

Title: Consultation on including a health objective in the Licensing Act 2003 related specifically to cumulative impact IA No: Lead department or agency: Home Office Other departments or agencies: Home Office is working jointly with the Department of Health	Impact Assessment (IA)		
	Date: 18/09/2012		
	Stage: Consultation		
	Source of intervention: Domestic		
	Type of measure: Primary legislation		
Contact for enquiries: Helen Brewis - Helen.Brewis@homeoffice.gsi.gov.uk or Emma Wilbraham - emma.wilbraham@dh.gsi.gov.uk			
Summary: Intervention and Options			RPC Opinion: Awaiting Scrutiny

Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Measure qualifies as One-Out?
£164m	-£105m	£12.2m	Yes IN

What is the problem under consideration? Why is government intervention necessary?

The Government set out a range of actions in the Alcohol Strategy to tackle alcohol-related harm, which it sees as unacceptably high. It has committed to enabling local authorities to take wider alcohol-related health harm into account in licensing decisions; a current gap, which would need to be amended through legislation. Some local areas experience significantly higher levels of harm. Recent evidence shows levels of health harm can be linked to the density of licensed premises. Local areas can introduce cumulative impact policies (CIPs) to limit density, but only based on the existing licensing objectives, which exclude health harms so they cannot consider the full range of impacts from alcohol, including chronic health harms.

What are the policy objectives and the intended effects?

The objective is to enable licensing authorities to consider all alcohol-related health harms (including liver disease, alcohol-related deaths or hospital admissions for example) when considering cumulative impact, in addition to evidence relating to the existing four licensing objectives. This would enable local areas to use CIPs to restrict the number of new premises selling alcohol, if there is evidence of significant local alcohol-related health problems. The power to introduce a CIP would remain discretionary, and as now, would introduce a rebuttable presumption that new licence applications and some variations will be refused. We will test the assumptions we have made about the impacts of the policy during the consultation process.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1 - do nothing
Option 2 - introduce a health-related licensing objective in the Licensing Act 2003 linked specifically to cumulative impact
Option 2 is the preferred option. The Government has committed to providing local areas with additional powers to tackle alcohol-related harm and giving health harms greater consideration in the licensing process; doing nothing will not achieve this. A health-related licensing objective linked to CIPs is a proportionate measure supported by the evidence base and the Government is consulting on how best to deliver this. Following earlier consultations the Government has dismissed simply introducing health as a fifth objective alongside the existing four as being disproportionate given the evidence base and anticipated larger costs to business. This impact assessment accompanies the consultation on Option 2

Will the policy be reviewed? It will be reviewed. If applicable, set review date: 04/2019					
Does implementation go beyond minimum EU requirements?			No		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	Micro Yes	< 20 Yes	Small Yes	Medium Yes	Large Yes
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded: n/a	Non-traded: n/a	

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Jeremy Browne MP:  Date: 20-09-12

Summary: Analysis & Evidence

Policy Option 2

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: 164

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	1		
High			
Best Estimate		0.7	18.9

Description and scale of key monetised costs by 'main affected groups'

There will be an impact on the profit of the alcohol industry and total business profits overall because of the restrictions on the number of licences issued; this is estimated as an economic loss of £18.9m per year. There would be estimated transition (familiarisation) costs for business of £0.2m and for licensing authorities of £0.5m. Exchequer losses are expected to be roughly £12m per year. During the consultation, further evidence will be sought to assist in assessing these costs.

Other key non-monetised costs by 'main affected groups'

The restrictions on the number of licences may mean a minor cost to individuals who drink alcohol as the volume of licensed premises in the area may not increase as it would otherwise have done or it may gradually reduce. During the consultation, further evidence will be sought to enable us to monetise this cost. The policy may also have a small adverse impact on competition in the alcohol retail sector.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0		
High			
Best Estimate			36.7

Description and scale of key monetised benefits by 'main affected groups'

Areas that use this measure should see a reduction in alcohol-related health and other problems, including numbers of alcohol-related hospital admissions, deaths and crimes. The total benefits will depend on the number of areas that use the new measure to introduce or extend a CIP and how large that CIP area is. We estimate them to be in the range of £322m over 10 years. As this is a discretionary power it is not possible to provide exact numbers of licensing authorities who will use it and take up may be gradual.

Other key non-monetised benefits by 'main affected groups'

Local residents in CIP areas should benefit from reduced alcohol-related health problems and there should also be benefits in reducing the impact of the night-time economy if levels of public nuisance and crime and disorder are also reduced as a result. There may be a benefit to business of consumers switching their expenditure from alcohol to other goods and from any decrease in levels of employees' sickness absence.

Key assumptions/sensitivities/risks

Discount rate (%)

3.5

There is uncertainty about the numbers of licence applications that would be rejected in areas that introduce or extend a CIP and about the numbers of licensing authorities that may use the power. Further information on these aspects will be sought during the consultation. The key risks are that considerably more or fewer licensing authorities use the power than currently envisaged leading to a greater cost to business or reduced impact on alcohol-related harms.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 12.2	Benefits: 0	Net: -12.2	Yes	IN

Evidence Base

A. Strategic Overview

A.1 Background

What is the problem under consideration? Why is government intervention necessary?

The Government wants to enable action at a local level to tackle alcohol-related health harm and crime and disorder based on local assessments of what is most appropriate for each community. Fifty years ago, the United Kingdom had one of the lowest drinking levels in Europe but it is now at about the EU average. The UK is one of the few European countries whose consumption has increased substantially over that period. A significant minority of people drink harmfully¹:

- over 9 million people (around a quarter of adult men (26%) and a fifth of women (19%)) say they drink above the NHS guidelines
- almost 1.2 million hospital admissions and 1 million violent crimes each year are alcohol-related
- alcohol is the third biggest lifestyle risk factor for disease and death in the UK after smoking and obesity
- liver deaths have risen by 25% over the last 8 years².

The Government Alcohol Strategy, launched on 23 March 2012, aims to radically reshape the approach to alcohol and reduce the number of people drinking to excess. It sets out how local and national government, the alcohol industry and people themselves can achieve this and includes a commitment to consult on introducing a health-related objective in the Licensing Act 2003 linked specifically to cumulative impact.

We estimate the costs of alcohol misuse in England as follows:

- NHS costs, at about £3.5bn per year at 2009-10 costs³
- Alcohol-related crime, at £11bn per year at 2010-11 costs⁴
- Lost productivity due to alcohol, at about £7.3bn per year at 2009-10 costs (UK estimate)⁵

Detailed evidence on alcohol misuse and harm in England is set out as part of the Department of Health's evidence to the Health Committee's inquiry into the Alcohol Strategy⁶.

There is a good evidence base for the link between outlet density and alcohol-related harm and to suggest that a reduction in density would lead to a reduction in both health and crime and disorder related harm (see Rationale). Licensing authorities can already use cumulative impact policies (CIPs) to limit the density of premises in their area, where they have evidence that the number of licensed premises is having a cumulative impact on the promotion of one or more of the licensing objectives. Currently licensing authorities can only consider health data that relates to the existing licensing objectives (preventing crime and disorder; protecting children from harm; public safety and preventing public nuisance) so such considerations are limited to acute harm such as injuries caused by violence or accidents, or unconsciousness when considering CIPs.

This is a pre-consultation impact assessment and is based on the best available evidence at the point of publication. We have set out within the impact assessment the areas where we hope to

¹ www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy

² Source: WHO/Europe, European HFA Database, January 2012

³ The Department of Health has updated the previous estimate of around £2.7bn at 2006-07 prices, using the same methodology

⁴ 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.

⁵ The Department of Health has updated the previous estimate of around £6.4bn at 2006-07 prices, using the same methodology

⁶ Government's Alcohol Strategy: written evidence submitted by oral witnesses pages 14- 31 /www.parliament.uk/documents/commons-committees/Health/Writtenevidencebyoralwitnesses.pdf

increase our evidence base through the consultation process. Impact estimates (both costs and benefits) therefore remain subject to change.

The total potential costs and benefits of this measure would depend on how many local areas choose to use it and in what way. Some of the data is therefore indicative. The consultation will seek further evidence and data to inform any future impact assessment (see annex B for more details on the planned areas for consultation and further evidence gathering).

Impact of the wider Alcohol Strategy

It is important to note that there will be impacts (both costs and benefits) from the other policies arising from the Government's Alcohol Strategy but for the purpose of this pre-consultation assessment we are appraising the introduction of a health-related objective for alcohol licensing relating specifically to cumulative impact (option 2) in isolation. Impact assessments will be revised following public consultation to reflect the agreed and combined package of measures being taken forward.

Policy context

In moderation, alcohol consumption can have a positive impact on adults' wellbeing, especially where this encourages sociability. Alcohol also plays an important part in the cultural life of this country; the industry as a whole contributes around £9 billion to the Exchequer through excise duty and there are nearly 200,000 premises licensed to sell alcohol.

Effective alcohol licensing that regulates sales and gives local areas the powers they need to tackle alcohol-related problems is essential. The Police Reform and Social Responsibility Act 2011 (PRSR Act) brought in a range of measures to deliver the coalition's commitment to rebalance the Licensing Act 2003 and enable local authorities to develop a licensing regime suitable to their local needs. This includes consulting on the inclusion of a health-related licensing objective linked to CIPs. The following background evidence has been considered in drawing up this option:

- Over 60 diseases or conditions can be caused by drinking alcohol⁷. The four biggest disease groups related to long term consumption are heart disease, stroke, liver disease, and cancer. Risks of these diseases, broadly, rise in line with levels of consumption. Over the last ten years, health harms have continued to grow. UK average alcohol consumption is now at about the EU average, having been much below it 50 years ago.
- There are clear differences in levels of alcohol-related health harm across the country. For example there is a wide variation in levels of admissions to hospital relating to alcohol. In 2011 annual rates ranged from 3,114 admissions per 100,000 residents in Liverpool to 849 per 100,000 residents in the Isle of Wight.
- There were 216,200 premises licences and club premises certificates in force in England and Wales as at 31st March 2010⁸, an estimated 0.5% increase over the previous year, but around 100 licensing authorities recorded a decrease over the 12 month period. In 2010, there were 35,100 on-trade premises; 48,700 off-trade premises and 82,300 on- and off-trade premises.
- In 2009/10, almost all applications for new licences were granted (97%), as were applications for variations (97%) and transfers (99.5%).
- As at 31st March 2010 there were 134 cumulative impact areas (CIA) and 83 licensing authorities had at least one cumulative impact area.

More details and background evidence are set out in Annex A.

⁷ Corrao et al. (2004): A meta-analysis of alcohol consumption and the risk of 15 diseases. *Preventive Medicine* 38, 613-9

⁸ Alcohol, Entertainment and Late Night Refreshment Licensing Bulletin for England and Wales, September 2010

A.2 Groups Affected

Retailers wanting to operate in areas with cumulative impact policies in place

The UK alcohol market is divided into two sectors, the off-trade, which would typically include supermarkets and off-licences and the on-trade, which would typically include pubs, bars, nightclubs and restaurants; some retailers are licensed to sell alcohol on and off the premises.

Option 2 would affect on- and off-trade retailers applying for new licences and some existing premises applying for licence variations in an area that uses the new measure to introduce a CIP including health considerations or decides to extend the geographic area of an existing CIP (potentially to include the whole licensing authority area) following consideration of health data. Existing retailers' licences would not be affected unless they wished to apply for a variation to their licence and that variation was considered to add to the cumulative impact. Based on the current CIP process, the effect would be that in the cumulative impact area, new licences and some licence variations would be refused (where a representation is made that the application or variation will add to the cumulative impact) unless the licence applicant is able to demonstrate that their licence would not add to the cumulative impact. Some retailers whose licences are refused on the basis of a CIP may want to challenge these refusals at appeal, resulting in legal costs.

Local authorities

Licensing authorities (district or borough councils in two tier areas) would be able to take alcohol-related health harms into consideration when making decisions about CIPs. This may mean new authorities introduce CIPs or those with an existing CIP extend it to cover a larger area. Upper tier and unitary local authorities will take on public health functions from April 2013 and we envisage the Director of Public Health will be best placed to collect and collate health-related information for use by the licensing authority.

Criminal Justice System

Any reduction in alcohol-related crime will benefit the Criminal Justice System. Increases in the number of licences that are refused on the basis of cumulative impact may result in a small increase in the number of appeals and so have an impact on Magistrates' Courts.

The NHS

Any reduction in alcohol-related health harms will benefit the NHS.

The public

Some local residents in CIP areas who drink alcohol could be affected as decisions to refuse licences may mean the volume of licensed premises in the area may not increase as it would otherwise have done or it may gradually reduce. However, there should also be a positive overall impact on the night-time economy and areas with demonstrable alcohol-related health problems should see a reduction in these problems.

Enforcement bodies

There is unlikely to be an impact on the police or others with regard to enforcement.

The extent to which all of these groups may be affected will depend on the number of licensing authorities that choose to use the new measure.

A.3 Consultation

Within Government

The Home Office and Department of Health are working jointly on this policy as it covers licensing and health. The original consultation on rebalancing the Licensing Act (July- September 2010) and the policies in the Alcohol Strategy were considered in discussions with and cleared by Cabinet committee, which included Her Majesty's Treasury and the Departments for Business, Innovation and Skills; Culture, Media and Sport; Education; Communities and Local Government; Ministry of Justice and Environment, Farming and Rural Affairs. Such discussions and clearance processes will continue as the proposals are developed.

Public Consultation

This impact assessment accompanies a public consultation on option 2.

The Rebalancing the Licensing Act consultation invited views on including the prevention of health harm as an overarching licensing objective. There was a mixed response - 38 per cent of respondents gave positive responses, 37 per cent gave negative responses and 25 per cent gave neutral responses (in total there were 798 responses).

Perceived benefits included improved population health, reduced burden on the NHS and increased responsibility amongst licensees. However, concerns were raised about how health data could be used in practice and that a health objective requiring all licensed premises to promote public health could be onerous.

The previous consultation invited views on a number of health-related options including a more general proposal to include health as a fifth licensing objective ('the prevention of health harm') which would have the potential for resultant conditions requiring businesses to promote sensible drinking messages, for example. The proposal under consultation is for a new, much narrower, health-related objective for alcohol licensing related specifically to cumulative impact. The Government felt a full licensing objective was disproportionate (see Rationale).

This consultation will seek views on:

- the potential impact of this proposal on local areas;
- how far the current CIP process might need to be amended to include consideration of alcohol-related health harms; and
- the evidence local areas have on alcohol-related health harms that could contribute to a CIP if this proposal were introduced.

The intention is also to learn from the experiences of licensing authorities who are already successfully using CIPs and can provide technical input based on their experiences of introducing and implementing CIPs. We intend to seek specific input from licensing authorities, health bodies and other practitioners on the technical details of this proposal through individual meetings and technical consultation groups. We will seek input from the alcohol industry on the potential impacts on different types of local businesses. More details on the consultation approach are set out at Annex B.

B. Rationale

There is a good evidence base for the link between outlet density and alcohol-related harm and to suggest that a reduction in density would lead to a reduction in both alcohol-related health harm and crime and disorder. This is summarised in public health guidance from the National Institute for Health and Clinical Excellence (NICE), published in June 2010.⁹ Underlying the NICE guidance, an extensive review¹⁰ of the evidence relating to alcohol policies, including the availability of alcohol, found a clear positive relationship between increased outlet density and alcohol consumption in adults. It also found that increases in alcohol outlet density tended to be associated with increases in alcohol consumption and alcohol-related morbidity and mortality and a range of other outcomes including those related to crime. After considering this evidence, NICE concluded that reducing the number of outlets selling alcohol was an effective way to reduce alcohol-related harm. This is also the conclusion of the World Health Organization report '*Alcohol in the European Union: consumption, harm and policy approaches*'¹¹. More information is given in Annex A.

CIPs are not mentioned specifically in the Licensing Act but the powers to introduce them are set out in statutory guidance issued under section 182 of the 2003 Act. They offer licensing authorities a tool to restrict the number of licensed premises in a specifically defined area if they have

⁹ Alcohol use disorders: Preventing the development of hazardous and harmful drinking, National Institute for Health and Clinical Excellence, June 2010

¹⁰ *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

¹¹ http://www.euro.who.int/__data/assets/pdf_file/0003/160680/Alcohol-in-the-European-Union-2012.pdf

evidence that a concentration of premises is having a cumulative impact on the promotion of one or more of the current licensing objectives, such as preventing public nuisance or crime and disorder. Health data can only currently be considered in the licensing process where it links to one or more of the licensing objectives. For example, evidence on Accident & Emergency attendances as a result of injuries caused by alcohol-related violent crime would be relevant to the public safety objective. Licensing authorities cannot currently take long-term alcohol-related health harms into consideration.

Given the levels of alcohol-related health harms and the evidence to support the link between outlet density and alcohol-related harm, the Government intends to enable local areas to consider alcohol-related health harm alongside evidence linked to the current licensing objectives when considering CIPs. The clear differences in the levels of alcohol-related health harm across the country also support introducing this as an evidence-based discretionary power. As the Alcohol Strategy makes clear, whenever possible the Government wants to pass power back to local communities who are best placed to determine appropriate local approaches to address alcohol-related harm.

The previous consultation in summer 2010 on rebalancing the Licensing Act 2003 included consideration of making “*the prevention of health harm a material consideration for licensing authorities, either as a fifth licensing objective or as a discretionary power available to the authority to address local problems.*” Making the prevention of health harm an unqualified fifth licensing objective on a par with the current four statutory licensing objectives (prevention of crime and disorder; prevention of public nuisance; public safety and the protection of children from harm), would have affected all licensed premises and covered all aspects of the licensing process with the potential for resultant conditions such as requiring businesses to promote sensible drinking messages or to promote low-alcohol or non-alcoholic drinks, for example. The Government feels that this would be disproportionate and would result in introducing legislation in an area where the alcohol industry is already taking voluntary action. The Department of Health is already working with industry, through the Public Health Responsibility Deal, to deliver better public information and awareness without regulation¹². For example, through the Responsibility Deal, 80% of bottles and cans will have health and alcohol unit information clearly labelled by the end of 2013 and public unit awareness information is already being made available in both the on- and off-trade through posters and on beer mats etc.

C. Objectives

The objective of this measure is to allow licensing authorities to take all alcohol-related health harms into consideration when making decisions about CIPs, should they wish to do so. We envisage allowing local areas flexibility over such decision-making but would require them to provide robust evidence to support the need for such a policy. The intention is that as is the case now, a CIP would introduce a rebuttable presumption against granting new licences in cumulative impact areas, but each application would still be considered on its own merits so local businesses would have the opportunity to demonstrate that their application would not add to the cumulative impact.

If successful, we would expect the broadening of CIPs to include consideration of alcohol-related health harm to mean that the volume of licensed premises in the area may not increase as it would otherwise have done or may gradually reduce, and so play a part in reducing both health and other alcohol-related harms in local areas that choose to use them.

D. Options

Option 1 is to make no changes (do nothing).

The Government has committed to provide local areas with additional powers to tackle alcohol-related harm and give health harms greater consideration in licensing; doing nothing will not achieve this.

¹² <http://responsibilitydeal.dh.gov.uk/2011/12/20/alcohol-pledges/>

Option 2 is to introduce a health-related objective in the Licensing Act 2003 linked specifically to cumulative impact

Currently a CIP can be introduced on the basis of any one of the four existing licensing objectives, where problems can be linked to the concentration of licensed premises in a specific area. The intention is to add health as a fifth health-related licensing objective or material consideration to the Licensing Act 2003. Licensing authorities would then be able to consider alcohol-related health harm alongside the other harms they consider now when making decisions about CIPs. We expect that CIP areas linked to health harm will be bigger than current CIP areas, due to the population-based nature of health data. We expect that this will also bring benefits in reducing alcohol-related crime, which may result from reduced consumption or from less crowding and fewer people on the streets at one time because of lack of increase or reduction in the number of venues.

As this is a discretionary power, we cannot say how many licensing authorities may use it, but it is likely that authorities in areas with high levels of alcohol-related harms in particular will find it of considerable value. CIPs are an existing power so areas with high levels of alcohol-related crime and disorder and other problems linked to the promotion of the existing licensing objectives are already likely to have introduced a CIP, if they have evidence linking these issues to cumulative impact. Based on the numbers who have already introduced a CIP, the wide variation in levels of alcohol-related harm in different parts of the country and the experience of implementing a similar measure in Scotland (see Annex B) we expect that the number of areas that decide to implement a new CIP on this basis will be fairly small. We will explore this issue further during the consultation period to see if there is other information that could inform our estimates in any future impact assessments on this policy. The highest levels of health and other harms from alcohol misuse are often in economically deprived areas. The new power could potentially contribute to reducing health inequalities.

A similar power has existed in Scotland since September 2009 and has to date been taken up by a small number of local authorities.

E. Appraisal (Costs and Benefits)

OPTION 1 – do nothing

This option involves no change so there are no additional costs or benefits.

OPTION 2 – introduce a health-related objective in the Licensing Act 2003 linked specifically to cumulative impact

General assumptions & data

All costs and benefits have been evaluated and monetised where possible. However, this a discretionary power, which will be used based on an assessment of the local situation so it is not possible to determine the total impacts nationally. The aggregated national impacts on businesses and on levels of alcohol-related harm will depend on the number of licensing authorities that choose to use this measure and are estimated in this impact assessment. As set out above, we think it likely that a fairly small number of licensing authorities (those with the highest levels of alcohol-related health harm) would use this power but will explore this further during the consultation.

Decisions about CIPs are discretionary so, as with other discretionary licensing powers, it will not be possible to say with certainty how many licensing authorities may use the measure or the extent of any CIPs that are introduced, and therefore how many licences may be refused in total as a result of this policy. For this impact assessment we have used the possible scenario that half of the licensing authorities with existing CIP areas use the new power and extend their cumulative impact area resulting in a 50% rejection rate of applications. We think it likely that some authorities would extend the cumulative impact area to cover a larger geographic area than this but have used a 50% rejection rate as our best estimate of the costs and benefits of the policy and for the estimated impacts on business. Decisions to refuse licences may mean the volume of licensed premises in an area may not increase as it would otherwise have done or may gradually reduce.

In reality, we would also expect fewer licensing authorities with existing CIPs to decide to use the new power but some licensing authorities that do not have a CIP to introduce one. Half of the licensing authorities with existing CIP areas – 42 – is around 12% of the total number of licensing authorities and represents a reasonable estimate of the number of authorities that we expect might use this new power. During the consultation period we will consider how we can refine this scenario for any further impact assessments on this measure.

We have used the most recently published licensing data (DCMS Licensing Statistical Bulletin 2009-10) but are aware that there have been changes since then – for example there are currently 344 licensing authorities rather than the 349 reported in the statistical bulletin. We expect a revised licensing statistics bulletin to be published in Autumn 2012 and revised data would therefore be available for any further impact assessments on this measure.

The licensing statistics do not include information on how many licence applications have been refused on the basis of cumulative impact under the current system. As set out in Annex B, we will explore whether it is possible to collect such data from some areas with CIPs during the consultation period to inform any further impact assessments.

We do not expect all licence variations to be affected. An application to include regulated entertainment (for example, to allow the playing of live music) or to change premises layout may not be viewed by the licensing authority as adding to the cumulative impact whereas a significant extension of opening hours may be seen to do so. We do not have information on the proportion of variations that may be affected (as it is not possible to determine the proportion of different types of licence variation) and have not included them in the assessments here. We will explore this further during the consultation to better understand how it may be possible to assess this aspect in any future impact assessment on this measure.

We are considering how far the CIP process might need to be amended to include consideration of alcohol-related health harms, which could have an impact on the administrative costs to licensing authorities and business. This will be addressed in any future impact assessment on this measure.

Costs

Costs to business

Transition costs

Option 2 will affect new licence applications and some licence variations in areas that choose to introduce a CIP or extend an existing CIP. We consider that retail managers (off-trade) and bar managers (on-trade) in such situations are likely to be responsible for familiarisation with the change in policy. We estimate that this would take up to a maximum of 30 minutes (see average hourly wages at annex C) and estimate one-off familiarisation costs as follows:

Business familiarisation costs

Premises Type	New / Prospective	Existing	Total Premises	Sector Cost
On-trade	1,230	22,600	23,800	£138,000
Off-trade	528	9,680	10,200	£68,100
			Total Cost (approx)	£200,000

This assumes that all prospective licensees and all managers of existing licensed premises within licensing authority areas that introduce a health-based CIP familiarise themselves with the changes to the legislation. We have assumed that all existing premises in such areas familiarise themselves in the first year, although they would not be affected by the measure unless and until they apply for a variation in some instances.

Lost profit

Rejections of on-trade and off-trade licence applications are expected to increase in areas that either introduce a CIP based on alcohol-related health data or extend the geographical area of a CIP. It is likely there would be a loss of revenue and profit to alcohol retailers and their suppliers as the number of licensed premises falls relative to what it otherwise would have been. We expect that licence applications will still be considered on their own merits. During the consultation process, we will consider how and to what extent premises may be able to demonstrate sufficiently that their application will not add to the cumulative impact and so may still be able to obtain a licence in a CIP area.

To the extent that there is a supernormal component to the profit that could not be earned elsewhere, the profit impact (before tax) is indicative of the economic cost associated with the reduction in sales. The ultimate target is to identify the pre-tax loss associated with reduced capital in the alcohol industry (including on-trade and off-trade retail, and the supply chain) when accompanied by increased capital elsewhere, to the extent that the capital in various parts of the industry has a higher return than average. This Impact Assessment uses additional data to arrive at a more accurate approximation of this cost. A recent report by Deloitte (2008) presents data on various financial parameters for the world's top 250 consumer products companies; specifically, it finds an average net margin of 6.1%¹³. By contrast, financial data from Morningstar suggests an alcohol industry average net margin of 13.42%, i.e. an excess of 7.32 percentage points¹⁴.

The ONS estimate total expenditure on alcohol in England and Wales to be £37.44bn¹⁵ per annum. For the 216,200 licensed premises¹⁶ this gives an average revenue of £173,183. Therefore for the purposes of this assessment we have calculated that the excess profit for possessing a licence is £12,677.

This figure can be used to estimate the lost economic profit due to fewer licences being granted if 50% of licensing authorities with existing CIPs extend them to give a 50% rejection rate.

3,109 licences were granted in licensing authorities with CIPs in 2009/10. Many of these will have been to existing premises making new applications because existing licences have lapsed or because they are making changes to premises that are too extensive to be covered under a variation application. We assume only 70%¹⁷ of applications are for genuinely new premises. Our scenario would reduce the number of licenses granted nationally by 544 in the first year of the policy, **implying an economic loss of approximately £6.9m per year.**

The lost excess profit figure would rise if licensing authorities rejected further applications in subsequent years after the policy is implemented. However, it is difficult to predict to what extent this will happen as it will depend on how licensing authorities decide to use these powers and how wide an area they consider it appropriate to include in a CIP.

A consequence of the reduction in revenue and profit will be reduced employment in the alcohol and related industries. Increased spending on other goods and services will create additional employment and profits in those areas, including in related industries. Aside from the cost set out above, the long run effect is a reallocation of economic resources rather than a reduction in economic capacity. For this reason we do not anticipate any adverse impacts on employment.

Administrative costs

For the purposes of this impact assessment, we have assumed that applications to vary a licence have no impact on outlet density (see general assumptions). Although it is possible that the inclusion of health considerations in CIPs may involve some extra costs to compile applications, we do not expect option 2 to have a substantial additional impact on the costs of making new applications or variations.

¹³ Global powers of the consumer products industry

¹⁴ www.morningstar.co.uk

¹⁵ Total consumer expenditure on alcohol in the UK in 2010 was £42.07bn (ONS figures). Nielsen (2008) estimate that 89% of this expenditure was in England and Wales.

¹⁶ Alcohol, Entertainment and Late Night Refreshment Licensing Bulletin for England and Wales, September 2010

¹⁷ Based on discussions with City of Westminster Council Licensing Service; these figures are therefore indicative and may vary across different local authorities.

We think there is the potential for a slight increase in the numbers of hearings or mediated hearings and appeals in relation to licence rejections on the basis of CIPs. The overall number of appeals is currently small. There were 118 appeals made in 2009/10 against licensing determinations (excluding appeals on licensing reviews), which is a small proportion of the 4,300 applications that went to committee hearing. We do not have information on how many of these appeals were against refusals on the basis of cumulative impact, but expect the proportion to be quite low. We think therefore that the increase under option 2 would be very small and would not have a substantial additional impact on the costs to business.

There are a number of aspects in relation to appeals that we want to explore during the consultation period to inform this aspect of any future impact assessment. Some of the current hearings and appeals will have been against licences that were granted, for example appeals lodged by the police or local residents, but we do not have details of the relative proportions. We do not have information on whether the appeal rate differs following determinations made on the basis of cumulative impact and, during the consultation period, we want to explore whether it is possible to collect such data from some areas with CIPs.

Total business costs

Year 1	Ongoing
£0.2m	£6.9m

Costs to the public sector

Transition costs

Licensing authorities will need to familiarise themselves with the change in policy. We estimate that this would mean up to a maximum of 30 minutes per licensing official per licensing authority (see average hourly wages at annex C). We estimate one-off familiarisation costs as:

Public sector familiarisation costs

	Familiarisation costs
For an individual licensing authority	£6.80
For 349 licensing authorities	£2,370

Administrative costs

There may be administrative costs for licensing authorities in drawing up and consulting on a CIP or extending a CIP based on health data. As part of the process for introducing a CIP licensing authorities are required to consult, because the CIP forms part of the authority's licensing policy statement. Estimates of the administrative cost of producing and revising licensing statements between 2005 and 2009 from 10 licensing authorities found that the average cost of revising the licensing policy statement was £7,550 per revision with £4,220 spent on administering the consultation. Although the Government has relaxed requirements on licensing policy statements so that they need only be updated every five years rather than every three, the introduction of a new CIP is a substantive change on which a revision of the overall licensing policy statement would be required. We have used these figures to estimate the following costs to licensing authorities to introduce or extend a CIP:

Public sector administrative costs

	Costs of introducing / extending a CIP
For an individual licensing authority	£11,800
For 42 licensing authorities	£494,000

We envisage the Director of Public Health as being best placed to collect, collate and analyse health-related information to support decisions about a CIP. This would include, for example, data on alcohol-related hospital admissions and deaths, rates of liver disease and numbers of people drinking at increasing or higher risk levels or who are dependent on alcohol. Such data are set out by local authority area in the North West Public Health Observatory's annual Local Alcohol Profiles for England¹⁸ including comparisons with national and regional averages. Areas may also want to carry out additional work such as local surveys or further analysis to supplement this data. We expect that much of this information and advice should link to that which the Director of Public Health will be providing to the Health and Wellbeing Boards from April 2013 as part of the process of the Joint Strategic Needs Assessment and development of health and wellbeing strategies. We do not expect option 2 to introduce significant additional costs and will test this during the consultation in discussion with those working in this area.

Whilst there will be costs to local areas in introducing or extending a CIP, we would also expect local areas to benefit from a reduction in the numbers and costs associated with alcohol-related health and crime problems.

HM Courts & Tribunals Service

We expect some appeals to go to court, which would mean costs to Magistrates' courts. It is not possible to assess these costs as we have not estimated costs to the various agencies within the courts service involved in licensing appeals and we do not know how many appeals may be involved. Costs will also depend on the nature of the appeal. We will explore whether it is possible to assess these costs during the consultation process.

Cost to the exchequer

Excise duty forms roughly a quarter of the final retail price of alcoholic drinks. If consumption fell significantly as a result of these proposals the exchequer may experience large losses in revenue. Inputting the change in alcohol premises density into the SchARR model (see Annex D for information on this model) we estimate that the policy would result in a 0.2% reduction in alcohol consumption. This implies a **£12m per year loss** to the exchequer. For details of how this figure is calculated see Annex E. Because this loss is not compensated for elsewhere in the economy – by for example an increase in consumer welfare, firm profits or other tax receipts - it represents a deadweight loss and thus an economic cost.

It should be noted that this estimate is crude and has not been assessed by HMRC. We will seek their input when creating a more detailed estimate for the next Impact Assessment that will be produced after this consultation.

Costs to individuals

We expect some loss of consumer surplus as a decrease in outlet density (relative to the do nothing option) reduces consumption by effectively increasing the price (in terms of time and effort) to the consumer of purchasing alcohol.¹⁹

Although we have information about prices, quantities and price responsiveness (elasticities) for the market as it stands, it is difficult to estimate changes in consumer surplus without making strong assumptions about patterns in the demand for alcoholic drinks at other hypothetical price

¹⁸ NWPHO Local Alcohol Profiles for England: <http://www.lape.org.uk/>

¹⁹ Consumer surplus is defined as the difference between how much consumers value a product and what they actually pay

levels.²⁰ Government analysts are currently developing a methodology to estimate the loss in consumer surplus and will continue to develop this throughout the consultation period with the aim of producing an estimate for the final Impact Assessment. We will ensure that any approach is consistent with that being developed in parallel for the modelling of lost consumer surplus resulting from minimum unit pricing.

Total monetised costs

Year 1	Ongoing
£0.7m	£18.9m

Benefits

This impact assessment uses the Sheffield Alcohol Policy Model (the SchARR model)²¹ to analyse the health and crime impacts of option 2 (see annex D for more information). The SchARR model explores the impact of alcohol control policies on alcohol consumption and alcohol harms, such as mortality and morbidity, health care costs and crime. The core of the model links changes in the prices of different types of alcoholic drinks to changes in alcohol consumption via a set of price elasticities to assess the impact of alcohol pricing policies on alcohol harms. The model is also able to deal with other factors that influence consumption, such as outlet density, where the impact on alcohol consumption, and ultimately, harms, is estimated using international evidence on the link between outlet density and alcohol consumption.

The evidence identified by the team which developed the SchARR model suggests that there is a wide range of uncertainty surrounding the impact of outlet density on alcohol consumption. Five of the six studies reviewed estimated that there would be a reduction in consumption in response to a decrease in outlet density. For a 10% decrease in the number of off-trade and on-trade outlets, the reduction in consumption ranged from 0.3% to 3.7%, with a median of 1.9%. The results of the current analysis are consistent with the study which found a 3.7% decrease in consumption. Although the estimates reported here should be regarded as illustrative, the SchARR model represents the only peer reviewed research (to our knowledge) which has attempted to convert changes in consumption arising from changes in outlet density into changes in harms. For the purposes of our analysis we have assumed that all premises are equally important as sources of alcohol. This enables us, using the SchARR model, to translate a change in number of outlets into a change in the level of consumption.

The tables below summarise the impacts in the scenario of 50% refusal for all genuinely new licence applications²² in 50% of Licensing Authorities with an existing CIP in England and Wales. Such a policy would result in 544 fewer new licenses being granted in the first year the policy is implemented. This represents a 0.63% reduction in the number of licensed premises in the first year and a 0.23% reduction in alcohol consumption.

²⁰ We effectively need to map out the entire demand curve.

²¹ Purshouse R et al. (2009). Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group. Sheffield, University of Sheffield, School of Health and Related Research (SchARR).

²² Based on discussions with the Licensing Department at the City of Westminster Council we estimate that roughly 30% of new applications are for existing premises seeking to reinstate a licence, carry out a very significant variation or for a reason other than to establish an entirely new premises.

Health benefits

The table below shows the estimates of the health benefits expressed in terms of health care costs and quality adjusted life years (QALYs) gained in relation to health in the first year and once the full effects of the model have worked through (after ten years). A reduction in alcohol-related hospital admissions covers a wide range of alcohol-related conditions including alcoholic liver disease, heart disease, cancers, poisoning, falls and injuries, assault and road traffic accidents.²³

The direct health cost component comprises the health care costs of treating alcohol-related conditions. Gains in health-related quality adjusted life years (QALYs) show the increase in the number of life years in good health as a result of reductions in mortality and morbidity from alcohol-related conditions. A health related QALY is valued at £60,000 in accordance with Department of Health methods.²⁴

Reduction in alcohol-related health harms per annum (year 1 and year 10) for England and Wales²⁵ undiscounted

Health impacts (p.a.)	Year 1				Year 10			
	Deaths	Hospital admissions	Direct health care costs	QALYs valued at £60,000	Deaths	Hospital admissions	Direct health care costs	QALYs valued at £60,000
	-18	-740	-£3.2m	£10.5m	-88	-2,930	-£9.4m	£43.4m

Crime benefits

The table below shows the estimates of the crime benefits expressed in terms of crime costs each year.

Alcohol-related crimes include, among others, sexual offences, assault and criminal damage. The benefits to crime happen immediately from year one with no time-lag. The costs of crime to society are calculated by using the Home Office cost of crime estimates and measure the cost to society of crime (through the cost to victim services, health services, the cost of lost output, the cost of stolen and damaged property and the costs to the police and the criminal justice system).²⁶ Where savings are not “cashable”²⁷ they reflect the potential to reallocate resources to alternative uses. These savings do not include the increase in quality-adjusted life years from a reduction in crime and therefore underestimate the potential savings.²⁸

Reduction in alcohol-related crimes per annum (figures are constant each year) undiscounted

Crimes	Crime costs (£)
-5,600	-5.8m

²³ Health harm reductions are mostly likely to relate to chronic diseases rather than acute conditions such as injuries. This is because much of the alcohol-attributable health harm occurs in middle or older age groups who are at greater risk of developing these conditions.

²⁴ The Home Office calculation of total benefits from reductions in alcohol-related health harms differs from the standard methodology the Department of Health (DH) uses. Whilst this analysis only monetises the QALYs directly attributable to the policy, DH typically assume that any savings in direct health costs will be reinvested and produce one additional QALY for every £25,000 saved, at a benefit of £60,000 per QALY.

²⁵ ScHARR model results are based on English population figures so results are uprated by 6% to include effect on Welsh population

²⁶ Based on Brand and Price (2000) and Dubourg et al (2005) unit costs of crime. The ScHARR model uses unit costs in 2003 prices therefore are underestimates of the potential savings from any reductions in crime.

²⁷ Based on Brand and Price (2000) and Dubourg et al (2005) unit costs of crime. The ScHARR model uses unit costs in 2003 prices therefore are underestimates of the potential savings from any reductions in crime.

²⁸ Gains in health-related quality adjusted life years (QALYs) show the increase in the number of life years in good health as a result of reductions in mortality and morbidity from alcohol-related conditions.

Total monetised benefits

The table below shows the total monetised benefits, which include the cost savings due to better health and lower crime and the monetary value of health QALYs gained.

Total monetised benefits per annum undiscounted

Year 1	Year 10
£19.5m	£58.4m

Employment benefits

The costs of lost productivity due to alcohol misuse are substantial. The Government estimates these costs in total at £7.3bn per year in 2009-10²⁹ and that alcohol-related sickness absence accounts for 7-11% of all sickness absence. Reductions in alcohol-related harm may therefore benefit businesses if levels of sickness absence decrease. For alcohol-related unemployment, there are a number of studies with no unanimity of outcome, as the team that developed the SchARR model noted³⁰. It is technically difficult to investigate this area, as allowance has to be made for three possible effects:

- unemployment causes some heavy drinking,
- some unobservable individual factor such as low education may cause people both to be unemployed and to drink heavily,
- heavy drinking may cause unemployment.

Reduced alcohol consumption is expected to lead to employment benefits in the form of increased productivity and reduced absenteeism. We have not included an assessment of the employment benefits but, during the consultation period, we will explore whether it is possible to do so in any future impact assessments.

Benefits to individuals

Individual local residents in CIP areas may also benefit from reduced alcohol-related health problems and the positive impacts on the night-time economy.

ONE-IN-ONE-OUT (OIOO)

Option 2 has a direct impact on business and therefore is in scope for OIOO, with the following costs for the purposes of OIOO:

Costs (INs) £m undiscounted, best estimate

One off/transition <i>Familiarisation</i>	Average annual <i>lost alcohol profit</i>
0.2	12.6

One off/transition

Businesses will incur one off costs as they familiarise themselves with changes to the legislation - these are described in more detail on page 9 and 10 above. We estimate these costs to equal approximately **£0.2m**

Average annual

These costs consist of the lost profit suffered by the alcohol industry as a direct consequence of the policy. For the purposes of the OIOO calculation we do not offset these costs with the indirect

²⁹ The Prime Minister's Strategy Unit, Alcohol Harm Reduction Project, Interim Analytical Report, 2004; updated by internal Department of Health analysis, 2012.'

³⁰ Purshouse R et al. (2009). Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group. Sheffield, University of Sheffield, School of Health and Related Research (SchARR).

benefits to businesses in other sectors as consumers switch consumption from alcohol to other products. As stated earlier (page 10) financial data from Morningstar suggests an alcohol industry average net profit margin of 13.42%. Applying this to the predicted loss in revenue due to the policy gives a direct average annual loss to business of **£12.6m per year**. (544 fewer premises, each with an average revenue of £173,184 per year)

Benefits (OUTs)

Nil

Net

This is a net IN of £12.2m (equivalent annual cost)

OVERALL COSTS AND BENEFITS

This table reports 10-year discounted costs and benefits, and net present value.

Summary of costs and benefits

Costs	Benefits	NPV
£158m	£322m	£164m

F. Risks

Option 2 - introduce a health-related objective in the Licensing Act linked specifically to cumulative impact

There is a risk that few licensing authorities will decide to adopt or extend a CIP on the basis of evidence on alcohol-related health harms resulting in little impact on health and other harms. We will consider this during the consultation process to understand possible legislative and other challenges to licensing authorities using this power.

There is a risk that more licensing authorities than expected decide to adopt or extend a CIP on the basis of evidence on alcohol-related health harms resulting in many licences being refused. We will consider this during the consultation process to understand what evidence local areas would need to use to demonstrate levels of alcohol-related health harm, how controlling numbers of premises could reduce such harm in their area and the need for local discretion.

We are considering how far the CIP process might need to be amended to include consideration of alcohol-related health harms and what health-related evidence local areas may need to gather to introduce or extend a CIP on health grounds. There is therefore a risk that the administrative costs to licensing authorities and business may change if the process changes, which will be addressed in any future impact assessment on this measure.

G. Enforcement

We do not expect that the proposed policy will require any significant increase in enforcement activity. As outlined above, there will be some additional administrative costs for licensing authorities. It is expected that one of the consequences of this policy will be a safer night-time economy, which would be expected to lead to a reduction in enforcement costs rather than any increase.

H. Summary and Recommendations

The table below outlines the costs and benefits of the proposed changes over a 10 year period.

Costs and Benefits		
Option	Costs	Benefits
2	<i>Monetised</i> £158m (best estimate)	<i>Monetised</i> £ 322m (best estimate)
	Familiarisation costs Lost profit to alcohol industry Local authority CIP policy costs Exchequer costs from lower alcohol duty revenues	Improved health Reduced crime
	<i>Non-monetised</i> Loss of consumer surplus Adverse impact on competition	<i>Non-monetised</i> Lower unemployment Lower absenteeism

The Government has committed to consulting on including a health-related licensing objective in the Licensing Act linked specifically to cumulative impact (option 2). The consultation process will allow full consideration of including data on alcohol-related health harms in the CIP process and possible local impacts.

The analysis in this impact assessment gives an **estimated overall net benefit of £164m** and suggests that this would be a potentially useful tool particularly for areas that have high or particularly fast-rising levels of alcohol-related health harm.

I. Implementation

The Government would implement option 2 through primary and possibly also secondary legislation, as well as additional explanation via statutory guidance that the Secretary of State is required to issue under the Licensing Act 2003. This would mean the policy receives full Parliamentary scrutiny and an implementation timetable would be subject to the necessary Parliamentary procedures.

Implementation of the policy would be at a local level with licensing authorities deciding whether to introduce or extend a CIP on the basis of their own assessment of the local situation.

J. Monitoring and Evaluation

The duty to review all new policies after a minimum of five years would apply to this policy. We envisage that such a review would consider the impact that the policy has had locally and have suggested a review date of 2019 based on possible implementation in 2014. This may be amended in any future impact assessment to reflect detailed proposals.

K. Feedback

Feedback is being sought through the consultation proposals set out at A3 and in Annex B.

L. Specific Impact Tests

Small Firms Impact

Option 2 would affect on- and off-trade retailers applying for new licences and some licence variations in an area that uses the new measure to introduce or extend the geographic area of a CIP and this would include small businesses and micro-businesses.

As set out above, this is a discretionary power so it is not possible to determine the total impacts nationally. The numbers of businesses affected will depend on the number of licensing authorities that choose to use this measure. The licensing statistics do not include information on how many licence applications have been refused on the basis of cumulative impact under the current system. We will explore whether it is possible to collect such data from some areas with CIPs during the consultation period, which may give more information on the proportions of micro, small and large businesses affected. The Government will consider the need to seek a waiver from the small business moratorium as the policy is developed further. We will seek input from the alcohol industry on the potential impacts on different types of local businesses.

Competition Impact

This proposal may have an impact on competition as introducing or extending a CIP is intended to restrict the number of new outlets entering the alcohol retail market. We believe that generally, this would have an adverse impact on competition in areas in which the policy is implemented as it makes it easier for existing retailers to engage in anticompetitive behaviour, such as charging excessively high prices.

However, this needn't always be the case. In situations where existing businesses have no significant constraint on the amount they can supply – such as retailers in the off sales market – fierce price competition can still exist even with a relatively small number of firms and limited threat of other firms entering the market. Since each firm could potentially expand its market share by cutting its price below that of its rivals each firm has an incentive to keep its prices relatively low. This could minimise the otherwise adverse impact on competition in this sector.

In the on trade this scenario is less likely. Pubs, bars and other outlets are constrained in the amount they supply by the physical size of their premises. Even if they cut prices they are unlikely to expand market share significantly as this is restricted by the capacity of the building they occupy. They therefore have less incentive to lower their prices in order to undercut their rivals. The adverse impact on competition is therefore likely to be worse in the on trade than the off trade sector.

Although we believe the impact on competition will be negative we don't think it will be significant – the expected relative reduction in the number of licenses is only 544 in the first year of the policy. Because of this, and the fact that competition depends on many factors other than simply the number of firms in a market – such as the geographic dispersal of retailers and the power of retailer branding – we have not attempted to monetise this cost.

Social Impact

The intention is to enable local areas to consider data on alcohol-related health harm such as alcohol-related hospital admissions and deaths, rates of liver disease or numbers of people drinking at increasing or higher risk levels or who are dependent on alcohol when making decisions about CIPs. If successful, we would expect such CIPs to play a part in reducing both health and other alcohol-related harms in local areas that choose to use them.

There is a wide variation in levels of alcohol-related harm in different parts of the country. The highest levels of health and other harms from alcohol misuse are often in economically deprived areas. The new power could therefore potentially contribute to reducing health inequalities.

Policy background and evidence

Greater involvement for health in alcohol licensing was considered as part of the 2010 Rebalancing the Licensing Act consultation, which was carried out between July and September 2010, in advance of changes being taken forward in the Police Reform and Social Responsibility Act (PRSR) Act 2011. The consultation invited views on making health bodies Responsible Authorities for licensing and the implications of including the prevention of health harm as a licensing objective. The PRSR Act included provisions to make health bodies responsible authorities but in responding to the consultation, the Government concluded, *“We also see merit in the proposal to make the prevention of health harm a material consideration in the Licensing Act 2003. We want to ensure that this is considered alongside wider work to address the harm of alcohol to health. Accordingly, we do not intend to legislate at this stage but will consider the best way to do so in the future.”*

In the Alcohol Strategy, published in March 2012, the Government announced that it would consult on a new health-related objective for alcohol licensing related specifically to CIPs, as this is where there is the strongest evidence base for the impact on health and other harms.

Licensing statistics

The latest licensing statistics available come from the Alcohol, Entertainment and Late Night Refreshment Licensing Bulletin for England and Wales, which was published by the Department for Culture, Media and Sport (DCMS) in September 2010. Revised licensing statistics are expected to be published in Autumn 2012. The 2010 bulletin shows the following estimated comparisons between 31st March 2009 and 31st March 2010:

- The total number of premises licences and club premises certificates in force in England and Wales was 215,100 on 31st March 2009 and 216,200 on 31st March 2010. Therefore there was an estimated 0.5% increase in the number of premises licences but around 100 Licensing Authorities recorded a decrease over the 12-month period.
- The total number of premises licences with ‘on-sales of alcohol only’ was 35,300 in 2009 and 35,100 in 2010, less than a 1% decrease.
- The number of ‘off-sales alcohol only’ premises licences was 47,500 in 2009 and 48,700 in 2010 (an increase of 1,200). The number of premises licences with ‘both on and off sales’ increased by around 1% from 81,500 in 2009 to 82,300 in 2010.
- The total number of ‘on-sales alcohol only’ club premises certificates in 2009 was 8,200. This decreased by around 4% to 7,800 in 2010. However there was also an estimated 1% increase over the same 12 month period for club premises certificates with ‘both on and off-sales of alcohol only’ from 8,700 in 2009 to 8,900 in 2010.

In 2009/10:

- 9,900 new premises licences applied for, of which 9,100 were granted (97% of all decided outcomes) and 250 were refused.
- 6,900 variation applications made to change the terms of a licence, for example the opening hours, the licensable activities or the conditions. 6,400 of these variations were granted (97%), with 170 refused (3%).

Alcohol-related health harms

Detailed evidence on alcohol misuse and harm in England is set out as part of the Department of Health’s evidence to the Health Committee’s inquiry into the Alcohol Strategy³¹

People who drink alcohol vary enormously in how much they drink and how often, where and what they drink but around a quarter of adult men (26%) and a fifth of women (18%) reported drinking at

³¹ Government’s Alcohol Strategy: written evidence submitted by oral witnesses pages 14- 31 /www.parliament.uk/documents/commons-committees/Health/Writtenevidencebyoralwitnesses.pdf

levels which are above the NHS guidelines. 2.2m people said they drank more than twice the NHS guidelines, putting themselves at most risk of illness and death from alcohol. Over 60 diseases or conditions can be caused by drinking alcohol.³² The four biggest disease groups related to long term consumption are heart disease, stroke, liver disease, and cancer. Risks of these diseases, broadly, rise in line with levels of consumption. Further details are given in the evidence document.

The risk of alcohol dependence rises with both the volume of alcohol consumption³³ and a pattern of binge drinking³⁴. The risk of dependence is increased³⁵ by starting drinking at a young age³⁵. In 2007, there were an estimated 1.6 million people moderately or severely dependent on alcohol in England. Disability adjusted life years (DALY) are a measure of combined ill health (adjusted for severity) and premature death. 10% of the UK burden of disease and death, as measured by DALYs lost, is related to alcohol, compared with 15% for smoking³⁶. 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.

ONS data suggests lower than average consumption among those with the lowest weekly incomes³⁷. 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 deprived³⁸.

Trends in consumption and harm

UK average alcohol consumption is now at about the EU average, having been much below it 50 years ago. 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 peaked 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.

Since 2000, off-trade sales (e.g. supermarkets, off-licences) of alcohol have come to be dominant over on-trade sales (e.g. pubs, clubs). By 2009, the off-trade share had advanced to 65%.³⁹ 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 alcohol⁴⁰.

Over the last ten 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, i.e. from conditions wholly caused by alcohol, rose by 30%. In contrast, total deaths in England fell by 7%⁴¹. 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; in 2010, alcoholic liver disease accounted for over 80% of all chronic liver disease deaths in England and Wales⁴².

³² Corrao et al. (2004): A meta-analysis of alcohol consumption and the risk of 15 diseases. *Preventive Medicine* 38, 613-9

³³ 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

³⁴ 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

³⁵ 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

³⁶ 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

³⁷ Information Centre for Health and Social Care: *Statistics on Alcohol: England, 2011*, Table 2.11

³⁸ *Indications of Public Health in the English Regions, 2008*, Table 10

³⁹ *BBPA Statistical Handbook, 2010*

⁴⁰ *Central Policy Review Staff report on alcohol, 1979*

⁴¹ Jones L, Bellis MA, 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.

⁴² Source: *Mortality Statistics: Deaths registered in England and Wales (Series DR), 2010*, Office for National Statistics

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. (A consultation is underway on producing an indicator of alcohol-related admissions based on primary diagnostic codes only for use in the Public Health Outcomes Framework⁴³)

Regional differences in alcohol-related health harm

There are clear differences in levels of alcohol-related health harm across the country. These are set out in detail in the North West Public Health Observatory's annual Local Alcohol Profiles⁴⁴. The profiles contain 25 alcohol-related indicators for every local authority, mapped against national and regional averages. For example, when the most recent profiles were issued in August 2011, NWPHO observed:

- There is a wide variation across England in levels of admissions to hospital relating to alcohol. Annual rates ranged from 3114 admissions per 100,000 residents in Liverpool to 849 admissions per 100,000 residents in the Isle of Wight.
- Over the five years to 2009/10 there has been a 25% increase in the number of people being admitted to hospital due to conditions only caused by alcohol. The highest rates are reported in Liverpool where the rate for men (1,082 per 100,000) is 7.8 times higher than in Wokingham (138 per 100,000), and the rate for women in Liverpool (517 per 100,000) is 16.5 times higher than in the City of London (31 per 100,000).
- Of those people who report that they consume alcohol (i.e. excluding non-drinkers), on average 7.6% are higher risk drinkers ranging from 16.1% in Hounslow to 2.5% in Peterborough.
- Highest rates for deaths from chronic liver disease were in Blackpool (46.3 per 100,000 for males and 20.9 per 100,000 for females), and the lowest rates were in the City of London (0 per 100,000 for both males and females) and West Somerset (0 per 100,000 for females).
- There is a strong correlation between areas with high levels of alcohol-related admissions and deprivation. Of the quarter (81) of local authorities with the highest rates of admission, over two-thirds (56) are also among the quarter of local authorities with the highest levels of deprivation.

Outlet density

There is a good evidence base for the link between outlet (i.e. concentrations of licensed premises) density and alcohol-related harm.

NICE commissioned an extensive review of the international evidence relating to some alcohol policies including controls on the availability of alcohol, which was published in 2009⁴⁵. The review found:

- A clear positive relationship between increased outlet density and alcohol consumption in adults.
- A similar positive relationship between alcohol outlet density and alcohol consumption in studies focusing on young people.
- No apparent trend differentiating the impact of alcohol outlet licence type on alcohol consumption.
- A number of natural experiments that demonstrated the effects of changes in alcohol outlet density on alcohol consumption and alcohol-related outcomes. Increases in alcohol outlet density tended to be associated with increases in alcohol consumption and alcohol-related morbidity and mortality.
- An evidence base demonstrating positive relationships between outlet density and a range of outcomes including rates of violence, drink-driving, pedestrian injury, and child maltreatment.

On the basis of this review, NICE concluded⁴⁶ that *“International evidence suggests that making it less easy to buy alcohol, by reducing the number of outlets selling it in a given area and the days and hours when it can be sold, is another effective way of reducing alcohol-related harm. In Scotland, protection of the public’s health is part of the licensing objectives.”* Discussions with the researchers who carried out the evidence review indicate that the evidence published since then supports their conclusions in their earlier review.

⁴³ <http://ranzetta.typepad.com/files/alcohol-related-hospital-admissions-consultation.pdf>

⁴⁴ NWPHO Local Alcohol Profiles for England: <http://www.lape.org.uk/>

⁴⁵ *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

⁴⁶ *Alcohol-use disorders: preventing the development of hazardous and harmful drinking* NICE public health guidance 24, June 2010

In *Alcohol no ordinary commodity* Babor et al⁴⁷ consider a range of interventions that have been suggested to reduce alcohol-related harm considering the evidence base for each. They conclude that restricting outlet density is an effective policy.

The WHO report *Alcohol in the European Union: consumption, harm and policy approaches*⁴⁸ looks at the evidence base for areas of alcohol policy and makes recommendations for best practice for European countries. It concludes that “*The accumulation of research evidence about the impact of interventions regarding the physical availability of alcohol has been really impressive during recent decades. Much more is known now of the effects of restrictions on the physical availability of alcohol than half a century ago*” and that limiting the density of licensed premises can be an effective policy in reducing harm.

Purshouse et al⁴⁹ give an example of a 10% reduction in national outlet density having an estimated effect of a 2.3% reduction in consumption and an annual reduction of 710 deaths, 22,500 hospital admissions, 61,000 crimes and 284,000 days off work.

Given the levels of alcohol-related health harms and the evidence to support the link between outlet density and alcohol-related harm, the Government intends to enable local areas to consider alcohol-related health harm alongside other harms when considering cumulative impact policies.

Cumulative Impact Policies

“Cumulative impact” is not mentioned specifically in the Licensing Act 2003 (the 2003 Act) but the power for authorities to introduce Cumulative Impact Policies (CIPs) is set out in statutory guidance issued under section 182 of the 2003 Act, and is described as *‘the potential impact on the promotion of the licensing objectives of a significant number of licensed premises concentrated in one area’* (paragraph 13.19). The power to introduce a CIP is discretionary. A CIP can be introduced on the basis of any one or more of the four existing licensing objectives when problems are linked to the impact of concentrations of customers of licensed premises in a specific area.

The licensing objectives are:

- prevention of crime and disorder
- public safety
- prevention of public nuisance
- protection of children from harm

The revised statutory guidance laid on 25 April stated that CIPs can apply to concentrations of on or off-trade premises. Previously, the guidance stated that CIPs ordinarily only applied to the on-trade.

The full process for introducing a CIP is set out in Chapter 13 of the statutory guidance. Licensing authorities should consider cumulative impact when developing their statements of licensing policy. Licensing authorities must establish an evidence base to support the introduction of a CIP and identify the boundaries of the area in which problems are occurring. They must then consult with responsible authorities and subject to this consultation, publish details of the CIP in its Licensing Policy Statement. A CIP introduces a rebuttable presumption that applications for the granting or variation of premises licences or club premises certificates which are likely to add to the existing cumulative impact will be refused or subject to limitations if relevant representations are made to this effect.

However, the statutory guidance states clearly that every application should still be considered on its own merits and there may be cases where the applicant has clearly demonstrated in their operating schedule that their application will not add to the cumulative impact. For example, a large

⁴⁷ *Alcohol No Ordinary Commodity—Research and Public Policy*, 2nd edn Oxford University Press, 2010, ISBN: 978-0-19-955114-9. By T. F. Babor, R. Caetano, S. Casswell, G. Edwards, N. Giesbrecht, K. Graham, J. Grube, P. Gruenewald, L. Hill, H. Holder, R. Homel, E. Osterberg, J. Rehm, R. Room and I. Rossow.

⁴⁸ http://www.euro.who.int/__data/assets/pdf_file/0003/160680/e96457.pdf

⁴⁹ Purshouse R et al. (2009). Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0. Report to the NICE Public Health Programme Development Group. Sheffield, University of Sheffield, School of Health and Related Research (SchHARR).

nightclub or pub with a large capacity may add to the cumulative impact, but a small restaurant or theatre may not.

As CIPs are not set out in legislation they do not have a formal statutory footing. However the statutory guidance is binding to the extent that licensing authorities are expected to have regard to it unless there is good reason not to do so. Setting out the process for CIPs in the statutory guidance has given licensing authorities significant flexibility in how to implement these policies and apply them to different types of premises.

Health bodies are responsible authorities under the Licensing Act 2003 and therefore may input into licensing decisions and cumulative impact policies in this capacity. For example, a health body could provide evidence to support the introduction of a new cumulative impact policy or make a representation that an application should be refused on the basis of an existing cumulative impact policy. However, currently any representations must be linked to the existing licensing objectives.

Relevant licensing legislation in Scotland

Protecting and improving public health is a licensing objective in Scotland under the Licensing (Scotland) Act 2005. This Act also imposes an additional requirement (under section 7) for licensing authorities to consider the issue of 'overprovision' in their statements of licensing policy. Licensing authorities are required to state whether there is an issue generally with overprovision in their area, or with regards to specific localities or types of licensed premises and if overprovision is identified consider implementing a policy where there is a rebuttable presumption against granting new licences or particular types of licences in specific localities. As a licensing objective in Scotland, protecting and improving public health must be considered when determining whether to implement an overprovision policy. Unlike CIPs which are discretionary, all licensing authorities in Scotland are required to consider the issue of overprovision and take proactive measures to address it. Overprovision policies have not yet been implemented by many authorities in Scotland, but we are working closely with areas such as West Dunbartonshire which have implemented such policies, to learn lessons from how these are being implemented.

Numbers of CIPs and licences affected

As on 31st March 2010 there were 134 cumulative impact areas (CIA) of which 22% (29 CIAs) were in Greater London Authorities and 19% (26 CIAs) in other metropolitan districts. 83 Licensing Authorities had at least one cumulative impact area, including 29 Licensing Authority areas which had two or more cumulative impact areas.

Whilst these are the latest official statistics currently available, more recent data is available from a survey on late night licensing conducted by law firm Poppleston Allen⁵⁰, findings from which were published on 9th February 2012. Calculations are based on comparison with the 2010 figures published by DCMS.

Findings from this survey reported that 93 Licensing Authorities have now adopted a Cumulative Impact Policy in their area, a 12% increase since 1st April 2010. 11 authorities adopted a Cumulative Impact Policy for the first time and one authority removed its Cumulative Impact Policy. 25 new Cumulative Impact Areas have been created since 1st April 2010.

Poppleston Allen reported that there are now 158 designated Cumulative Impact Areas in England & Wales, with some Licensing Authorities having more than one, resulting in a rise in Cumulative Impact Areas of nearly 18% from April 2010.

In the same period they reported that 15 Licensing Authorities expanded the geographical area of a Cumulative Impact Policy, whereas only two narrowed the area covered. 25 new Cumulative Impact Areas have been adopted across the England & Wales and only one has been removed. The figures show a large concentration of 40 Cumulative Impact Areas in Greater London, which hosts 25% of the total number of Cumulative Impact Areas across England & Wales.

⁵⁰ <http://www.popall.co.uk/news/general/popplestonallenssurvey-theimpactofcumulativeimpactpolicies.asp>

Issues to be considered during the consultation process

There will be a public consultation on option 2, which will seek views on:

- the potential impact of this proposal on local areas;
- how far the current CIP process might need to be amended to include consideration of alcohol-related health harms; and
- the evidence local areas have on alcohol-related health harms that could contribute to a CIP if this proposal were introduced.

We also want to discuss the detail of the current process with licensing authorities who are already successfully using CIPs and the data available on alcohol-related health harm at a local level. We will therefore seek specific input from licensing authorities, health bodies and other practitioners on the technical details of this proposal. We envisage this being carried out through a number of individual meetings and technical consultation groups.

These more technical discussions with those familiar with licensing, CIPs and health data will look at issues such as:

- what evidence local areas will be able to use to demonstrate levels of alcohol-related health harm and how controlling levels of premises density could reduce such harm in their area;
- how far there would need to be specific guidance on compiling and analysing local evidence to ensure this assessment is done rigorously;
- how far the current CIP provisions in statutory guidance or new legislation might need to be amended to include the use of alcohol-related health data as health data is usually population based;
- how licensing authorities may define CIP areas,
- what impact the policy could have on local businesses and the need for local discretion,

As set out above, a similar power has existed in Scotland since September 2009 and has been taken up by a small number of local authorities. We therefore intend to discuss this with those in the Scottish Government and licensing authorities in Scotland.

The licensing statistics do not include information on how many licence applications have been refused on the basis of cumulative impact or how many appeals there have been following determinations made on the basis of cumulative impact. This information is available to licensing authorities, which allows them to assess the impact locally, but it is not collected nationally. During the consultation period we will explore whether it is possible to collect such data from some areas with CIPs. The consultation includes a question on possible impacts on the local area, backed up with evidence.

We do not have information on the proportion of variations that may be affected and will discuss this aspect with licensing authorities during the consultation. We will explore whether it is possible to collect such data from some areas with CIPs during the consultation period, which may give more information on the proportions of micro, small and large businesses affected. We will seek input from the alcohol industry on the potential impacts on different types of local businesses, including competition effects. During the consultation process, we will consider how premises may be able to demonstrate sufficiently that their application will not add to the cumulative impact and so may still be able to obtain a licence in a CIP area.

We will also consider any significant administrative costs for licensing authorities or the new local authority public health function in collecting and assessing alcohol-related health data relevant to the CIP process. During the consultation period, we will be considering how far the CIP process might need to be amended to include consideration of alcohol-related health harms. Any changes could have implications for the administrative costs to licensing authorities and business, which would be reflected in any future impact assessment on this measure.

Average hourly wage of local authorities and alcohol retailers

Job role	Average hourly wage ⁵¹
Licensing officers ⁵²	£13.60
Trading Standards officers	£18.19
Bar manager (on-trade) ⁵³	£11.62
Retail manager (off-trade)	£13.33

⁵¹ Figures have been up-rated by 21% to include non-labour costs

⁵² This is the median hourly wage for local government administrative occupations (licensing officers) and business and public service associate professionals (Trading Standards Officers). Data was obtained from the 2011 Annual Survey of Hours and Earnings. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-256648>

⁵³ This is the median hourly wage for publicans and managers of licensed premises (on-trade) managers and directors in retail and wholesale (off-trade) and staff in the retail and pub sectors. Data was obtained from the 2011 Annual Survey of Hours and Earnings - <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-256648>

The Sheffield Alcohol Policy Model

The Sheffield Alcohol Policy Model (SchARR model) has been (and is being further) developed to explore the impact of alcohol control policies on alcohol consumption and alcohol harms, such as mortality and morbidity, health care costs, crime and labour market effects. The core of the model links changes in the prices of different types of alcoholic drinks to changes in alcohol consumption via a set of price elasticities modelled on the basis of consumption and price information drawn from national surveys and market research data. The model then utilises international evidence on the link between alcohol consumption and harm to assess the impact of alcohol pricing policies on alcohol harms.

In addition to consumption changes brought about by changes in price, the model is able to deal with other factors which influence consumption, such as outlet density, licensing hours and advertising expenditure. When a change in, for example, relative outlet density is entered into the model, the impact on alcohol consumption and, ultimately, harms is estimated using international evidence on the link between outlet density and alcohol consumption. A systematic review of the literature examining this link identified five key studies, which gave six estimates of the responsiveness (elasticity) of alcohol consumption to outlet density. Excluding one estimate of elasticity implying an increase in consumption as outlet density falls, the estimates of the percentage change in consumption for a 10% change in outlet density range from a 0.3% reduction to a 3.7% reduction. The harm impacts generated by the model for the purpose of the current exercise are based on the assumption of a 3.7% change in consumption for a 10% reduction in outlet density.

A limitation of the model acknowledged by the authors is the absence of routine national data on outlet densities, as a result of which the establishment of a robust baseline for England is not possible. In addition, it is recognised that the population-level modelling approach does not allow for the local nature of the implementation of outlet licensing policies. Nevertheless, modelling results produced for NICE have been used to underpin a set of public health guidance on the prevention of harmful drinking. On the basis of the international evidence, NICE has recommended that consideration should be given to the revision of legislation on licensing, such as enabling decisions on licence applications to take into account the link between outlet density and alcohol-related harm (including health harms).

To quantify the relationship between levels of consumption and alcohol attributable harms the SchARR model uses a methodology built around two concepts:

- 1) Alcohol Attributable Fractions (AAF): The proportion of the harm attributable to alcohol.
- 2) Relative Risk (RR): The risk that a person exposed to a certain degree of alcohol will experience/cause a particular harm relative to a person not exposed to alcohol.

The two can be used to produce an equation for each harm and crime type showing how risk of causing that harm increases as alcohol consumption increases.

To calculate the crime harms the SchARR model uses the Offending Crime and Justice Survey (OCJS) which asks whether, in the offender's view, they undertook the offence because they were drunk. This is more conservative than the alternative OCJS question which asks whether the offender was drunk at the time of the incident, which is used by the Home Office to calculate the cost of alcohol-related crime.

The SchARR model uses this as an alcohol attributable fraction (AAF), for males and females aged under 16 and 16-25 yr olds separately. Risk functions were estimated from the AAFs, based on a mapping of crime categories from OCJS to the modelled crime types. The study selected a threshold of risk, i.e. a level of consumption where risk starts. Risk for crime is assumed to start at 4 units a day for men and 3 units for women. The risk functions for 16-25 year olds was re-used for over 25s due to the lack of data for the latter. This approach is not ideal since it is likely that AAFs

for older individuals are different to those for younger individuals. Whilst this is a limitation, the ScHARR team argue that it is not likely to impact greatly on the modelling results since individuals over 25 years old contribute to less than 30% of all crimes.

The potential impact fraction (PIF) is calculated based on the consumption distribution at time 0 and time t and the estimated risk function (derived from the above AAF). The PIF is then applied directly to the baseline number of offences to give a new volume of crime for time t. The model uses the consumption distribution for the intake in the heaviest drinking day in the past week (peak consumption) since crime was assumed to be a consequence of acute drinking rather than average drinking (and so there is no time delay between change in exposure to alcohol and subsequent change in risk of committing a crime).

The crime harms outcomes are presented in terms of number of offences prevented and associated cost of crime and QALY impact to the victim.

For health harms, the ScHARR model considers 47 separate acute and chronic conditions related wholly or partially to alcohol. The health harms include those wholly attributable (AAF=100%, acute and chronic) such as alcohol liver disease and accidental poisoning and partially attributable (acute and chronic) such as throat cancer. A mean lag of 10 years was assumed for all chronic conditions. While such a lag may under/over-estimate the true mean time lag for some conditions, given the lack of consensus it is considered to be a plausible estimate. The time lag for acute conditions was assumed to be zero since benefits associated with a reduction of acute harms occur instantaneously.

The direct health cost component comprises of NHS cost reductions, measured by number of reduced illnesses, deaths and hospitalisations. This cost is broken down by hospital inpatient and day visits, hospital outpatient visits, accident and emergency visits, ambulance services, NHS GP consultations, Practice Nurse consultations, dependency prescribed drugs, specialist treatment services and other health care costs.

Health related QALYs are calculated by using the difference in health-related quality of life (utility) in individuals with alcohol health harms and the quality of life measured in the general population (or 'normal health').

Details of Calculations

Cost to exchequer

The SchARR model includes elasticities that determine how consumption changes in response to changes in alcohol outlet density. If the policy were to reduce the number of alcohol outlets by 544 (as assumed in our illustrative scenario for policy option 2) this would reduce consumption by 0.2%. The model, however, can also work at a more detailed level and estimate the change in units consumed per consumer for each type of beverage. These figures are given below (RTDs are 'ready to drink' premixed beverages such as alcopops):

Beer	-0.7687
Wine	-0.8033
Spirit	-0.2675
RTD	-0.0751

Current duty rates⁵⁴ are then applied to obtain the duty loss per consumer.

Beer and cider	0.166824889
Wine	0.208533989
Spirits	0.2681
RTDs	0.2681

This is then multiplied by the number of drinkers in England and Wales - estimated by Sheffield University for the purposes of the SchARR model to be 31,197,686 – to get the total exchequer revenue loss figure of £12,092,904 per year.

⁵⁴http://customs.hmrc.gov.uk/channelsPortalWebApp/channelsPortalWebApp.portal?_nfpb=true&_pageLabel=pageExcise_ShowContent&id=HMCE_PROD1_031971&propertyType=document