containers and advertisements: International experience and evidence of effects*, Drug & Alcohol Review, 28(4), pp 426–435.

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, [207, 208] This is a position endorsed by the World Health Organisation, which chooses not collaborate with any of the sectors of the alcohol industry.[209]

5.3 Alcohol Concern's own research has highlighted the frequency and volume of exposure by children and young people to alcohol advertising. In the UK over £800 million is spent on alcohol advertising. Over one million children were exposed to alcohol advertising during the televised England games of the World Cup in June 2010.[210] In a study of more than 400 children aged 10 and 11, the number of these able to identify alcohol branding and advertising was found to be comparable to, and in some cases, greater than those who recognised brand and advertising for products known to appeal to and often aimed at children, such as ice cream and cake.[211]

5.4 It is therefore disappointing that the Government's new strategy fails to provide firm action to strengthen regulations on alcohol marketing, especially given that many young people feel that current regulations do not provide adequate protection to their peers. A survey of over 2,300 under-18s suggests that people from this age group are highly aware of alcohol promotion and that existing rules are insufficiently robust to protect them from unnecessary exposure. Similarly, Alcohol Concern's Youth Alcohol Advertising Council, a group of 10 under-18s from across the country that meet quarterly to review selected alcohol advertising against key principles of the Advertising Standards Code, have identified what they regard as frequent breaches of compliance with both the wording and spirit of the Code.[212] The group has a made a number of complaints about alcohol advertising and very few have been upheld.

5.5 It is also concerning to find in the new strategy the wish to encourage "advertising which builds more positive associations (for example, between alcohol and positive socialising) instead of negative ones (for example, between alcohol and wild, disinhibited behaviour)". Current rules rightly prohibit advertising that implies that alcohol can enhance the social success of an individual or event, although a study of the industry's internal marketing documents by Hastings *et al*[213] concluded that, in practice, this a theme frequently incorporated into alcohol advertising. Young people in the UK have by far the most positive expectations of alcohol in Europe and are least likely to feel that it might cause them harm;[214] implying that alcohol is an aid to socialising is unlikely to be helpful in this context.

5.6 Alcohol Concern believes the Government should seriously review the role performed by the Advertising Standards Authority and the Portman Group in relation to the regulation of advertising. More should be done to pre-vet advertising. There is also more that can be learned by France who have stricter controls over advertising in place such as the restriction only to advertise "factual" information (eg ABV strength, ingredients, point of origin) rather than emotional or social associations and also their controls over sponsorship of events which appeal to young people.

6. Investing in Treatment Services

6.1 Around half of the £2 billion spent on public health and treatment currently goes on drugs initiatives meanwhile, latest available figures show that local PCTs spend an average of £600k a year on alcohol treatment and counselling services, representing just 0.1% of a typical PCT's yearly spending.[215] Yet nationally 13–20% of all hospital admissions are alcohol-related and this figure is widely considered to be an underestimate, as coding of alcohol-related disorders is "notoriously inaccurate" and evidence of alcohol-related problems can easily be missed or ignored.[216] There is an urgent need to provide care for a large and growing group of patients with alcohol-related health problems. Presently a lack of coordinated action means that "care is imperfect and spending is poorly targeted and ineffective", very few hospitals have dedicated alcohol services and only 5.6% of dependent or harmful drinkers access treatment, compared to 67% of dependent or harmful drug users.[217]

6.2 Historically, there has been a lack of high-level support for alcohol services, which has resulted in a piecemeal approach to planning and development. With 1.6 million people in England experiencing alcohol dependency support for this group must be made a greater priority than indicated in the strategy.

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6.3 The Strategy does propose interventions for some specific groups, including offenders and young people who binge drink, but fails to address the significant proportion of the population who, although not dependent, regularly drink at or above published guidelines over a long period of time, which can lead to or contribute to a range of health conditions. We believe that there should be full implementation of the NICE guidelines relating to alcohol treatment, which provide an excellent, evidenced-based guide to effective intervention and referral systems.

6.4 Changes to the public health system that are due to take place in 2013 offer real opportunities to develop a more cohesive and cost-effective approach to preventing and treating alcohol problems. However there is also a serious risk that a lack of appropriate expertise and guidance will lead to these opportunities being lost, or to an unacceptable disparity in the level and quality of services across the country. Local authorities and their colleagues in clinical commissioning groups will require support in the form, perhaps, of a national service framework that could be adapted to local needs, backed up by the opportunity to share best practice. Such a framework could be led by a dedicated alcohol team within Public Health England, with established experts setting out, and supporting the implementation of, principles for action, rather than prescriptive plans.

6.5 Similarly, the NHS Commissioning Board should provide local commissioning groups with guidance on the best practice for commissioning comprehensive alcohol treatment services, based on the NICE guidance and the forthcoming quality standard on alcohol dependence. They must hold commissioning consortia to account on their performance against a set of indicators relating to alcohol treatment services, linking to the shared mortality improvement area to reduce the under 75 mortality rate for liver disease in the NHS Outcomes Framework.

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