The Government Response to the Health Select Committee Report on Alcohol

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
March 2010

Cm 7832

£9.50

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ISBN: 978 0 10 178322 4

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID P002354660 03/10 2212 19585

Printed on paper containing 75% recycled fibre content minimum.

The Government Response to the Health Select Committee Report on Alcohol (First Report of Session 2009-10)

Introduction

1. Alcohol is an increasing public health challenge. While many people in the UK enjoy a drink responsibly and keep within the Government's *lower-risk* drinking guidelines, unfortunately, too many drink too much, often without being aware of it. This is not only damaging the health of those individuals, it is placing a burden on their families, the NHS and on the wider economy. Alcohol misuse is estimated to cost the health service about £2.7 billion per annum.[1] Department of Health statistics show that alcohol-related hospital admissions are rising and there were an estimated 945 thousand alcohol-related admissions in England in 2008/09. This represents 7% of all hospital admissions and the number of these alcohol-related admissions is rising at about 11% a year.

2. The Government is working harder than ever to address the rising trend of harms and attendant costs to society and we believe we are beginning to see some impact from these steps. The Government is seeking to provide both the information and the environment that people need to make healthier choices when drinking alcohol. The NHS is seeking to prevent and address the many alcohol-related harms to people's health.

3. The current levels of alcohol-related hospital admissions, death, crime and disorder are unacceptable, as are the attendant costs to society. We have made significant progress in addressing them, but we are acutely aware that the challenge is growing and that it may take many years to tackle the established drinking culture. No one action can deliver the changes we need. Whilst we are working to deliver the current Government strategy, we welcome the Committee's conclusions and recommendations on where and how to take this work forward.

4. Our renewed Alcohol Strategy, *Safe, Sensible, Social – Next Steps in the National Alcohol Strategy*, published in June 2007, set out a new approach to achieve significant and measurable reductions in the harms caused by alcohol over a sustained period. It is a comprehensive strategy which tackles the range of alcohol harms, from under-age drinking and harms to children, to binge drinking, street crime and disorder, to the longer-term health harms like cancers, liver disease and alcohol dependency.

[1] *The cost of alcohol harm to the NHS in England*, DH July 2008.

5. The strategy aims to shape an environment which actively promotes a healthier approach to drinking. We have sought to do this through investment in better information and communications, and by drawing on the skills and commitment of all those working to reduce the harm alcohol can cause, including the NHS, the police, local authorities, voluntary organisations, prison and probation staff, the alcohol industry, the wider business community and the media.

6. We focus our action across four areas:

- *helping people make informed decisions* (e.g. campaigns and labelling);
- *creating a healthier environment* (e.g. licensing and enforcement regimes, mandatory code on alcohol retailing);
- *providing advice, support and treatment for people at risk* (e.g. providing "brief interventions" in primary care, treatment services for most dependent drinkers);
- *improving the delivery system on alcohol misuse services* (e.g. Government indicator on alcohol-related hospital admissions; Alcohol Improvement Programme, publication of guidance and support tools for the NHS).

7. Our strategy for alcohol supports the Government's wider preventative health strategy which addresses all public health issues. Most recently on this front, we have published *NHS 2010-2015: from good to great. Preventative, people centred, productive* in December 2009. This document reaffirmed our commitment for the NHS to work effectively with national and local partners, including local authorities and the third sector, to promote health and access to preventative services. (This includes secondary prevention, such as early interventions and management of longer-term conditions, as well as primary prevention).

8. There is a balance to be struck in public health, however, as elsewhere, between Government intervention and personal choice and responsibility. People want to be healthy, they welcome Government help in making healthy choices easier, but they also value personal autonomy and the freedom to make their own decisions. The Government needs to balance the need to act to protect the public from harm with preserving people's proper responsibilities for their own health and the wider societal considerations.

9. Adults need good information to make informed choices about how much to drink. This means investing in hard hitting information like our *Alcohol Effects* campaign (£6.8 million in 2009/10) as well as ensuring that basic information on units and the *lower-risk* limits is available, e.g. on alcohol labels, so that people understand how many units they are drinking and what the health risks are. For children, in addition to providing information, this means ensuring that they are protected from the risks of harm associated with under-age exposure to alcohol. Our new, and strengthened, campaigns launched in January and February 2010 are arming people with the facts about alcohol health harm. These will raise

public awareness further on the link between drinking too much and poor health, and on the harm that alcohol can do to children.

10. For everyone, we need to ensure that support and treatment is available to help people who are trying to change their behaviour in a healthier direction. We have provided an incentive for GPs to help secure this through a *Directed Enhanced Service* which encourages them to offer early interventions to all their new patients. Furthermore, our wide-ranging support to the NHS provided by the Alcohol Improvement Programme ensures that health harms from alcohol are identified earlier and that interventions are provided when people need them. This will impact on the number of alcohol-related hospital admissions.

11. Beyond the health arena, new powers and toughened enforcement under the *Policing & Crime Act 2009* gave the Government the power to introduce a new mandatory code of practice to target the most irresponsible retail practices. The new mandatory code will clamp down on alcohol-fuelled crime and disorder and under-age sales. It will also ensure that on-trade premises make small measures of beers, wine and spirits available to customers and it gives licensing authorities greater powers to initiate reviews of problem premises. We are also determined to take action on cheap alcohol and these new powers tackle the worst type of irresponsible promotions in pubs and clubs, such as "Drink as much as you like for £10" deals. These measures should make it easier for customers to moderate their alcohol consumption.

Government Responses to the Committee's Recommendations

"NHS policies to address alcohol related problems"

HSC Recommendation 1

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

12. The Government agrees that all Primary Care Trusts (PCTs) will want to develop strategies to address all of the Public Health needs of their local populations, identified through their Joint Strategic Needs Assessments (JSNAs) including those for alcohol. Since April 2008, PCTs have been required to undertake JSNAs with their local partner organisations for all the Public Health needs of their local populations, including their needs for alcohol services.

13. JSNA assessments should be soundly based on accurate local data and should form the basis of each PCT's strategy to address the local priorities identified for action. Strategic Health Authorities (SHAs) oversee this process and are able to challenge PCTs to ensure that PCTs' plans make provision for alcohol, where appropriate.

14. The Department of Health (DH) has provided resources and guidance to PCTs to assist them through all the stages required for developing their strategies. This has ranged from providing PCTs with relevant national and local data at the

outset to assist them with their JSNAs, to guidance on implementing World Class Commissioning (WCC) assurance processes and specific support tools like the *Ready Reckoner*,[2] which allows PCTs to model the impact their interventions should have. This support, alongside a comprehensive assurance system, will strengthen PCTs' commissioning skills and capabilities towards a standard that is world class.

15. To help PCTs devise and deliver their strategies, the DH has also provided alcohol-specific commissioning guidance[3] which includes advice on a set of seven *High Impact Changes* (HICs) for alcohol misuse services. These help PCTs identify key actions for their strategies which will deliver against the *Vital Signs* indicator on alcohol-related hospital admissions.

16. Complementary guidance[4] provided tools for local partners undertaking JSNA, including the processes for stakeholder involvement, engaging with communities and guidance on using the JSNA to inform local commissioning.

HSC Recommendation 2
Targets for reducing alcohol related admissions should be mandatory.

17. Since April 2008, the DH has been responsible for delivering against a Public Service Agreement (PSA) indicator on alcohol-related hospital admissions. This indicator, included within the *Vital Signs* is the first ever commitment to monitor how well the NHS is tackling alcohol-related health harm.

18. We do not agree that the relevant PSA indicator for alcohol-related hospital admissions should be mandatory for PCTs. The DH has adopted a devolved approach to planning and managing priorities, as set out in the *NHS Operating Framework* and underpinned by the *Vital signs*. Within this, PCTs have devolved responsibility to decide whether or not to adopt the indicator as a priority, following assessment of their local needs.

19. In 2009/10, 98 PCTs have decided to adopt the alcohol indicator as a local priority, this includes 45 of the 50 PCTs with the highest rates of alcohol-related admissions. SHAs are responsible for oversight of this process and are able to ensure that each PCT has plans that properly reflect all their local needs, including the needs that they have for alcohol services, where the indicator has been adopted.

20. The DH has provided support to underpin PCTs' delivery of the indicator and to improve outcomes on alcohol-related harm. In 2009/10, all PCTs published their performance against the whole range of *Vital Signs* to reflect their performance during 2008/09, including the alcohol indicator, SHAs will have used this evidence in considering the appropriateness of PCTs' plans for 2010/11.

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[2] *Alcohol learning Centre, Ready Reckoner* http://www.alcohollearningcentre.org.uk/

[3] *Signs for improvement: commissioning interventions to reduce alcohol-related harm*, July 2009

[4] *Creating Strong, Safe and Prosperous Communities*, http://www.communities.gov.uk/publications/localgovernment/strongsaferprosperous

21. All PCTs are also assessed on their progress against *World Class Commissioning* (WCC) competencies and on the overall calibre of their governance. An integral part of the WCC assurance system requires PCTs to demonstrate skills in correctly identifying their priorities and in strategic planning. In developing their strategic plans as part of the WCC assurance process, PCTs are expected to make clear links between the assessed needs of their population, their priority health outcomes, the initiatives in place to deliver those outcomes and the financial plans to support those initiatives. In Year 1 of WCC assurance the 'rate of hospital admissions for alcohol related harm' was amongst the top ten priority health outcomes chosen by PCTs.

22. Taken together, these processes should ensure that the alcohol services commissioned reflect local needs and make the appropriate contribution to reducing alcohol-related hospital admissions.

HSC Recommendation 3

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

23. The DH agrees this recommendation, as planned, fully integrated, treatment pathways are essential to providing quality services for alcohol misuse. Links from acute healthcare settings, and other settings where people may first present with alcohol-related illnesses or other harms, are important for early diagnosis and onward referral. We have made it clear in our *High Impact Changes*[5] that best practice suggests that alcohol health workers employed in hospitals should link to treatment services and community services. Not all of these workers will be specialist nurses, but the same links should be in place where such staff are employed.

24. The DH first provided guidance for developing, commissioning and delivering integrated local systems of alcohol interventions in *Models of Care for Alcohol Misusers (MoCAM)*.[6] Most recently, DH has provided specific advice on alcohol treatment pathways for patients[7] which provides good practice guidance on the development of integrated care pathways for people with alcohol problems. This includes specialist alcohol treatment services and treatment in community alcohol services.

25. The DH is currently refining the available evidence on effective practice in acute hospital and other settings to determine what works best. In November 2007, we initiated a £4 million research programme with projects in GP practices, hospital Accident & Emergency departments and in criminal justice settings. This research aims to identify best practice for each setting on the identification of alcohol misuse, brief interventions and onward referral for specialist treatment as required. These projects will report later in 2010 and we will use the evidence they provide to inform further developments in these areas.

[5] *High impact Changes, Alcohol Improvement Programme*, DH, November 2008

[6] *Models of Care for Alcohol Misusers* (MoCAM) DH 2005

[7] *Local Routes: Guidance for developing alcohol treatment pathways* Department of Health, 1 December 2009

26. In addition, following referral from the DH, the National Institute for Clinical Excellence (NICE) has now reviewed the available evidence and is developing further evidence-based guidance for the NHS. NICE began consulting on this in autumn 2009[8] and new NICE guidance will address the full range of care required from prevention through to alcohol dependency.

HSC Recommendation 4
There should be more alcohol nurse hospital specialists.

27. The DH agrees that alcohol specialists are important in hospital settings. We have already recognised the importance of the roles that alcohol health workers, including specialist nurses, can play in hospitals by including them in the *High Impact Changes* recommended to PCTs. However, it is for PCTs, not the Government, to decide on the numbers of such posts that may be required, in accordance with their assessments of local needs.

28. Alcohol health workers in hospitals can offer a variety of interventions for alcohol misuse services from early interventions, like brief advice, following an alcohol related accident, to securing appropriate referrals into treatment for patients with alcohol-related diseases and/or dependency. Research shows that such posts can also quickly cover the costs of investment. For example, the employment of specialist alcohol misuse nurses in acute hospital settings is effective in reducing alcohol-related admissions and repeat visits to Accident & Emergency departments.[9]

29. Reports from the Regional Alcohol Managers (RAMs) indicate that alcohol nurse and health worker posts are being created increasingly in hospitals across the country. In the West Midlands Region, for example, hospitals in Birmingham now have six alcohol liaison nurses in place, with another two being recruited. In addition, there are 20 alcohol health workers who undertake a range of interventions from identification and brief advice, to screening in Accident & Emergency departments and support on care plans when patients are discharged from hospital. Some of the nurses are also focusing on the medical management of the more dependent drinkers identified.

30. The DH is aware that different approaches to alcohol health workers in hospitals are developing in different areas and we have commissioned a study from Alcohol Concern to investigate and describe the different models being delivered currently across the country.

HSC Recommendation 5

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

[8] NICE consultation *Alcohol use disorders – clinical management guideline*, 17 September to 12 November 2009.

[9] For example, *Alcohol can the NHS afford it?* Royal College of Physicians 2001.

31. We partly agree this recommendation as the Government provides PCTs with the resources to commission services, including the alcohol services that they commission, through their general allocations. PCTs have considerable freedom to determine how and where to allocate those resources. However, it should be noted that any savings are not delivered in cash that can be transferred. The effect of alcohol treatment interventions is to reduce alcohol-related admissions, but this takes the form of freeing capacity so that more patients can be admitted. Cash could only be extracted by restricting capacity in line with some anticipated reduction in alcohol related admissions.

32. We do, however, agree that funding to enable service development is important. This is why, since 2007/08, the DH has ensured that funding is available to PCTs within their general allocations specifically to improve their commissioning of alcohol services. The DH has also provided other extensive resources to PCTs, linked to the *Vital Signs* indicator, to provide support in the form of key data, guidance and practical tools to support development.

33. In addition, in 2008/09 and 2009/10, 20 of the most deprived PCTs, with the highest levels of alcohol-related hospital admissions, have been awarded extra funding (£200,000 each in 2009/10). This additional funding is specifically to help underpin their development of alcohol services. The investment should help enable these PCTs to implement the DH's seven *High Impact Changes* to reduce hospital admissions and, in the light of evaluation, to spread better understanding of alcohol as a mainstream issue within the NHS.

34. Evaluation of this initiative is being undertaken by DH to show what has been achieved and the lessons learned. Learning will be shared with the rest of the NHS and some of the PCTs that have benefited to date are already beginning to share and showcase their work.

35. The DH has also invested £2.7 million in 2008/09 and 2009/10 to establish Regional Alcohol Managers (RAMs) in each NHS Region to influence and enable service development. This investment underpins the DH *Alcohol Improvement Programme* (AIP),[10] which from, November 2008, has brought together all the relevant DH guidance and support resources for PCTs. The RAMs coordinate the AIP in each Region, working with PCTs and local partnerships. Together, this has ensured that PCTs received comprehensive central and regional support for their commissioning and management of alcohol services.

36. The DH expects PCTs' response to the indicator, underpinned by DH support, to make a significant impact on the rising trend in hospital admissions. There is good evidence that the *High Impact Changes* including specialist treatment and early interventions have the potential to reduce the number of alcohol related admissions in the short, medium and longer term.

[10] *Alcohol Improvement Programme*, DH, November 2008

HSC Recommendation 6

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

37. We partially agree this recommendation, as treatment services for alcohol misuse should compare favourably with the levels of quality and access to treatment offered for other NHS services. However, we would not expect the types or duration of treatment to be the same for different substances.

38. Direct comparisons of illegal drug addiction with alcohol dependency are not appropriate, given the significant differences in the needs of the respective patient groups and in the types of treatments that they receive. Our aim is to optimise access to high quality treatment in accordance with the needs of each patient group. All those with dependence on substances should have access to suitable assessment and appropriate support. At local level, commissioners of services can take into account a wide range of factors relevant in assessing treatment needs and the level of provision for different groups.

39. The National Alcohol Treatment Monitoring System (NATMS) data for 2008/09 show a very encouraging level of performance on waiting times for specialist alcohol treatment, with an average waiting time of 2.1 weeks for alcohol treatment overall and of 0.8 of a week for young people under 18. This is not yet being achieved uniformly across the country but, overall, 80% wait less than three weeks and 91% wait less than six weeks. This is considerably better than previous estimates of waiting times and indicates that where patients are referred for treatment this is being delivered promptly. GPs can now be more confident in identifying patients who require referral into specialist treatment.

40. NATMS data also show that the numbers receiving treatment for alcohol misuse at any one time are also rising, slowly but steadily. The data from 2008/09 and the first three quarters of 2009/10 indicate a rising trend, and the total number of patients treated for the three quarters of 2009/10 is already just over 100,000.

41. Treatments differ between different drugs and are different again for alcohol. For example, the urgency and intensive treatments required for the most addictive drugs demand a particular level of access that reflects this and, for example, intensive treatment may need to be available for up to 50% of heroin addicts in any one year. In the case of alcohol, an international research model[11] suggests that in any one year specialist treatment should be available for 15% of the alcohol-dependent population for a medium level of service.[12] In its commissioning guidance on alcohol for PCTs in July 2009 (and in line with the research) the DH recommended that PCTs set an ambition to reach 15% of their alcohol dependent population. We recognise that this sets PCTs a considerable challenge.

[11] See Alcohol Needs Assessment Research Project (ANARP) DH 2005

[12] *A systems approach to estimating the required capacity of alcohol treatment services* – British Journal of Addiction 85 (1990)

42. Nevertheless, treatment for both alcohol and drugs needs to be effective with relevant follow up to address the problem of "revolving door" patients. To improve treatment, it is important to be able to monitor the impact of alcohol services provided. The NATMS data will allow services to identify the progress of individual treatment episodes and to monitor repeat treatment visits by the same patient over time. This will give the services insight into the efficacy of the care they provide overall.

43. The new NATMS data also enable PCTs to monitor their own performance against other PCTs for the first time and these data will show any variations and gaps in services for scrutiny and remedial action within NHS monitoring systems. The data set will thus provide an effective benchmark against which any poorer performing PCTs can plan to improve the alcohol services that they commission.

HSC Recommendation 7

Alcohol treatment services must be more proactive in seeking and retaining subjects in treatment with detailed long-term treatment outcome profiling.

44. The Government partially agrees this recommendation. We would encourage treatment services to be proactive within their local community to ensure that their services are made available to the local people who may need them (for example, at suitable times of day, at outreach centres etc). We would also agree that treatment services should be proactive in ensuring that patients complete any course of treatment that they commence. In doing so, they should work actively with patients to agree clear and comprehensive care plans that support any actions identified to promote their recovery. However, while some patients may need to be retained for a short period of inpatient care or residential rehabilitation, others who are alcohol dependent will only need treatment in the community.

45. The treatment that the services provide needs to have relevant follow up to ensure that it has been effective. We recognise that alcohol dependence can be a chronic, relapsing condition and that more than one episode of care and a range of interventions may be needed. Hence, it can be very important to monitor an individual's progress over time. As the data resource provided by the NATMS builds, it will help services map their progress and give them insights into the efficacy of the care that they provide.

46. We are currently considering the identification of effective treatment outcome profiles from those in existence now for alcohol services. As there is currently no professional consensus on a single preferred and suitable measurement tool, the DH has commissioned a briefing paper to identify the most appropriate outcome measures and relevant tools for application in alcohol treatment settings. The briefing paper will be published, together with DH advice, later in the spring of 2010.

HSC Recommendation 8
Funding should be provided for the National Liver Plan.

47. The DH has made a commitment to develop a National Strategy to combat Liver Disease and a National Clinical Director has taken up post from 18 January 2010 to develop the National Strategy and to oversee its implementation. In the current funding context, the NHS will have to release significant efficiency savings to meet increasing demand and rising expectations and realise its vision of high-quality care for all. There are a number of ways in which quality and productivity can be increased together, though more upstream intervention, better organisation of services and reduced waste. We will look at these principles as we develop the Liver Strategy.

48. The appointment of the National Clinical Director will ensure that clinical evidence and outcomes for patients are at the heart of our work to improve the quality of services to tackle liver disease.

49. In October 2009, the British Association for the Study of Liver (BASL) and the British Society for Gastroenterology (BSG) published their report, *A Time To Act: Improving liver health and outcomes in Liver Disease (a national plan)*. The evidence provided in this report will help to provide a solid foundation for the Liver Strategy and the new Clinical Director is already working with BASL and BSG to take this work forward.

50. In developing the liver Strategy, we plan to explore best practice in the use of nurse specialists in liver disease treatment, in both hospital and community settings. This will include looking at resources currently provided for training and recruitment locally and nationally and consideration of service delivery models which explicitly include nurses.

HSC Recommendation 9
Improved access to treatment for alcohol dependency is a key step in the development of early detection and intervention in primary care.

51. We agree with this recommendation, as specialist treatment services for alcohol dependency are an essential element in the care pathway for those patients who present to GPs in primary care and who require this level of intervention. Both early interventions and specialist treatment are cost-effective interventions that will reduce harm as shown by the indicator on alcohol-related hospital admissions. This is why we have included them both in the seven *High Impact Changes* that DH has recommended to PCTs since July 2009. As above, we are already seeing better access to specialist treatment and a rising trend in the number of patients treated. This should give GPs greater confidence when they seek to refer patients to these treatment services.

52. Many GPs are already actively engaged in early detection and interventions in primary care. The NAO found in 2008 that 45% of GPs were screening at least

some of their patients and offering early interventions. DH has also provided significant support and incentives to develop early detection and intervention more widely across primary care.

53. From 2008/09, the DH has provided an incentive through a Directed Enhanced Service (DES) in the form of specific funding of £8 million. PCTs allocate this to GP practices that opt to deliver identification of alcohol misuse, followed by brief advice, where appropriate, for newly registered patients. In addition to the incentive of the DES, the DH has provided a *Primary Care Service Framework* for PCTs, to support the wider development of brief interventions in primary care. PCTs can use the Framework alongside, or independently of, the DES and some are using it to develop wider-ranging interventions as Local Enhanced Services for alcohol in Primary Care settings.

54. On 6 January 2010, NHS Employers announced that they had reached agreement with the BMA's General Practitioners Committee that the two-year clinical Directed Enhanced Services (DESs), including the DES for alcohol, which were due to end on 31st March 2010, will continue for a further year. Many GP practices needed time to introduce the new DESs and their achievement in 2008/09 and 2009/10, while improving, has not been as high as we would have hoped. This extra year should ensure that the maximum number of patients benefit from the DES.

55. The Department also introduced new Read codes from 2008/09 to improve the records available for GPs' work on alcohol. As a result, GP practices can now be credited for all their screening and brief intervention work. This should also encourage more detection and interventions in Primary Care.

HSC Recommendation 10
Clinical staff in all parts of the NHS need better training in alcohol interventions.

56. The Government agrees with the Committee that relevant staff across the NHS would all benefit from appropriate training on alcohol misuse. The DH has taken steps to ensure that this is available where it is needed.

57. The DH has developed an e-learning programme for GPs and other Primary Care professionals who wish to undertake brief interventions. This has been available since February 2009 and some 2,600 doctors and nurses have completed the programme in its first year.

58. The DH has also fostered the introduction of undergraduate medical training on alcohol. Medical schools began including this in their curricula from 2009. This will ensure that all newly qualified doctors can identify and handle substance misuse problems, including those for alcohol. Over the next ten years, every doctor leaving medical school (circa 60,000 in total) will be equipped to deal with alcohol-related harm.

59. The DH has also provided start up funding to the Royal College of General Practitioners (RCGP) for a short training course, *Certificate in the management of alcohol problems in primary care*, to increase the competencies of relevant clinical staff to respond to people misusing alcohol. This is now up and running and has been offered to staff since October 2009.

HSC Recommendation 11

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

60. The Government agrees that identification and early interventions should take place in health and other settings where patients with alcohol misuse problems may present. As above, DH is piloting approaches to identify best practice in hospital, probation and primary care settings.

61. Primary and community clinicians bring particular advantages based on the volume of direct contact they have with patients and the public, representing 80-90% of overall NHS contacts. They also have a key role in coordinating care and helping people navigate the wider health and care system, and their referral decisions instigate the great majority of patient pathways.

62. The introduction of the DES for alcohol in Primary Care requires PCTs to offer all GP practices in their area the opportunity to take part in the DES. This is part of the guaranteed investment in GP practices for 2008/09 and 2009/10 for enhanced services for patients. As such, the DES provides much the same impetus to development as would inclusion in the Quality and Outcomes Framework (QOF). In addition, if GP practices choose not to participate in the DES, then the funding remains with the relevant PCT to use it to commission services from other providers.

63. Although originally a two year DES, the DES for alcohol will now be continued for a further year, into 2010/11. The position will be reviewed during 2010 taking into account practices' performance to date. PCTs also retain the option of using the *Primary Care Service Framework* for alcohol to commission services from a wider range of providers for a wider population during 2010/11.

64. Following a pubic consultation, the National Institute for Clinical Excellence (NICE) is now responsible for overseeing an independent process for developing and reviewing clinical and health improvement indicators in the QOF. Any potential changes to the QOF need to be considered by NICE as part of the new process. Any proposals to develop a new indicator must now be made through the NICE suggestion facility on the NICE website. The facility for proposing new indicators for the 2012/13 QOF was available between 8 February and 8 March 2010 and was publicised widely, including e.mails sent direct to a wide range of stakeholders. The proposals made to NICE, including those from the DH on alcohol, are then considered by the NICE independent Advisory Committee.

HSC Recommendation 12

Once detected, patients with alcohol issues should progress through a stepped program of care.

65. The Government agrees with this recommendation, as the DH has provided detailed guidance on stepped care for alcohol misuse in the form of *Models of Care for Alcohol Misusers (MoCAM)* since 2005. *MoCAM* provides best practice guidance for developing, commissioning and delivering a planned and fully integrated local system of alcohol interventions.

66. *MoCAM* sets out a framework for interventions on four levels, including the specialist services required for people who are dependent on alcohol. It provides a framework for alcohol interventions on which services can be commissioned based on local need. *MoCAM* provides overall commissioning guidance on treatment services, care planning to assess and address individuals' needs for specialist care, the structured treatment that may be needed to meet them and the range of other ongoing support required to prevent relapse after any treatment is completed.

67. *MoCAM* was informed by the *Review of the effectiveness of treatment for alcohol problems*, commissioned by the Department from the National Treatment Agency, which appraised the evidence base for the full range of treatments available for people with alcohol problems. PCTs can map their services against those in MoCAM, to identify, and address, any gaps in the level of service capacity available.

68. In addition, following referral from DH, the National Institute for Clinical Excellence (NICE) is now developing further evidence-based guidance for the NHS. The new NICE guidance will cover the full range of care and support required for people with alcohol misuse problems. The new guidance will be published in three stages, starting in March 2010.[13]

HSC Recommendation 13

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

69. The National Institute for Clinical Excellence (NICE) has already published some guidance on school-based interventions for young people.[14] However, the Government recognises that there is not a wealth of research into effective interventions in this area. There is a particular paucity of evidence on interventions for young people under the age of 16.

[13] *Prevention and early identification of alcohol use disorders in adults and young people* NICE. Due for issue March 2010.

[14] *Interventions in schools to prevent and reduce alcohol use among children and young people* NICE, November 2007

70. Most recently, following a referral from DH, NICE has undertaken a review of the available research on interventions for young people from the ages of 10 to 17. It has done this as part of its preparations for the new guidance that it is preparing currently. The first of the new guidance will be issued in March, as above, and, *Alcohol-use disorders in adults and young people – clinical management* will then be published in May 2010. Further NICE guidance, for treating alcohol dependency in young people and adults, is also in preparation.[15]

71. Although the latest statistics on young people show that fewer are now drinking alcohol, the statistics also show that those who do drink are drinking more. Given these statistics on consumption and the increasing levels of exposure of young people to alcohol, we need to be sure that appropriate interventions are available for this vulnerable group.

72. DH and DCSF will give careful consideration to the findings and new guidance from NICE, once published, with a view to determining whether any further research might still be needed to identify and secure suitable interventions for young people.

"Education and information policies"

HSC Recommendation 14

People have a right to know the risks they are running. We recommend that information and education policies be improved by giving more emphasis to the number of units in drinks and the desirability of having a couple of days per week without alcohol.

73. The Government agrees this recommendation and we take our role in informing and educating the public on the risks very seriously. Our 2007 alcohol Strategy identified the need for more work to help people estimate their consumption, to recall the recommended limits and to understand the health and other risks of exceeding them. Our approach, as part of a wide-ranging programme of policy interventions, is to provide unit and risk information through a range of media, including national campaigns, the NHS, alcoholic drinks labels and notices in licensed premises.

74. Public understanding of alcohol units and health risks is beginning to improve since our *Know Your Limits* campaigns. Early evaluation of these initiatives shows awareness is improving and that we have made progress in addressing gaps in public education. For example when asked whether they had heard of measuring alcohol consumption in units, 90% of respondents said that they had (against 79% in 1997). There has been a similar increase in the number who have heard of daily drinking limits, from 54% in 1997 to 75% in 2010.[16]

[15] *Alcohol dependence and harmful use: diagnosis and management in young people and adults*. Due for issue by NICE in January 2011.

[16] *Opinions survey, Drinking: adults' behaviour and knowledge in 2009*, NHS 2010.

75. *Know Your Limits* was first launched in May 2008 when it drew attention to the UK Chief Medical Officers' lower-risk guidelines and the units in typical drinks and it made self help material available through a website,[17] the *NHS Direct, Drinkcheck* and *Drinkline* services. Associated leaflets and other support materials were also made available for use in Primary Care as part of the campaign.

76. Most recently, in February 2010, the DH launched a new national alcohol awareness campaign that highlights the risk of the unseen damage that can be caused by drinking more than the recommended limits. DH has invested £6.8 million in this *Alcohol Effects* campaign which draws attention to the unseen harms like heart disease, cancers and strokes that alcohol can cause. The campaign is backed by three leading health charities – the British Heart Foundation, Cancer Research UK and the Stroke Association.

77. This followed the campaign launched in January 2010 by the Department for Children, Schools and Families (DCSF), *Why let drink decide?* This builds on the CMO's guidance[18] published in December 2009. It aims to advise parents, children and young people on how to establish a safe and sensible relationship with alcohol. It also raises awareness of how alcohol can make young people vulnerable to risks such as unwanted pregnancies, road traffic accidents and poor marks at school. DH and DCSF are committed to continue working together on this campaign, which will run until 2012.

HSC Recommendation 15

We also recommend that all containers of alcoholic drinks should have labels, which should warn about the health risks, indicate the number of units in the drink, and the recommended weekly limits, including the desirability of having two days drink-free each week.

78. We agree that Government should provide the public with consistent unit and health information and providing consumers with this information is crucial to our alcohol Strategy. Including this information on the labels of alcoholic products supports the *Know Your Limits* campaigns and is an integral part of our campaign to raise consumer awareness and understanding. Labels are a key vehicle for unit and health information in that they target drinkers in proportion to their consumption; the more bottles or cans consumed the greater the potential for the information to be seen. Government wishes the vast majority (at least 75% by 2014) of labels to have unit and health information in order for consumers to be better informed

[17] *Know Your Limits* website: www.nhs.uk/units

[18] *Guidance on the consumption of alcohol by children and young people* Sir Liam Donaldson Chief Medical Officer for England, December 2009

79. The Chief Medical Officer currently recommends daily limits rather than weekly. These are that men should not regularly drink more than 3-4 units of alcohol daily and women should not regularly drink more than 2-3 units daily. His advice also makes it clear that, in addition, people should also take a break for 48 hours after an episode of heavy drinking to let the body recover.

80. The Government aims to meet its objective of improving the unit and health content of labels on drinks in the most proportionate way and, on 15 February 2010, we launched a UK-wide public consultation on the options for action. The consultation seeks stakeholders views on three policy options, namely:

- whether we should allow the current voluntary agreement to continue;
- whether there is any real prospect for a targeted and *strengthened* self-regulatory agreement with the alcohol industry to improve the coverage and consistency of unit and health information on labels;
- whether a mandatory requirement with its associated costs is required to deliver the wide and consistent coverage needed for labelling information to play its necessary part in informing the public.

81. The consultation will run until 9 May 2010.

82. Any new regulations for England would be made under the *Food Safety Act*, in cooperation with the Food Standards Agency and these would require notification to the EU before coming into force. The Government is taking soundings with other Member States and the EU Commission as a contingency. It is also a particular concern that a future EU requirement for calorie labelling on alcohol labels, which the UK Government supports, should be complemented by alcohol unit and health information being made widely available on labels.

83. Ministers will consider the next steps on alcohol labelling based on the responses to the public consultation and taking into account the findings of other relevant research.

HSC Recommendation 16

We doubt whether a voluntary agreement would be adequate. The Government should introduce a mandatory labelling scheme.

84. The Government's general approach to legislation in the alcohol industry is first to seek commitments to self-regulation, wherever this may be effective and feasible, and it is right that we continue to do so. We will work with the alcohol industry where we can, but where it does not act responsibly, we will act in a proportionate way to protect the consumer, young people, and local communities.

85. We reached a UK-wide voluntary agreement on labelling with the alcohol industry in May 2007. At the time, we made it clear that we would expect specific information on units and health to be on the majority of alcohol product labels by the end of 2008. In June 2007, the Government's alcohol strategy, *Safe. Sensible. Social. – the next steps in the National Alcohol Strategy* committed the Government to monitor the implementation of this agreement and to consult on legislative options, should insufficient progress be made.

86. The Government made a further commitment, in its Safe.Sensible.Social consultation in 2008,[19] to consult stakeholders on how to improve compliance if progress on implementing the agreement remained slow. Two independent monitoring exercises to monitor progress on implementation have since taken place. The latest results, based on samples purchased in April 2009, are disappointing.

87. The independent monitoring exercises have shown that it has not been possible to engage enough of the alcohol industry in delivering the voluntary agreement. Only 15% of products were compliant by April 2009. Although, on a best-case scenario, industry suggestions show this could increase to 19% of labels by the end of 2010, it is clear that the limited and variable market coverage achieved to date is not adequate.

88. We have always made it clear as part of the voluntary labelling agreement that, if monitoring showed that uptake of the voluntary approach was too slow, regulation would be considered. This position was strongly endorsed by respondents to the 2008 DH consultation on labelling. We must now seriously consider a mandatory requirement.

89. The DH has recently received commitments from some major manufacturers who were not implementing the voluntary agreement that they will now do so. We will take these commitments into account when considering our next steps.

90. As above, the UK-wide consultation launched on 15 February 2010 includes the possible content of new regulations to make unit and health information mandatory on labels. We will take account of the Committee's views on labelling and would welcome any comments that they wish to make on the specific consultation questions.

[19] *Safe.Sensible.Social – Consultation on further action* – DH July 2008.

"Marketing and the drinks industry "

HSC Recommendation 17

The current system of controls on alcohol advertising and promotion is failing the young people it is intended to protect. The problem is more the quantity of advertising and promotion than its content. This has led public health experts to call for a ban. It is clear that both the procedures and the scope need to be strengthened.

91. The Government continues to take the issue of excessive drinking very seriously and through the Alcohol Harm Reduction Strategy is committed to minimising the health harms, violence and antisocial behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly. In particular, promoting the health of children and young people and ensuring that suitable safeguards are in place is a Government priority.

92. The Government therefore continues to ensure that emerging concerns about the possible impacts of advertising or weaknesses in regulation are fully examined – such as the regulation of alcohol advertising and the promotion of foods that are high in fat, salt and sugar (HFSS foods) to children. Where there is evidence of likely harm sufficient to justify action, we believe that the responsible regulators will act robustly.

93. A number of studies, including those undertaken by Government and Ofcom/Advertising Standards Authority (ASA) have shown that the number of younger children who drink alcohol appears to have fallen in recent years. Ofcom/ASA found that the proportion of 11-13 year olds who have never drunk alcohol increased from 31% in 2005 to 46% in 2007.[20] The *Smoking, Drinking and Drugs* Survey[21] showed that 48% of 11-15 year olds claimed not to have drunk alcohol in 2008, compared with 39% in 2003. However, the same survey shows that those young people who do drink alcohol are drinking larger amounts than in the past.

94. The advertising regulatory system is committed to upholding high standards in alcohol advertising. The Advertising Codes contain special rules for alcohol, which are in addition to the general Code provisions that all advertisements must not mislead, harm or offend. The system is designed to ensure that all alcohol advertisements are socially responsible and in particular that children and young people are protected from harmful or inappropriate advertising and marketing through the strict rules already in place.

[20] Young people and Alcohol Advertising Nov 2007 http://www.ofcom.org.uk/research/tv/reports/alcohol_advertising/alcohol_advertising.pdf

[21] Smoking, Drinking and drug use among young people in England in 2008

95. The alcohol advertising rules were tightened significantly in October 2005 to ensure that they remained relevant and appropriate. This was done in response to the 2004 Alcohol Harm Reduction Strategy, which suggested a possible link between young people's awareness and appreciation of alcohol advertising and their propensity to drink.

96. The updated rules are designed to protect young people in particular and the general population in two ways. Rules on the content of adverts prevent the association of alcohol with youth culture, and also ensure that adverts do not reflect or encourage any anti-social or undesirable behaviours associated with alcohol misuse. Extensive scheduling restrictions are also in place to protect young people by preventing adverts from being placed in or around programmes of particular appeal to children. These rules are actively promoted and enforced by the ASA. Furthermore, the regulatory regime provides suitable training and guidance; pre-publication advice and clearance; proactive monitoring of advertisements and a detailed complaints and investigations procedure.

97. In addition to the extensive regulatory regime for advertising, the Portman Group´s *Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks*, which is supported throughout the industry, seeks to ensure that drinks are marketed in a socially responsible way and to an adult audience only. The Code complements and reflects the Committee of Advertising Practice (CAP) and Broadcast Committee of Advertising Practice (BCAP) codes. For example, it prevents any targeting of under 18s, the suggestion that drinking makes consumers socially or sexually successful or the use of models who are, or look, under 25.

98. The broadcast and non-broadcast advertising regulations, as well as other promotional rules such as controls on sponsorship are already based on evidence of a possible link between alcohol promotion and harm. Regulators are clear that the rules must be robust and based on best evidence. If further evidence were to emerge that particular advertising, marketing or promotional techniques have the potential to pose a risk of harm or fail to adequately protect children and young people, then the regulators would have a duty to consider this fully and take appropriate and proportionate action.

99. The review by the School of Health and Related Research (ScHARR) at the University of Sheffield[22] found, *"consistent evidence from longitudinal studies that exposure to TV and other broadcast media is associated with inception of and levels of drinking"*. The evidence relating to the size of the impact of advertising from these and other studies is less clear. There is also a lack of evidence specific to the UK. (See also the later response to the Committee's recommendation on the watershed).

[22] *Independent Review of the Effects of Alcohol Pricing and Promotion*, the School of Health and Related Research, University of Sheffield 2008 http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_4001740

100. The ScHARR review highlighted the substantial uncertainty of the available evidence on the potential impact of restrictions on advertising, and advocated further research. It also demonstrated that there exists disagreement in the academic research literature on the efficacy of advertising bans.

101. The Government's view is, that, while the Committee has drawn attention to an important issue from some emerging evidence on potential harm to young people, there is some way to go before there is a strong enough case for the specific restrictions and controls the Committee has recommended.

102. The Government will continue to monitor the effectiveness of the UK's regulatory regimes to ensure that the structures in place remain sufficient to protect the public (and children and young people in particular) especially with regard to the regulation of new digital media.

103. The DH and the Department for Children, Schools & Families (DCSF), in consultation with the Department for Culture Media & Sport (DCMS) and other Departments, will jointly commission a review of the current evidence on potential harm to children and young people from alcohol advertising, promotion and sponsorship. It will:

- Assess the evidence available on the potential impact of the various forms of advertising, promotion, and sponsorship;
- Seek to provide an objective view of the available evidence to inform a debate which is sometimes polarised;
- Provide a framework for further research.

104. Government and the responsible regulators will examine the findings of this review and consider if any further actions on alcohol advertising, promotion and sponsorship might be both proportionate and necessary in order to have a significant impact on alcohol related harm.

Procedures

HSC Recommendation 18

The regulation of alcohol promotion should be completely independent of the alcohol and advertising industries; this would match best practice in other fields such as financial services and professional conduct.

105. The Government is strongly supportive of the current regulatory system and notes that appropriate levels of independence are already built into the system.

106. Advertising in the UK continues to be controlled through a system of statutory co-regulation and self-regulation which is policed by the ASA. Self-regulation of non-broadcast advertising and the ASA have been running since 1962. The success of this system led Ofcom to take the decision to contract-out the statutory regulation of broadcast advertising to the ASA (a measure approved by Parliament) and the ASA assumed responsibility for TV and radio advertising in November 2004, with Ofcom retaining statutory backstop powers.

107. The advertising regulatory system incorporates suitable due process to ensure a robust, responsive and evidence-based approach. The rules governing alcohol advertising were developed in line with Government's better regulation principles, which state that regulation must be transparent, accountable, proportionate, consistent and targeted. The rules were drafted in light of the best available evidence about the impact of alcohol advertising on society. The broadcast advertising rules are developed by BCAP with advice from an independent non industry panel (the Advertising Advisory Committee) and must be approved by Ofcom which is, of course, completely independent of the alcohol and advertising industries.

108. Enforcement of the rules is administered by the ASA Council. Two thirds of Council members are independent of the advertising industry, as is the chair. This ensures an independent perspective while providing access to industry expertise. We understand that that no member of the ASA Council has links to the alcohol industry. We also understand that the alcohol industry is not directly represented on either CAP or BCAP.

109. Furthermore, as noted in the recent independent report commissioned by the Government on *The Impact of the Commercial World on Children's Wellbeing*,[23] the advantages of the current system are that it enables the ASA to respond quickly to public concern and to ensure that advertisers abide by both the spirit and the letter of the Codes. The ASA also meets the standards set out by the European Commission with regard to Self Regulatory Organisations, this includes specific standards in relation to effectiveness, coverage and independence.

110. When developing advertising rules, CAP and BCAP place a significant emphasis on achieving consistency between Codes for different media. It is important that the rules are easy to understand and apply in all media settings.

111. We will to continue to monitor the effectiveness of the UK's regulatory regimes to ensure that the structures in place remain sufficient to protect the public, and children and young people in particular.

[23] *The Impact of the Commercial World on Children's Wellbeing: Report of an Independent Assessment.* DCSF December 2009. http://publications.dcsf.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00669-2009

HSC Recommendation 19

Young people should themselves be formally involved in the process of regulation: the best people to judge what a particular communication is saying are those in the target audience.

112. The effective contribution of relevant stakeholders, including individuals and organisations representing the interests of young people and parents, has been recognised by regulators as an important aspect in the elaboration and assessment of the advertising codes.

113. Previously Ofcom and ASA commissioned a major two-stage research project (2005/2007) to assess the impact of the strengthened alcohol advertising rules on young peoples' attitudes to alcohol advertising. This work was based on interviews with over 3000 young people.

114. More recently, as part of CAP and BCAP's work to review the advertising Codes they held a full 12-week public consultation on the proposed new Codes. CAP and BCAP consulted directly with numerous family and children's groups, as well as Government Departments, EU Directorates and Political Parties to ensure the rules remain relevant and robust. CAP and BCAP received around 4,500 individual responses including from a wide range of organisations with an interest in young people/child/parent engagement.

115. In addition, the ASA Council currently includes members with a sound understanding of child protection issues.

116. In consulting on the Chief Medical Officer's *Guidance on the consumption of alcohol by children and young people* and in the development of the *Why Let Drink Decide?* Campaign, the DCSF consulted extensively with young people and parents on their attitudes to alcohol. This included more than 2,000 linked interviews with children and parents on their attitudes to alcohol. This research will be considered as part of the review to be commissioned by DCSF and DH.

117. Both Government and regulators recognise that in planning any future research they should always think carefully about how best to consider the views of interested parties, including children and young people, as is evidenced by the regulators' past work on alcohol and HFSS food advertising. We will therefore maintain our work with the ASA, Ofcom and other regulators to see how they might continue to take on board the views of children and young people.

Scope

HSC Recommendation 20

The current controls do not adequately cover sponsorship, a key platform for alcohol promotion; the codes must be extended to fill this gap.

118. There are already current controls that cover all forms of alcohol sponsorship.

119. With regard to broadcasting:

- Paid for sponsorship of TV and radio programmes is regulated by Ofcom under both the Broadcasting Code and the BCAP code. Sponsorship "bumpers" to their broadcast content are subject to the same strict BCAP rules applied to the content of spot adverts. In addition, sponsorship bumpers cannot contain advertising messages;
- Similarly, the scheduling of Sponsorship on TV and radio must comply with the BCAP code (e.g. alcohol sponsorship of a programme of particular appeal to children cannot take place);
- Undue prominence rules in the Broadcasting Code also guard against disproportionate coverage of any incidental event sponsorship that may be contained within TV and radio programmes containing sponsorship e.g. sporting events, music festivals etc;
- The Government has also taken the decision to exclude alcoholic drinks from the list of items allowed to be product placed on TV when the legislation is enacted later in 2010.

120. In addition to the rules on broadcasting, the Portman Group regulates all other forms of alcohol sponsorship, including sports sponsorship (which includes a specific rule that sponsorship should only be undertaken if at least 75% of the audience or participants are aged over 18) in line with the restrictions on the placement of alcohol advertising set out in the CAP Code.

121. As such, we believe that alcohol sponsorship is already covered by the existing regulatory regimes. However, we will continue to monitor the effectiveness of these regulatory systems to ensure they maintain appropriate public protections – particularly for children and young people. We will take account of the findings of the review to be commissioned by DH and DCSF.

HSC Recommendation 21

New media are becoming dominant in alcohol promotion and present particular regulatory challenges, including the inadequacy of age controls and the problems presented by user-generated content. Expert guidance should be sought on how to improve the protection offered to young people in this area.

122. The majority of new media advertising is already covered by the non-broadcast advertising code and are therefore subject to the rules on alcohol and the protection of children that it contains. The current Code already extends significantly into online space and digital media, including but not limited to:

– online advertisements in paid-for space (including banner or pop-up advertisements and online video advertisements);

– paid-for search listings;

– preferential listings on price comparison sites;

– viral advertisements; in-game advertisements;

– commercial classified advertisements;

– "advergames" that feature in display advertisements;

– advertisements transmitted by Bluetooth;

– advertisements distributed through web widgets and online sales promotions and prize promotions;

– SMS adverts on mobile phones.

123. However, both Government and industry have recognised the need to ensure that new media regulation can respond to the rapid changes in technology. Industry has therefore been considering the extent of new media regulation, particularly in the light of the recommendations set out in the Government commissioned Byron Review – '*Safer Children in a Digital World*'.[24] The review recommended industry take steps to 'future proof' the current system for advertising regulation, taking account of new forms of online advertising outside the remit of the existing regulatory system.

124. The Advertising Association (AA), as the body representing the entirety of the advertising industry, has finalised the industry agreement on the extension of the ASA's self-regulatory remit to those areas of the online space not currently covered by the CAP Code.

125. The objective is to extend the remit of the CAP Code in the light of digital developments and to enhance consumer trust around commercial activity in the online world. The review will also extend to online space the existing protections around alcohol advertising and the specific protections afforded to children contained within the CAP Code.

[24] *Safer Children in a Digital World: the report of the Byron Review* DCSF 2008 www.dcsf.gov.uk/byronreview/

126. The advertising industry is therefore looking to extend the ASA's remit into marketing on companies' own websites and other non-paid-for space (including social networking sites). This has raised difficult issues about separating advertising from editorial and requires careful definition in order to come up with robust and workable regulatory solutions. Under the AA's proposals a range of new spaces online would be brought within CAP's remit. These will include:

- Companies' own marketing communications on their own websites;
- "Advergames" that feature in display advertisements are already covered by the CAP Code (see above) but the extended remit would also cover those advergames containing marketing communications that are designed on behalf of and/or hosted on a company's own website;
- User-generated content (UGC) not already covered by the CAP Code would come within its scope under the extended remit being proposed. Thus, UGC that has been actively endorsed by the advertiser will come within remit, but not, for example, spoof/parody advertisements created by individuals on their own initiative that do not form part of a company's marketing strategy.

127. The Government welcomes and encourages the action being taken by the regulators and industry in reviewing these areas. However, we will monitor the development of these new regulatory systems to ensure that suitable public protections are put in place, particularly for children and young people. We will take account of the findings of the review to be commissioned by DH and DCSF.

HSC Recommendation 22

There is a pressing need to restrict alcohol advertising and promotion in places where children are likely to be affected by it. – Billboards and posters should not be located within 100 metres of any school. (There used to be a similar rule for tobacco.)

128. The Outdoor Advertising Association (OAA) whose membership covers more than 95% of poster sites in the UK has a standards charter that asks its members not to place alcohol adverts on sites near schools. This sets out that, in the interests of responsible advertising to protect minors from undue exposure to alcohol advertising, OAA members shall consider (as a voluntary and unilateral measure) not displaying alcohol advertising on their panels located within a 100 metre radius of any school entrance.

129. The CAP Code contains a specific rule which states that no medium can be used to advertise alcoholic drinks if more than 25% of its audience are under 18. The CAP Code also contains an overarching social responsibility provision and advertisers must comply with the spirit, as well as the letter of the rules. The ASA have indicated that they would consider complaints about alcohol adverts being placed too close to schools under these rules.

130. The Government recognises that appropriate regulatory systems already exist to address concerns about this form of advertising. However, we will continue to monitor the regulatory regimes to ensure that suitable protections are put in place for children and young people.

HSC Recommendation 23

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

131. The extent of the regulation of alcohol advertising has continued to be considered closely by Government, through a range of policy developments such as the Alcohol Harm Reduction strategies, and by the regulators including, where appropriate, through action to strengthen the alcohol advertising rules.

132. This situation has remained under close scrutiny. Calls for a pre-9pm watershed ban and the lack of evidence to support this intervention were considered at length by Ministers as part of the 2007 Alcohol Harm Reduction Strategy review. The review concluded no such action should be considered until the effectiveness of current advertising restrictions – particularly in protecting children and young people – had been assessed.

133. The Government therefore set out a commitment to review the relationship between alcohol pricing and promotion and harm, with research subsequently undertaken by Sheffield University (ScHARR). The ScHARR review looked at a range of alcohol issues, including the links between alcohol price, promotion and harm, to help assess the adequacy of a range of regulatory controls, including the current alcohol advertising restrictions.

134. In response to the Department of Health's 2008 consultation paper: *Safe, Sensible, Social* – the Secretary of State for Culture, Media and Sport asked CAP and BCAP to make a full assessment of the research on alcohol undertaken by Sheffield University as part of their wider advertising code review.

135. Whilst the ScHARR review indicated there was evidence of small but consistent effects of advertising on consumption by young people at an individual level (this related to mainly US based studies), overall the review indicated substantial uncertainty in the evidence on the potential impact and efficacy of advertising restrictions (including total bans and watershed bans). The review concluded that there is an ongoing methodological debate on how advertising effects can and should be investigated and called for further research and methodological developments for establishing a definite causal relationship.

136. CAP and BCAP have reviewed the ScHARR findings, as requested by Government. CAP and BCAP announced on 16 March 2010 their conclusions following consultation was that there is insufficient evidence to suggest the already robust alcohol advertising rules need to be strengthened further. As part of their code review process, CAP and BCAP considered all the additional evidence submitted through their public consultation.

137. In addition to consideration by CAP and BCAP, further mechanisms exist under the Communications Act, and as part of the current co-regulatory system, to ensure that Ofcom gives full consideration to the extent of the broadcast advertising codes. Under this system, Ofcom retains statutory responsibility for broadcast standards in advertising and the sponsorship of programmes. So, whilst BCAP is responsible for setting, reviewing and revising standards codes for broadcast advertising, Ofcom must approve any recommended code changes. If evidence suggested that the rules did not ensure adequate protection of young people, then Ofcom would need to take appropriate and proportionate action.

138. Separately, given the current economic climate, extensive regulatory interventions such as a 9pm watershed ban or a ban on alcohol advertising would most likely have a significant impact on the creative industries, in particular the impact of greater restrictions on commercial public service broadcasters' ability to fulfil their public service obligations. It is not clear that this impact would be a proportionate or effective response to the potential harm the Committee seeks to prevent. The *Digital Britain*[25] report, published in 2009, highlighted the current pressures on the existing commercial public service models that have resulted, primarily, from declining advertising revenues.

139. Clearly, any call for further regulation would need to be properly assessed in relation to broadcast media to determine the evidence base for further restrictions and to show that any demonstrable positive impact was proportionate to the likely resultant loss of income. We will continue to monitor the regulatory regimes to ensure that suitable protections are put in place for and children and young people. We will take account of the findings of the review to be commissioned by DH and DCSF.

HSC Recommendation 24
Cinema advertising for alcohol should be restricted to films classified as 18.

140. Alcohol advertising in cinemas is subject to the non-broadcast placement restrictions set out in the CAP Code. These rules state that no medium should be used to advertise alcohol if more than 25% of its audience is under 18 years of age.

[25] *Digital Britain report* DCMS/BIS 2009

141. The Cinema Advertising Association (CAA) has a dedicated Alcohol Film Panel that works to ensure that alcohol ads are screened in line with the CAP Code in order to limit the exposure of alcohol advertising to under-18s. This includes profiling, and all advertisements are vetted before appearing on screens. Alcohol advertisements can only appear alongside films deemed by the CAA as suitable and having an audience profile of 75% adults. In addition to this, the cinema industry (in 2008) agreed not to include certain genres of film in any alcohol packages (such as comic strip-based films, "Teen Horror" and "Gross-out" comedies).

142. Furthermore, any advert shown in cinemas is subject to the same classification process as any other material shown in a cinema, and that adverts with a higher rating may not be shown alongside a film with a classification deeming it suitable for a young person.

143. As with the proposals set out at 7.7 above, the proposed restriction would have a significant impact on the cinema industry. Such a restriction would have a detrimental impact on many independent cinemas, leading to a significant reduction in the cultural diversity of films for UK audiences, job losses, a reduction in revenue for the British film industry, and ticket price rises for cinemagoers. It is not clear that this impact would be a proportionate or effective response to the potential harm the Committee seeks to prevent.

144. Clearly, any call for further regulation would need to be properly assessed in relation to cinema to determine the evidence base for further restrictions and to show that any demonstrable positive impact was proportionate to the likely resultant loss of income. We will continue to monitor the regulatory regimes to ensure that suitable protections are put in place for and children and young people. We will take account of the findings of the review to be commissioned by the DH and DCSF.

HSC Recommendation 25

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

145. The CAP Code already contains a specific rule which states that no medium can be used to advertise alcoholic drinks if more than 25% of its audience are under 18. Whilst for broadcast media the current rules prevent the targeting of children through the Broadcasters Audience Research Board 120 index system.

146. It is unclear what evidence has led the HSC to propose 10% as an appropriate threshold for the percentage of under-18's exposed to alcohol advertising. Neither is any clear evidence presented in the Select Committee's report in relation to any potentially affected media to support such further restrictions – in particular, what changes this recommendation would have on harmful consumption or the cost to industry. It is not clear that the impact on the advertising industry would be a proportionate or effective response to the potential harm the Committee seeks to prevent.

147. Office of National Statistics (ONS) figures show that, in mid 2008, around 1 in 5 of the population was under 16, therefore the 10% advertising threshold proposed by the HSC represents a very tough test.

148. It is far from clear that such interventions are supported by the current evidence base. Therefore, as set out above, calls for further regulation along these lines would need to be properly assessed in relation to all media to determine the evidence base for further restrictions and to show that any demonstrable positive impact was proportionate to the likely resultant loss of income.

149. We will continue to monitor the regulatory regimes to ensure that suitable protections are put in place for children and young people. We will take account of the findings of the review to be commissioned by the DH and DCSF.

HSC Recommendation 26

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

150. The Government recognises the alcohol industry's commitment to promoting its products in a socially responsible manner and only to those over 18 through the Portman Group's Code of Practice. As an example, although industry has noted that there is no specific evidence to suggest a link between such marketing and underage drinking, under this code any children's size replica sports kit, which displays the name of an alcoholic brand, will have to remove the sponsor from the shirt. (This includes the English and Scottish Football Premier Leagues). These changes apply to any new sponsorship after 1 January 2008. In addition, controls also exist on music sponsorship that prevent alcohol companies sponsoring concerts that are particularly popular with under 18s.

151. A recent study on the possible impact of a ban on alcohol sports' sponsorship, undertaken by the Cardiff Business School,[26] investigated attitudes to alcohol, sport and sport sponsorship among 14/15 year olds in a typical UK city. Following initial focus group discussions, a questionnaire survey was completed by a total of 294 pupils from five schools. The study found that there were no significant statistical correlations between sports sponsorship awareness and attitudes to alcohol use. The results suggest that banning alcohol sponsorship of sport would only have a significant impact if it were part of a much wider campaign designed to break the longstanding links between sport and alcohol in British male culture.

152. Further restrictions on sponsorship are likely to have a significant effect on major events (such as the Carling Cup (football), Guinness Premiership (rugby union) etc). Sponsorship by alcohol companies is worth many millions to British sport generally – money which in many cases is then used to support youth and grassroots development programmes.

[26] Research by Cardiff Business School, published by International Journal of Sports Marketing and Sponsorship.

153. Similarly, many music events rely on commercial sponsorship and alcohol sponsors contribute to the UK's thriving live music scene. Until recently, Carling sponsored live music events ranging from major international festivals like Reading through to supporting the Academy Music Group which runs smaller music venues across the UK.

154. We will continue to monitor the regulatory regimes to ensure that suitable protections are put in place for children and young people. We will take account of the findings of the review to be commissioned by the DH and DCSF.

HSC Recommendation 27

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

155. As set out above, the majority of new media advertising is covered by the non-broadcast advertising codes and are therefore subject to the rules on alcohol and the protection of children that it contains. Furthermore, industry has finalised proposals to extend the ASA's remit into marketing on companies' own websites and other non-paid-for space.

156. The Government welcomes the action being taken by the regulators and industry in extending new media regulation in these areas. However, we will monitor the development of these new regulatory systems to ensure that suitable public protections are put in place, particularly for children and young people. We will take account of the findings of the review to be commissioned by DH and DCSF.

HSC Recommendation 28

Alcohol promotion should not be permitted on social networking sites.

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

157. As set out above, the majority of new media advertising is already covered by the non-broadcast advertising codes and are therefore subject to the rules on alcohol and the protection of children that it contains. Where an advertiser was taking out a paid-for display advertisement on a social networking site this would continue to fall within the present remit of the CAP Code. However, industry is planning to extend the ASA's area of self-regulation into companies' own websites and other non-paid-for space, including social networking sites.

158. The Government will continue to work with the Portman Group and industry to ensure that adequate age control systems on websites are in place.

HSC Recommendation 29

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

159. The Government continues to promote a programme of public health campaigns. Through the Alcohol Harm Reduction Strategy, the Government has been determined to play its full role, working with industry and public health partners. In July 2008, the Government consulted on a proposal to have health information as an end-frame of advertisements. (It was suggested the end-frame could take up the final sixth of the advert). The responses to the proposal were divided. Evidence of the impact of end-frames was a subject of vigorous debate.

160. In September 2009, the alcohol industry launched the *Campaign for Smarter Drinking* (CFSD). The campaign is an industry-funded initiative to reduce binge drinking amongst 18-30 year olds with financial and logistical support of many major producers, retailers and trade associations. The Government agreed to support the CFSD, and not to proceed with the end frame proposal, providing that CFSD was adequately funded and effective when measured against key performance indicators, and providing that industry also renewed adequate levels for funding for the *Drinkaware Trust*, an industry funded charity, with a minority of alcohol industry trustees, whose objective is to reduce harm from alcohol.

161. In December 2009, *Drinkaware* announced that industry had agreed to contribute funding of over £5m per annum for the next three years. *Drinkaware* targets increasing and higher-risk drinkers and under-18s and has now taken on management of the CFSD.

162. The Government welcomes the industry commitment to the *Drinkaware Trust*. We will closely monitor the performance of the *Drinkaware Trust* over the coming three years. We will continue to keep under review the evidence on how best to reduce harmful drinking, including the balance between alcohol advertising and public health messaging.

163. "Licensing, binge-drinking, crime and disorder"

HSC Recommendation 30

The Policing and Crime Act 2009 gives the police greater powers to confiscate alcohol from under 18s, introduces a mandatory code in place of the industry's voluntary code and has made it easier to review licences. We support the introduction of mandatory conditions and urge the Government to implement them as a matter of urgency.

164. The Government commenced the new alcohol powers in the *Policing and Crime Act* on 29 January, with the exception of the mandatory code, which is currently before Parliament. We accept the Committee's recommendation and have made implementing the code a priority.

165. To this end, we laid draft regulations in February that are being debated during March. Subject to this process, regulations will commence in April 2010 to prohibit the worst on-trade promotions (e.g. all you can drink offers), pouring alcohol directly into customers' mouths and require on-trade premises to offer free tap water. The two remaining conditions will commence in October 2010, requiring on-trade premises to offer smaller measures of beer, wine and spirits, and requiring all premises to verify the age of any customer that looks under 18.

HSC Recommendation 31

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

166. The Government agrees that local people should have sufficient opportunity to influence licensing decisions that affect them and, as our evaluation of the impact of the 2003 Act indicated, believes that its licensing reforms have given local residents and local agencies a much greater say over alcohol licensing in their area. We note that the number of licensing reviews has been steadily increasing. This suggests growing confidence in using the powers provided by the Licensing Act. The Government continues to work closely with local authority representatives. Ministers have written to local authorities to encourage them to take a tougher, "red card" and "yellow card" approach to problem premises. Feedback suggests that many authorities are using, or plan to use, such an approach. We will continue to monitor the use of licensing powers.

HSC Recommendation 32

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

167. The Government accepts that it should be easier for local authorities to tackle groups of very late licensed premises and has brought forward proposals in the Crime and Security Bill currently before Parliament. However, as the evidence from ACPO suggested, licence reviews and revocations are far from being the only means of regulating the sector. Much enforcement on the ground is done through effective partnerships and, where necessary, securing improvements through the threat of formal action. While it is difficult to quantify such action, the successes of areas such as those recognised in last year's Beacon Council awards for managing the night time economy show how the existing powers and interventions can be used to tackle long seated problems of alcohol related crime and disorder successfully.

HSC Recommendation 33

It is of concern that section 141 of the Licensing Act 2003, which creates the offence of selling alcohol to a person who is drunk, is not enforced. We note the police and Home Office's preference for partnerships and training, but do not consider these actions should be an excused for not enforcing a law which could make a significant difference to alcohol-related crime and disorder. We call on the police to enforce s141 of the Licensing Act 2003 more effectively.

168. Whilst we agree in principle that the offence of selling to a person who is drunk should be enforced there are a number of practical difficulties in doing so. A successful prosecution needs the sale to be witnessed and to prove beyond reasonable doubt that the person was drunk. This is obviously a subjective decision and difficult to prove. Successful prosecutions have proved very resource intensive and require surveillance by undercover officers. These would need to be carried out in large numbers to make a difference to levels of crime and disorder. Previous campaigns to increase the number of prosecutions have not yielded results and the police feel that their resources for tackling alcohol-related crime and disorder can achieve greater results elsewhere.

169. The system of licence reviews, which was introduced for the first time as part of the Licensing Act 2003, provides a means of tackling problems where it would not be practical or proportionate to rely on criminal prosecution. So, where the condition of people leaving a premises suggests that sales to drunks are likely, this may be grounds for seeking a review of the licence and for appropriate measures put in place to ensure that such sales are not being made.

HSC Recommendation 34

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

170. The Government accepts the recommendation to monitor the impact of interventions under the new alcohol licensing system in Scotland.

171. Although health is not an objective of the Licensing Act 2003, measures under the four licensing objectives should also provide public health benefits, even though that is not their primary purpose. So, for example, the public safety objective may help prevent acute injuries and accidents, while the licensing objective to protect children is an area where local NHS Primary Care Trusts have statutory responsibilities. Licensing policies also contribute directly to the overall strategy of reducing harm from alcohol. The Secretary of State's statutory guidance suggests that licensing authorities should familiarise themselves with the national alcohol harm reduction strategy.

172. The Licensing Act 2003 requires all licensees (not just those selling alcohol) to have regard in all their activities to each of the licensing objectives. It is not necessarily clear that it is reasonable that all licensees should have an overriding objective to protect the health of their customers, nor is it clear how they could give effect to such an objective. In particular, licensees have no control over consumption away from licensed premises and in people's homes where the majority of alcohol is now drunk.

173. It should be noted that, unlike Scotland, the Licensing Act in England and Wales also covers regulated entertainment and the sale of late night hot food and drink. A new licensing objective to promote public health would therefore also apply to a wide range of licensable activities and events including late night takeaways, restaurants, theatres, school and PTA events, live music events and cinemas.

174. We agree that the Government should monitor the impact of the experience in Scotland. While there is no presumption that public health should be a licensing objective, we will look at the impact of specific national and local interventions in Scotland to determine whether such measures might help local licensing authorities in England and Wales to support local strategies, including the protection of health. We will take account of findings from the planned evaluation of Scotland's Alcohol Strategy to be commissioned shortly by NHS Health Scotland.

"Supermarkets and off-licence sales"

HSC Recommendation 35

Over recent decades, an ever-increasing percentage of alcohol has been bought in supermarkets and other off-licensed premises. Such purchases exceed those made in pubs and clubs by a large margin. A public health objective in the licensing legislation would apply to off-licenses as well as pubs and could be used to place limits on the number of outlets in an area. This aspect of the Scottish licensing legislation should be closely monitored with a view to its implementation in England.

175. The Government is not convinced that there is compelling evidence to intervene to limit the density of premises, but will consider any emerging evidence from Scotland. The Government would need to consider the best mechanism or actions delivered in Scotland which would properly balance the interests of the wider local community.

HSC Recommendation 36

Although they acknowledged that alcohol was a dangerous commodity, supermarkets told us that they used discounts and alcohol promotions because they were engaged in fierce competition with each other. This is not a responsible approach to the sale of alcohol. Retail outlets should make greater efforts to inform the public of the dangers of alcohol at the point of sale.

176. There are examples of supermarkets voluntarily providing unit information, responsible drinking messages or other information at point of sale. The major off-trade retailers, including supermarkets, have committed to fund the independent Drinkaware Trust from 2010 to 2012. Drinkaware runs consumer education campaigns targeting underage drinkers, young adults and regular harmful drinkers. This includes point of sale information in the off-trade. Government will keep under review the effectiveness of this initiative, including its impact on drinking behaviour and harm.

HSC Recommendation 37

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

177. Our response on price sets out the action the Government is taking in that area.

178. There is no conclusive evidence to suggest that the placement of alcohol in supermarkets contributes to social problems or health harm. However, DCMS Ministers have written to local authorities to suggest that tough conditions around the placement of alcohol in problem premises could be considered when, for example, there is evidence of alcohol theft or underage sales. The Government will be interested to see the impact of such measures in Scotland as part of the commitment above under *Licensing, Binge drinking Crime and Disorder* to monitor the impact of the new licensing laws in Scotland.

"Prices: taxes and minimum prices"

Price

HSC Recommendation 38

The consumption of alcohol, like that of almost all other commodities, is sensitive to changes in price as all studies have shown. The increase in alcohol consumption over the last 50 years is very strongly correlated with its increasing affordability. Increasing the price of alcohol is thus the most powerful tool at the disposal of a Government.

We believe that the Government should introduce minimum pricing for the following reasons:

- **It would affect most of all those who drink cheap alcohol, in particular young binge-drinkers and heavy low income drinkers who suffer most from liver disease**
- **It is estimated that a minimum price of 50p per unit would save over 3,000 lives per year, of 40p 1,100 lives per year.**
- **Unlike rises in duty (which could be absorbed by the supermarkets' suppliers and which affect all sellers of alcohol) it would benefit traditional pubs and discourage pre-loading.**
- **It would encourage a switch to weaker wines and beers.**

However, without an increase in duty, minimum pricing will lead to an increase in the profits of supermarkets and the drinks industry and an increase in marketing, promotions and non-price competition.

179. The Government accepts the evidence that price can influence the levels of consumption of alcohol and that different groups, including young people, binge drinkers and people who drink at higher risk levels will respond differently to price changes. We are also very much aware of the concern that selling alcohol at very cheap prices encourages people to drink more than the recommended levels, causing attendant health and social harms. Matters relating to duty are addressed in the section on tax below.

180. The Sheffield University review broke new ground by modelling the possible benefits of specific price interventions.[27] However, while there is wide ranging evidence from the Sheffield review and other sources on the effect of price in some areas, for example on levels of consumption, there is a need for better understanding in some areas such as crime and disorder. In addition, the remit for the Sheffield review did not consider issues around the potential impacts on businesses and the economy or on the current level of public understanding of, or support for, the issues around price.

181. Following publication of the Sheffield review, the Government committed to taking forward further work to develop the evidence base on cheap alcohol. The Home Office is now taking that work forward, with a view to developing a better understanding of the wider implications that any action on price might have on the economy, on levels of crime and disorder and on the public. We anticipate that the research reports will be completed by the end of March 2010. The findings will then help to inform the Government's next steps.

182. The Home Office has already taken measures under the Policing and Crime Act which will address irresponsible promotions in the on trade. Draft regulations were laid in February 2010 setting out a number of licensing conditions which ban the most irresponsible promotions and practices in the on-trade. These include activities such as "All you can drink for £10" and "Women drink free". Banning these types of promotions and practices will ensure that alcohol is sold more responsibly and should reduce levels of alcohol-related crime and disorder in the night-time economy.

HSC Recommendation 39

The introduction of minimum pricing would encourage producers to intensify their marketing. This will make it all the more important to control marketing

183. The Government's response to marketing and industry is set out in our replies to *Marketing and the drinks industry* above.

[27] Independent Review of the Effects of Alcohol Pricing and Promotion – University of Sheffield (2008)

Tax

HSC Recommendation 40

The Treasury must take into account public health when determining levels of taxation on alcohol as it does with tobacco

184. The primary purpose of alcohol duty is to raise funds for the public finances. Her Majesty's Treasury (The Treasury) takes a wide range of issues into account when deciding on alcohol taxation. These include the Government's strategy on the wider health and social impacts associated with alcohol consumption as well as impacts on tax receipts and on the alcohol industry and other stakeholders.

185. Alcohol duty rate decisions are a matter for the Chancellor at the Budget where a decision will be made in the light of the advice which he has received from all Departments across Government. In the context of public health and alcohol taxation, this would include advice from DH on the health harms from drinking, from the Home Office and the Ministry of Justice on the impacts of drinking on crime and disorder and from DCSF on harms to children.

186. Where there is evidence that tax policy is an effective approach to support wider Government policy, for example health and other social objectives, the Treasury could consider its use as long as it was consistent with the public finances. In the case of tobacco, it is generally accepted that all consumption carries a significant risk of health harm, whereas the Government sets out "lower risk" levels for alcohol below which the risk of health harm is relatively small.

HSC Recommendation 41

Alcohol duty should continue to rise year on year above incomes, but unlike in recent years duty increases should predominantly be on stronger alcoholic drinks notably on spirits.

187. Alcohol duty does increase year on year currently. The Budget in March 2008 announced that the rates of duty on alcohol products would increase by two per cent above inflation until 2012/13.

188. Increases in alcohol duty, where they do impact upon the price paid by consumers, will decrease the level of average consumption. However, it is not always clear that duty changes do pass through in to price changes, particularly in the off-trade.

189. Spirit duty is already at a higher rate per unit of alcohol than for other products. The duty per unit of alcohol is around 23p on spirits, around 17p on wine and 16p on beer. The Treasury continues to keep all tax policy under review.

HSC Recommendation 42

The duty on spirits per litre of pure alcohol was 60% of male average manual weekly earnings in 1947; in 1973 (when VAT was imposed in addition to duty) duty was 16% of earnings; by 1983 it was 11% and by 2002 it had fallen to 5%. We recommend that in stages the duty on spirits be returned to the same percentage of average earnings as in the 1980s.

190. The Government recognises that alcohol has become more affordable as a result of incomes growing faster than prices. However, prices on alcohol products have risen faster than the retail price index and so are now more expensive compared to other goods than they were in 1983.

191. The Treasury continues to keep all tax policy under review. When considering any particular changes in duty, The Treasury looks at the extent to which those changes would produce additional revenue yield as well as any representations about them from the Secretaries of State in other Departments in their letters to the Chancellor of the Exchequer.

192. As above, alcohol duty rate decisions are a matter for the Chancellor at the Budget in the light of advice received from Departments across Government.

HSC Recommendation 43

Cider is an extraordinary anomaly; the duty on industrial cider should be increased. To protect small real cider producers, their product should be subject to a lower duty.

193. HM Treasury announced it would review the cider duty regime in the 2009 Pre-Budget Report in December 2009 with an intention to bring forward proposals at Budget 2010. The Treasury has invited other Government Departments to contribute to this review.

HSC Recommendation 44

Beer under 2.8% can be taxed at a different rate: we recommend that duty be reduced on these weak beers; although at present there are few producers of beers of this strength, the cut should encourage substitution.

194. The introduction of a reduced rate of duty for beers below 2.8% abv is permitted. However, there is currently little evidence about the demand for beers at this strength which represents less than 0.5% of the beer market.

195. The Republic of Ireland has introduced a reduced rate for these beers. This has encouraged some innovation with the introduction of new products, but it is

HSC Recommendation 45

In the longer run the Government should seek to change EU rules to allow higher and more logical levels of duty on stronger wines and beers; it should also seek to raise the strength of beer which can be subject to a lower duty rate from 2.8 to slightly higher levels.

196. The alcohol duty regime is constrained by the EU rules.

197. The current constraints prevent Member States from making the kind of adjustments to taxation that the Committee seeks, for example to create a greater duty differential between higher and lower strength drinks.

198. The Treasury will consider its position on EU tax issues, taking advice from interested Departments across Government, once details for any consultation on the review of alcohol taxation by the Commission are published.

199. The Government continues to support the principle of fiscal sovereignty, consistent with EU rules in this area, but any changes to EU alcohol taxation must be agreed unanimously by all Member States.

Department of Health
March 2010.

Published by TSO (The Stationery Office) and available from:

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