

Chapter 6

Case study –
Alcohol and tobacco



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Introduction

- 6.1 Alcohol and tobacco are enjoyed legally by many people in the UK and elsewhere (for further information on policy internationally see Appendix 6). Alcohol is of considerable social significance and it features as part of many religious and cultural events. Many people take pleasure in drinking moderate amounts of alcohol without any demonstrable harm. At this level it has been shown to have some health benefits, although it is disputed whether these are offset by other harms (see Box 6.1). However, excessive consumption¹ is extremely harmful to individual consumers and is often also linked to public safety problems that impact upon third parties, such as drink-driving. For tobacco, even smoking a small number of cigarettes regularly is harmful to the individual and people around them.
- 6.2 Public health measures aimed at limiting the harms caused by alcohol and tobacco raise some similar ethical issues. We therefore consider alcohol and tobacco together in this case study, comparing and contrasting similarities and differences where they occur. In particular, both alcohol and tobacco are supported by major manufacturing, advertising and distribution industries, and we consider the role of these industries.
- 6.3 To be effective and enforceable, public health policies aimed at reducing the consumption of substances that people enjoy usually require a certain threshold of public support. Governments might also decide to take political considerations into account. As expressed by one respondent to our consultation: “If most people smoke, then restricting their activities is not going to win an election; public opinion had to be changed first” (Les Dundon). It is notable that in the UK there were major policy initiatives to try to reduce smoking and passive smoking by the incoming Labour Government in 1998,² whereas strategies for alcohol³ were not forthcoming until much later and they have been much less far-reaching.

Box 6.1: Does drinking a moderate amount of alcohol confer health benefits?

It is widely reported that consuming a small amount of alcohol, particularly red wine, leads to a reduction in risk of coronary heart disease.⁴ The amount of alcohol that offers this protection without increasing risk of other health problems is disputed but thought to be low, in the region of one or two alcoholic drinks a few times a week. Some researchers dismiss the theory that alcohol can be protective, and have concluded that coronary protection from light to moderate drinking of alcohol is very limited and unlikely to outweigh the harms caused.⁵

¹ In this Report we use ‘excessive’ alcohol consumption to refer to drinking that leads to alcohol use disorders as defined in the Alcohol Needs Assessment Research Project (ANARP). The report used the World Health Organization categorisation of disorders of alcohol use, which specifies three categories: ‘hazardous drinking’, people drinking above recognised ‘sensible’ levels but not yet experiencing harm; ‘harmful drinking’, people drinking above ‘sensible’ levels and experiencing harm; and ‘alcohol dependence’, people drinking above ‘sensible’ levels and experiencing harm and symptoms of dependence. Department of Health (2005) *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (London: Central Office of Information).

² Department of Health (1998) White Paper: *Smoking Kills*, available at: <http://www.archive.official-documents.co.uk/document/cm41/4177/contents.htm>.

³ Scottish Executive (2002) *Plan for Action on Alcohol Problems* (Edinburgh: Scottish Executive); Prime Minister’s Strategy Unit (2004) *Alcohol Harm Reduction Strategy for England*, available at: <http://www.cabinetoffice.gov.uk/strategy/downloads/su/alcohol/pdf/CabOffice%20AlcoholHar.pdf>; Department of Health, Home Office, Department for Education and Skills and Department for Culture, Media and Sport (2007) *Safe. Sensible. Social. The next steps in the National Alcohol Strategy* (London: Department of Health Publications).

⁴ For example, see Mukamal KJ, Chiuve SE and Rimm EB (2006) Alcohol consumption and risk for coronary heart disease in men with healthy lifestyles *Arch Intern Med* **166**: 2145–50; Britton A and Marmot M (2004) Different measures of alcohol consumption and risk of coronary heart disease and all-cause mortality: 11-year follow-up of the Whitehall II Cohort Study *Addiction* **99**: 109–16.

⁵ For example, see Jackson R, Broad J, Connor J and Wells W (2005) Alcohol and ischaemic heart disease: probably no free lunch *Lancet* **366**: 1911–2.

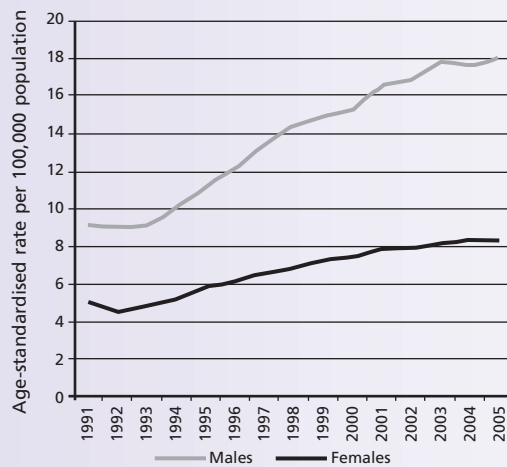
Harms caused by alcohol and tobacco to drinkers and smokers themselves

6.4 Excessive alcohol consumption and the use of tobacco are major contributors to ill health. However, while the association of smoking with disease and premature death is well known, it is less clear that the long-term risks of consuming excessive amounts of alcohol are as well understood across the population, or at least taken as seriously.⁶ Analysis for the World Health Organization (WHO) suggests that in developed countries tobacco is the leading single risk factor for mortality while alcohol is third (with blood pressure being the second most significant risk factor).⁷ A study published in the *Lancet* in 2007 compared the 'harm scores' for several illegal drugs and also alcohol and tobacco. Alcohol scored more highly than tobacco in this assessment based on judgements of doctors about physical harms, dependence and social harms caused by these substances.⁸

Alcohol

6.5 Alcohol-related harms are usually the result of chronic and dependent drinking, and/or episodic 'binge' drinking.⁹ Excessive consumption on a single occasion can also be damaging and even, on very rare occasions, fatal. The health effects of alcohol misuse include high blood pressure, cirrhosis of the liver, pancreatitis, cancer and mental health problems.¹⁰ Increases in consumption correlate with rises in the alcohol-related death rate throughout the 1990s (see Box 6.2 and Figure 6.1). National Statistics has calculated that the annual number of alcohol-related deaths in the UK has more than doubled from 4,144 in 1991 to 8,386 in 2005,¹¹ although figures from different sources vary. Worldwide, WHO

Figure 6.1: Alcohol-related death rates by sex in the UK, 1991–2005*



*Source: National Statistics *Alcohol-Related Deaths*, available at:

<http://www.statistics.gov.uk/CCI/nugget.asp?ID=1091&Pos=2&ColRank=1&Rank=192>, Crown copyright material is reproduced with the permission of the Controller of HMSO under the terms of the Click-Use Licence.

⁶ Rates of smoking have reduced in recent years (see Box 6.4) whereas alcohol consumption has increased, despite indications of the risks involved. See Association of Public Health Observatories (2007) *Indications of Public Health in the English Regions 8: Alcohol*, available at: http://www.apho.org.uk/apho/publications/Alcohol_Indications.pdf; Rose D (2007) Alcohol abuse undoing gains from curbs on smoking *The Times* 14 August, available at: http://www.timesonline.co.uk/tol/life_and_style/health/article2253774.ece.

⁷ Lopez AD, Mathers CD, Ezzati M, Jamison DT and Murray CJL (2006) Global and regional burden of disease and risk factors, 2001: systematic analysis of population health data *Lancet* **367**: 1747–57; Yach D, Hawkes C, Gould CL and Hofman KL (2004) The global burden of chronic diseases: Overcoming impediments to prevention and control *J Am Med Assoc* **291**: 2616–22.

⁸ Nutt D, King LA, Saulsbury W and Blakemore C (2007) Development of a rational scale to assess the harm of drugs of potential misuse *Lancet* **369**: 1047–53.

⁹ See Plant M and Plant M (2006) *Binge Britain: Alcohol and the national response* (Oxford: Oxford University Press).

¹⁰ National Statistics (2004) *Health Survey for England 2003 Volume 2 Risk factors for cardiovascular disease*, available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4098712.

¹¹ The definition of alcohol-related deaths used by National Statistics includes those causes regarded as most directly due to alcohol consumption; National Statistics (2006) News Release: *Alcohol-related death rates almost double since 1991*, 7 November, available at: <http://www.statistics.gov.uk/pdfdir/aldeaths1106.pdf>.

estimates that there are approximately 76.3 million people with diagnosed disorders caused by alcohol, with consumption of alcohol the cause of 3% of all deaths (one third due to unintentional injuries) and 4% of all disability-adjusted life years.¹² In all regions, more males than females were found to suffer from disorders for which alcohol is considered to be causal, and these conditions were found at a higher level in developed countries than developing countries (see also Box 6.3).¹³

6.6 Drinking even small amounts of alcohol is not without risk of harm if combined with other behaviours such as driving or workplace activities, and drinking larger quantities of alcohol is associated with the risk of personal injury. Together with the health risks posed by alcohol directly, alcohol thus has a major impact on the cost and workload of the NHS (see also Box 6.7).¹⁴

Box 6.2: Prevalence of drinking

- In 2005, a survey found that 72% of men and 57% of women in Great Britain had had an alcoholic drink on at least one day during the previous week.¹⁵
- Levels of alcohol consumption have risen significantly over the past 50 years. During this time, the per capita consumption in the UK has doubled from approximately four litres to over eight litres of pure alcohol per year.¹⁶ Since 1978, when questions about alcohol consumption were first asked as part of the General Household Survey (a population survey), men have reported a slight increase in overall weekly alcohol consumption and women have reported a much more marked increase.¹⁷ There is clear evidence of a relationship between increased overall consumption and an increase in the harm caused.¹⁸
- A national survey of Great Britain in 2005 found that exceeding the Government's recommended 'sensible drinking benchmarks' on at least one day in the week prior to the survey was more common among men (35%) than women (20%). These proportions had reduced since 2003.¹⁹ Heavy drinking was also more common among men (19% in 2005) than women (8%).²⁰
- Younger people were more likely than older people both to exceed the daily benchmarks (see graph below) and to drink heavily.²¹ Thirty-one per cent of men and 22% of women aged 16 to 24 years had drunk heavily on at least one day during the week prior to the national survey in 2005. Among those aged 65 years and over, these proportions were just 4% and 1%, respectively.²²
- An assessment in England in 2004 found that approximately 8.2 million people (38% of men and 16% of women) had an 'alcohol use disorder', meaning that their drinking is judged 'hazardous', 'harmful' or 'dependent' as defined by WHO.²³ The prevalence of alcohol dependence was 3.6% of the population of England, equating to 1.1 million people.²⁴
- Across Great Britain, the proportion of adults exceeding the daily benchmarks is highest in the North East (39%) followed by Scotland and Wales (both 35%). The lowest prevalence is in London and the East of England (both 25%), the South East and the West Midlands (both 27%).²⁵

Continued overleaf

¹² World Health Organization (2004) *Global Status Report on Alcohol 2004* (Geneva, Switzerland: WHO), p.1.

¹³ *Ibid.*, p.52.

¹⁴ Department of Health (2005) *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (London: Central Office of Information), p.2; Royal College of Physicians (2001) *Alcohol – can the NHS afford it?* (London: RCP).

¹⁵ National Statistics *Drinking*, available at: http://www.statistics.gov.uk/cci/nugget_print.asp?ID=1027, data from the General Household Survey 2005 and the National Statistics Omnibus Survey 2006. National Statistics notes that: "Obtaining reliable information about drinking behaviour is difficult. Surveys consistently record lower levels of consumption than would be expected from data on alcohol sales. This is partly because people may under-estimate how much alcohol they consume."

¹⁶ Academy of Medical Sciences (2004) *Calling Time: The nation's drinking as a major health issue* (London: Academy of Medical Sciences), pp.12 and 16.

¹⁷ National Statistics *A summary of changes over time: Drinking*, available at: <http://www.statistics.gov.uk/CCI/nugget.asp?ID=829&Pos=3&ColRank=2&Rank=960>.

¹⁸ See Academy of Medical Sciences (2004) *Calling Time: The Nation's drinking as a major health issue* (London: AMS), paragraph 2.19.

¹⁹ Government guidelines on sensible drinking are based on daily benchmarks of between three and four units per day for men and two to three units per day for women. National Statistics *Drinking*, available at: http://www.statistics.gov.uk/cci/nugget_print.asp?ID=1027, data from the General Household Survey 2005 and the National Statistics Omnibus Survey 2006.

²⁰ Heavy drinking is defined as over eight units a day for men and six units a day for women on at least one day during the week prior to the survey.

²¹ See footnote 20.

²² National Statistics *Drinking*, available at: http://www.statistics.gov.uk/cci/nugget_print.asp?ID=1027, data from the General Household Survey 2005 and the National Statistics Omnibus Survey 2006.

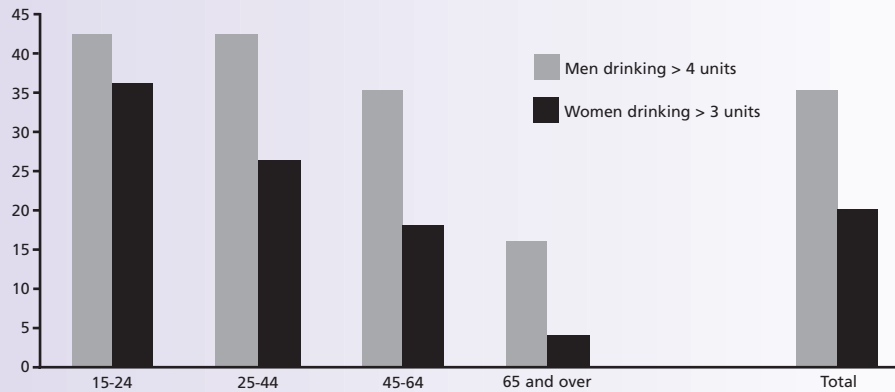
²³ For definitions, see footnote 1.

²⁴ Department of Health (2005) *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England* (London: Central Office of Information), p.3 and p.6.

²⁵ 2002–3 figures, National Statistics (2006) *Drinking*, available at: <http://www.statistics.gov.uk/CCI/nugget.asp?ID=922&Pos=1&ColRank=2&Rank=128>.

Box 6.2 (continued)

Percentage of men and women exceeding daily benchmarks for alcohol consumption by age on at least one day in the week prior to the national survey, Great Britain, 2005*



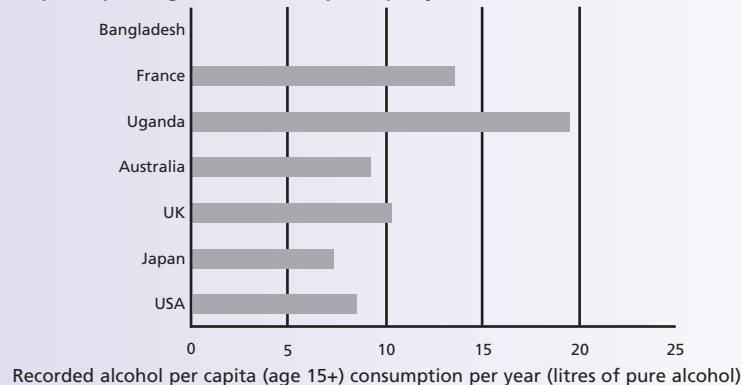
*Source: Goddard E (2006) *General Household Survey 2005: Smoking and drinking among adults, 2005* (Office for National Statistics), Crown copyright material is reproduced with the permission of the Controller of HMSO under the terms of the Click-Use Licence.

- The association of alcohol drinking with socio-economic classifications is complex and varies between the regions and countries of the UK. Although problems caused by alcohol affect people across the socio-economic spectrum, it is recognised that alcohol misuse plays a major role in the experiences of some of the most disadvantaged members of society, especially those who are homeless. The General Household Survey has shown over many years that there is little difference in usual weekly alcohol consumption between those classified as being in non-manual and manual households. Where differences do exist, it has been those in the non-manual categories who tend to have the higher weekly consumption, particularly among women.²⁶
- Minority ethnic groups in this country are more likely to be non-drinkers, particularly Bangladeshis (97% of men and 98% of women) and Pakistanis (89% and 95%), compared with the general population (8% and 14%). However, the drinking habits of Irish people in this country are similar to those of the general population, except that the mean number of days per week when alcohol is consumed is higher.²⁷

Box 6.3: Consumption of alcohol – international comparisons

The average amount of alcohol consumed in different countries worldwide ranged from 0 to 19 litres of pure alcohol per adult per year (age 15+) in 2000 or 2001.²⁸ Countries with no or very little recorded alcohol consumption are mainly Muslim countries, whereas the USA, European countries, Russia, Australia and New Zealand have the highest levels of total alcohol consumption. Several African countries have very high levels, including Uganda, which has the highest recorded alcohol per capita consumption in the world.²⁹

Total recorded alcohol per capita (age 15+) consumption per year in selected countries (2000/2001)*



*Source: Figures from World Health Organization (2004) *Global Status Report on Alcohol 2004* (Geneva, Switzerland: WHO), Table 3.

²⁶ Goddard E (2006) *General Household Survey 2005: Smoking and drinking among adults, 2005* (Office for National Statistics), p.50.

²⁷ Sproston K and Mindell J (Editors) (2006) *Health Survey for England 2004: The health of minority ethnic groups* (Leeds: The Information Centre).

²⁸ World Health Organization (2004) *Global Status Report on Alcohol 2004* (Geneva, Switzerland: WHO), Table 3.

²⁹ This is because the calculations included fermented beverages and estimates of locally produced beer.

Smoking

6.7 Smokers suffer considerable ill health and report a lower health-related quality of life than non-smokers at all ages.³⁰ Smoking causes lung cancer, bronchitis, emphysema, heart disease and cancers in other organs including the mouth, lip, throat, bladder, kidney, stomach, liver and cervix. This ill health translates into more hospital admissions and more sickness absences from work. Smoking was associated with on average 106,000 premature deaths a year in the UK between 1998 and 2002, equating to approximately one in six of all deaths (see also Figure 6.2).³¹ Half of all smokers will die prematurely; research has shown that men born in 1900–30 who were lifelong smokers died on average about ten years younger than non-smokers.³² It has been found that there are gains to stopping smoking at all ages³³ and hence, together with strategies that would reduce uptake, there is considerable potential to reduce the premature loss of life. (See Box 6.4 for data on the prevalence of smoking in various population groups and Figure 6.3 for some international comparisons.)

Box 6.4: Prevalence of smoking

- There was a dramatic increase and subsequent decline of cigarette smoking in the 20th Century in the UK. In 1974, 45% of people smoked compared with 35% in 1982. Since this time, the rate of decline has slowed. Prevalence has always been higher among men than among women; in 2005, 25% of men and 23% of women were smokers.³⁴
- The proportion of people who smoke declines with age; since the early 1990s, the prevalence of cigarette smoking has been higher among those aged 20–24 years than among those in other age groups.³⁵
- The number of cigarettes smoked per smoker has also declined from 14% of men in 1990 smoking 20 or more cigarettes a day to 10% in 1998 and from 9% to 7% for women in the same period. It has since remained virtually unchanged among both men and women, although there was a suggestion of a slight downturn in the couple of years prior to 2005. Cigarette consumption also varies by age, with those aged 35–59 years smoking the most (men: 16 cigarettes per day; women: 14 per day on average).³⁶
- Smoking has become associated with low socio-economic status and socially disadvantaged groups. One analysis suggests that as well as occupational grouping, socio-economic measures of deprivation such as housing tenure, unemployment and low educational status are independently associated with an increased prevalence of smoking among adults.³⁷ In the 1970s and 1980s in Britain, the prevalence of cigarette smoking fell more sharply among those in non-manual than in manual occupation groups, so that differences between the groups became proportionately greater. In England in 2005, 29% of those in manual groups and 19% of those in non-manual groups were cigarette smokers.³⁸ People in manual social classes also have more exposure to other people's cigarette smoke.³⁹
- Scotland generally has a higher smoking prevalence than England. In 2005, 27% of adults in Scotland were smokers, while in Wales 22% of adults were smokers.⁴⁰
- Smoking prevalence differs between ethnic and cultural groups in the UK. Self-reported cigarette smoking prevalence was 40% among Bangladeshi, 30% among Irish, 29% among Pakistani, 25% among Black Caribbean, 21% among Black African and Chinese, and 20% among Indian men, compared with 24% among men in the general population in England in 2004. For women, prevalence was higher among women in the general population (23%) than in most minority ethnic groups, except Irish (26%) and Black Caribbean women (24%). Ten per cent of Black African, 8% of Chinese, 5% of Indian and Pakistani, and 2% of Bangladeshi women smoked.⁴¹

³⁰ Kind P, Dolan P, Gudex C and Williams A (1998) Variations in population health status: results from a United Kingdom national questionnaire survey *Br Med J* **316**: 736–41.

³¹ Twigg L, Moon G and Walker S (2004) *The Smoking Epidemic in England* (London: Health Development Agency), p.2.

³² Doll R, Peto R, Boreham J and Sutherland I (2004) Mortality in relation to smoking: 50 years' observations on male British doctors *Br Med J* **328**: 1519–27.

³³ *Ibid.*

³⁴ Goddard E (2006) *General Household Survey 2005: Smoking and drinking among adults, 2005* (Office for National Statistics), p.4.

³⁵ *Ibid.*, p.5.

³⁶ *Ibid.*, p.9.

³⁷ Jarvis MJ and Wardle J (1999) Social patterning of individual health behaviours: The case of cigarette smoking, in *Social Determinants of Health*, Marmot M and Wilkinson RG (Editors) (Oxford: Oxford University Press).

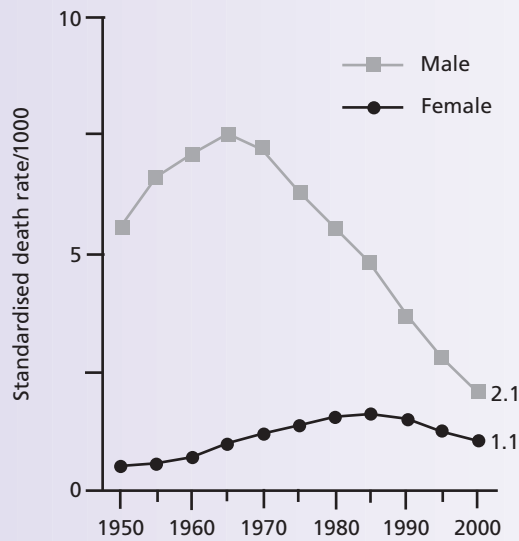
³⁸ Goddard E (2006) *General Household Survey 2005: Smoking and drinking among adults, 2005* (Office for National Statistics), p.6.

³⁹ Whincup PH, Gilg JA, Emberson JR *et al.* (2004) Passive smoking and risk of coronary heart disease and stroke: prospective study with cotinine measurement *Br Med J* **329**: 200–5.

⁴⁰ Goddard E (2006) *General Household Survey 2005: Smoking and drinking among adults, 2005* (Office for National Statistics), p.9.

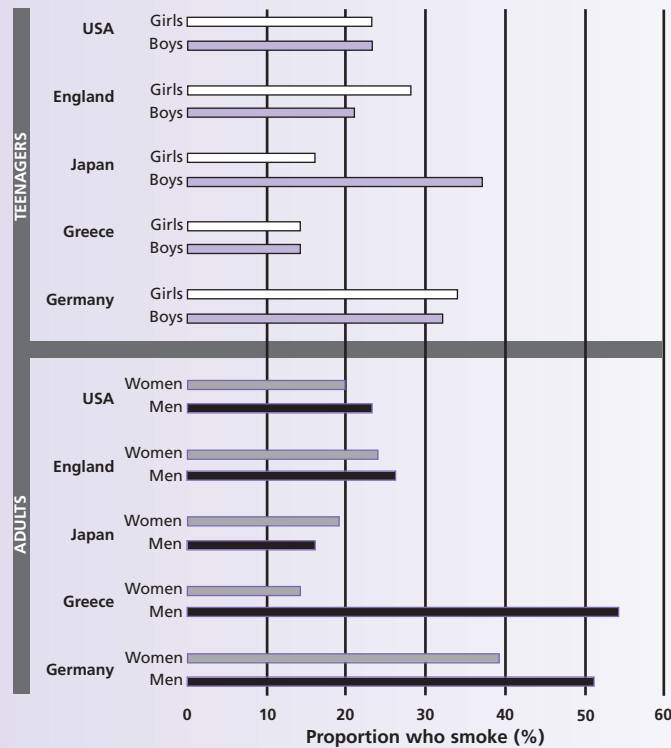
⁴¹ Sproston K and Mindell J (Editors) (2006) *Health Survey for England 2004: The health of minority ethnic groups* (Leeds: The Information Centre).

Figure 6.2: Deaths attributed to smoking ages 35–69 by sex in the UK, 1950–2000*



*Source: Peto R, Lopez AD, Boreham J and Thun M (2006) *Mortality from Smoking in Developed Countries 1950–2000: United Kingdom*, 2nd Edition, p.502, available at: <http://www.ctsu.ox.ac.uk/~tobacco/C4308.pdf>.

Figure 6.3: Proportion of people who smoke: UK, Japan, USA and highest and lowest in EU for teenage and adult populations*



*Figures from: Joossens L (2004) *Effective Tobacco Control Policies in 28 European Countries* (European Network for Smoking Prevention), available at: <http://www.ensp.org/files/effectivefinal2.pdf>; World Health Organization *The Tobacco Atlas*, available at: http://www.who.int/tobacco/statistics/tobacco_atlas/en/; Osaki Y, Minowa M, Suzuki K and Wada K (2003) Adolescent smoking behavior in Japan, 1996 *Nihon Arukoru Yakubutsu Igakkai Zasshi* **38**: 483–91; Centers for Disease Control and Prevention (2005) Cigarette smoking among adults – United States, 2004 *Morbidity and Mortality Weekly Report* **54**: 1121–4, available at: <http://www.cdc.gov/MMWR/preview/mmwrhtml/mm5444a2.htm>; Centers for Disease Control and Prevention (2006) Fact Sheet: *Youth and Tobacco Use: Current estimates*, available at: http://www.cdc.gov/tobacco/research_data/youth/Youth_Factsheet.htm.

Note: Figures are only approximately comparable for the different data sets (European countries, Japan and USA) as they may include differences in the way smokers are categorised and in the age of teenagers included. Data from the survey used to obtain figures for European countries are available for the separate countries of the UK only and therefore only data for England are shown in the graph. Figures in this category for the other countries of the UK are similar, although slightly lower than those for England.

Addiction

- 6.8 Both alcohol and nicotine are addictive substances. Assessment criteria have been developed by WHO (among others) to assist in determining whether someone is dependent on or addicted to psycho-active substances, alcohol or tobacco. A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:
- a strong desire or sense of compulsion to take the substance;
 - difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use;
 - a physiological withdrawal state when substance use has ceased or has been reduced, or use of the same (or similar) substance with the intention of relieving withdrawal symptoms;
 - evidence of tolerance (such that more of the substance is needed over time to feel its effect);
 - progressive neglect of alternative pleasures or interests because of the substance, increased amount of time necessary to obtain or drink the substance or to recover from its effects; and/or
 - persistence with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver.⁴²
- 6.9 With regard to tobacco, a report by the Royal College of Physicians concluded that “nicotine obtained from cigarettes meets all the standard criteria used to define a drug of dependence or addiction” and “nicotine is highly addictive, to a degree similar or in some respects exceeding addiction to ‘hard’ drugs such as heroin or cocaine”.⁴³ The definitions of addiction in the previous paragraph do not imply that people cannot change their behaviour, but that there are physical, psychological and social barriers that restrict their ability to change behaviour and may hinder permanent changes (see paragraphs 3.35–3.36). For many, psycho-social or pharmacological aids may be needed to help behaviour change as information about harms to themselves or others is not sufficient. An important difference between cigarettes and alcohol is that most (but not all) smokers are addicted to nicotine, although a lower, but not insignificant, proportion of drinkers are addicted to alcohol.

Harms to other people associated with alcohol and tobacco

- 6.10 The consumption of both alcohol and tobacco has an impact not only on the individual consumer but also on other people. Alcohol is associated with major health impacts and public order offences towards others, particularly through drink-driving, other accidents and violence (see Box 6.5). There has been more social recognition of the harms of alcohol in the UK in recent years but this has not been matched by modified behaviour. Wider availability and lower cost have been associated with an increase in consumption⁴⁴ and, as a result, harm caused. The exact level of this wider burden is difficult to measure.
- 6.11 Alcohol use generally increases risk-taking and violent behaviour. Excessive drinkers, as well as being more likely to initiate violence, are also more likely to become victims. There are several

⁴² World Health Organization *Dependence Syndrome*, available at: http://www.who.int/substance_abuse/terminology/definition1/en/index.html.

⁴³ Tobacco Advisory Group of the Royal College of Physicians (2000) *Nicotine Addiction in Britain* (London: Royal College of Physicians).

⁴⁴ Academy of Medical Sciences (2004) *Calling Time: The nation's drinking as a major health issue* (London: Academy of Medical Sciences), p.9.

direct impacts associated with drinking alcohol in terms of accidents on the road, at work and in the home, fires (often a joint risk with smoking), domestic violence, and public order and violent offences. It is notable that, of all the case studies reviewed in this Report, drinking alcohol causes the highest level of harm to others and yet new legislation to reduce the harm caused by excessive alcohol consumption has not been introduced in the same way as we have seen for smoking (see paragraph 6.13). Because of the level of harm to others caused by people who have consumed large amounts of alcohol, and in keeping with the classical harm principle (see paragraph 2.14), governments should act to reduce this harm. In some areas, this principle is clearly recognised. For example, coercive measures, such as prohibiting driving or operating machinery with a blood-alcohol level over prescribed limits, are publicly accepted and it is appropriate for the proper authorities to implement surveillance mechanisms to enforce these rules.

Box 6.5: Harm to others associated with alcohol

The UK Government estimated in 2004 that alcohol misuse was involved in the following harms that affect other people:⁴⁵

- 1.2 million violent incidents (approximately half of all violent crimes);
- 360,000 incidents of domestic violence (around a third);
- 530 deaths from drink-driving; and
- at peak times, up to 70% of all admissions to accident and emergency departments.

6.12 As regards harms caused to others by smoking, evidence has accumulated of the harm caused by environmental tobacco smoke (“passive smoking”). This is associated with lung cancer and heart disease, reduced lung function especially in people with asthma, and irritation of the eye, nose and throat. Passive smoking has been conservatively estimated to account for 12,200 deaths in the UK in 2003 from four conditions that can be caused by smoking or passive smoking.⁴⁶

6.13 In 2006/7, it became illegal to smoke in enclosed public places in all four countries of the UK⁴⁷ (this measure has also been taken in other countries, see Box 6.6). **As with alcohol, the harm to others caused by tobacco smoking justifies the implementation of coercive measures. The introduction in the UK of legislation to prohibit smoking in enclosed public places is therefore justified.**

Box 6.6: Bans on smoking in enclosed public places

Several regions and countries have introduced legislation to prohibit smoking in public places. In 2004, the first national comprehensive legislation to ban smoking in workplaces was enacted in Ireland, including restaurants, pubs and bars. It was very soon reported that compliance was “excellent”⁴⁸, and medical writers have called the ban “a runaway success”.⁴⁹ Cigarette sales fell by 8% in the first year of the ban.⁵⁰ There is evidence that respiratory symptoms in bar staff who do not smoke have declined.⁵¹ Data collected over time are needed to demonstrate any long-term effect on public health. So far, surveys have revealed that the ban in Ireland is popular, including among smokers.⁵² Since 2004, countries that have implemented legislation on smoking in workplaces include Australia, South Africa, Norway, New Zealand, Uganda, Italy, Sweden and Scotland. Certain states in the USA and Canada have had bans on smoking in enclosed public places for several years.

⁴⁵ Prime Minister’s Strategy Unit (2004) *Alcohol Harm Reduction Strategy for England*.

⁴⁶ The four conditions were lung cancer, ischaemic heart disease, stroke and chronic obstructive pulmonary disease; Royal College of Physicians (2005) *Going Smoke-free: The medical case for clean air in the home, at work and in public places*, available at: <http://www.rcplondon.ac.uk/pubs/contents/fe4ab715-2689-4a4a-b8c7-53e80386c893.pdf>.

⁴⁷ Smokefree *Smokefree regulations*, available at: <http://www.smokefreeengland.co.uk/thefacts/the-regulations.html>.

⁴⁸ McNicholas WT (2004) Controlling passive smoking through legislation in Ireland: An attack on civil liberty or good public health policy? *Eur Respir J* **24**: 337–8.

⁴⁹ Howell F (2005) Smoke-free bars in Ireland: a runaway success *Tobacco Control* **14**: 73–4.

⁵⁰ Editorial (2005) Ireland’s smoking ban is an admirable achievement *Lancet* **365**: 1282.

⁵¹ Allwright S, Paul G, Greiner B *et al.* (2005) Legislation for smoke-free workplaces and health of bar workers in Ireland: Before and after study *Br Med J* **331**: 1117–20.

⁵² Howell F (2005) Smoke-free bars in Ireland: A runaway success *Tobacco Control* **14**: 73–4; Fong GT, Hyland A, Borland R *et al.* (2006) Reductions in tobacco smoke pollution and increases in support for smoke-free public places following the implementation of comprehensive smoke-free workplace legislation in the Republic of Ireland: Findings from the ITC Ireland/UK Survey *Tobacco Control* **15** (Suppl. 3): 51–8.

- 6.14 Many non-smokers have experienced some exposure to environmental tobacco smoke. In 2003, 500 of the estimated 12,200 deaths from environmental tobacco smoke occurred because of exposure in the workplace.⁵³ However, even before the smoking bans in public places, most exposure occurred within the home.⁵⁴ For example, in Scotland, 61% of boys and 64% of girls aged 8–15 years reported being exposed to environmental tobacco smoke in their own or other people's homes.⁵⁵ These figures raise the question of whether the passive smoking legislation should be widened to extend to the home, i.e. whether measures are required to protect the most vulnerable, not only in public places, but also in private spheres. Children exposed to smoke at home have a higher risk of a range of health problems and exacerbation of other illness. These problems include pneumonia and bronchitis, asthma, respiratory symptoms and ear disease.⁵⁶ It is established that smoking by pregnant women is harmful to their babies as it increases the risk of low birthweight and miscarriage. It is also likely that pregnant women's exposure to environmental tobacco smoke could impact upon the fetus, and that parental smoking is a major cause of sudden infant death syndrome.⁵⁷ We note that some local authorities do not allow people who smoke to adopt children aged under five years old.⁵⁸
- 6.15 In principle, the general ethical and scientific arguments that apply to banning smoking in enclosed public spaces also apply to banning smoking in homes (and other places) where children are exposed to environmental tobacco smoke. However, this would be extremely difficult to enforce without compromising privacy. We recommend that the Department for Children, Schools and Families should communicate to local authority children's services that there may be exceptional cases where children, for example, those with a serious respiratory condition, would be at risk of such a substantial level of harm from passive smoking that intervention to prevent such harm may be ethically acceptable. This would usually need to be decided in the courts.

Entitlement to treatment and costs to the NHS

- 6.16 Alcohol- and tobacco-related illnesses lead to financial cost to the public healthcare system (see Box 6.7) and questions arise about whether this should affect people's access to treatment. We considered a similar situation in the case of obesity and concluded that treatment should generally not be denied because of reasons including the value of the community and risks of stigmatising or penalising people (see paragraph 5.42). We also found, however, that personal behaviour might need to be considered when assessing the potential effectiveness of a treatment for a patient.
- 6.17 We note that current Department of Health guidelines on liver transplantation require patients to have abstained from alcohol for six months, and people who are considered likely to continue to consume excessive amounts of alcohol are not offered a transplant.⁵⁹ We agree that, as in this example, **it might be justified for doctors to appeal to patients to change their behaviour in relation to alcohol and tobacco before or subsequent to an intervention provided by the NHS, provided that the change would enhance the effectiveness of the intervention, and people were offered help to do this. For example, alcohol treatment programmes might be offered in advance of performing a liver transplant as the cessation of excessive drinking would be likely**

⁵³ Royal College of Physicians (2005) *Going Smoke-free: The medical case for clean air in the home, at work and in public places*, available at: <http://www.rcplondon.ac.uk/pubs/contents/fe4ab715-2689-4a4a-b8c7-53e80386c893.pdf>.

⁵⁴ *Ibid.*

⁵⁵ Bromley C, Sprosten K and Shelton N (Editors) (2005) *The Scottish Health Survey 2003, Volume 3: Children* (Edinburgh: Scottish Executive), p.22.

⁵⁶ Royal College of Physicians (2005) *Going Smoke-free: The medical case for clean air in the home, at work and in public places*, available at: <http://www.rcplondon.ac.uk/pubs/contents/fe4ab715-2689-4a4a-b8c7-53e80386c893.pdf>.

⁵⁷ *Ibid.*

⁵⁸ See BBC News (2007) *Criticism of Smoker Adoption Ban*, available at: <http://news.bbc.co.uk/1/hi/england/hampshire/6730697.stm>.

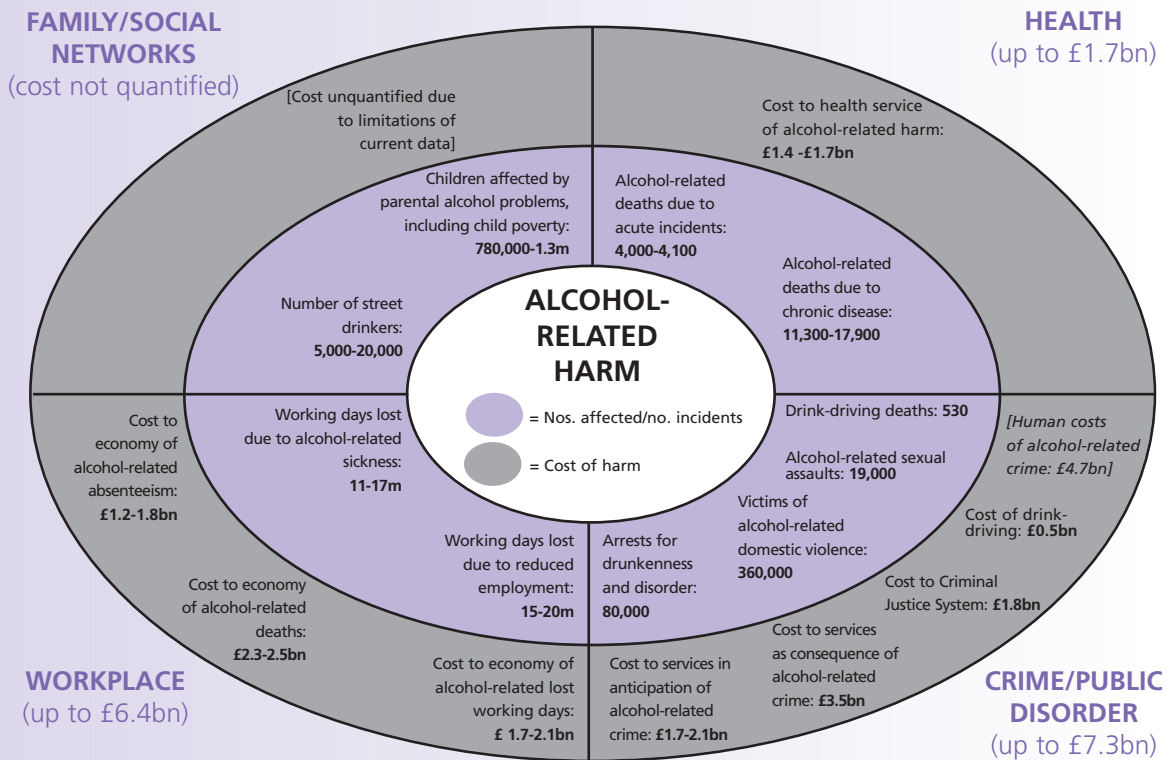
⁵⁹ Although, people who are successful in avoiding alcohol for this time period often no longer need a transplant. Department of Health (2005) *National Liver Transplant Standards*, available at: <http://www.dh.gov.uk/assetRoot/04/11/78/55/04117855.pdf>.

Box 6.7: Economic costs and revenue from taxation of alcohol and tobacco

Economic costs of alcohol consumption

Costs that arise from alcohol consumption include healthcare expenditure, prevention measures, work days lost due to ill health and the ill-effects of excessive alcohol consumption, and treatment and prevention services. Estimates of the cost to the NHS of alcohol misuse vary, ranging between 2% and 12% of the total NHS expenditure on hospitals (£3 billion per year).⁶⁰ In 2004, the Government calculated that the cost of alcohol-related harms in England was £20 billion per annum.⁶¹

Estimates of the cost of alcohol-related harms in England per year by the Prime Minister's Strategy Unit*



*Source: Prime Minister's Strategy Unit (2004) *Alcohol Harm Reduction Strategy for England*, available at: <http://www.cabinetoffice.gov.uk/strategy/downloads/su/alcohol/pdf/CabOffice%20AlcoholHar.pdf>, Crown Copyright, reproduced with permission.

Economic costs of smoking

Smoking is estimated to cost the NHS £1.7 billion per year.⁶² A full estimate of the total costs of smoking in the UK has not been calculated. It has, however, been estimated that annual savings of £3.9 billion to the UK economy would result from making workplaces completely smoke-free.⁶³ Further savings should arise in expenditure on healthcare from reducing childhood exposure to smoke and smoking during pregnancy.

Revenue from alcohol and tobacco

The alcohol and tobacco industries bring economic benefits to governments through taxation and employment. In the UK and many other countries, both alcohol and tobacco are subject to additional taxation over and above value added tax (VAT). The duty on alcohol and tobacco amounted to £8 billion and £7.6 billion respectively in 2006-7 (not including VAT) (each approximately 1.8% of total revenue).⁶⁴

⁶⁰ Strategy Unit, Cabinet Office (2003) *Alcohol Misuse: How much does it cost?*, p.15, available at: <http://sia.dfc.unifi.it/costi%20uk.pdf>; Royal College of Physicians (2001) *Alcohol – can the NHS afford it?* (London: RCP).
⁶¹ Prime Minister's Strategy Unit (2004) *Alcohol Harm Reduction Strategy for England*, available at: <http://www.cabinetoffice.gov.uk/strategy/downloads/su/alcohol/pdf/CabOffice%20AlcoholHar.pdf>.
⁶² Department of Health (1998) White Paper: *Smoking Kills*, available at: <http://www.archive.official-documents.co.uk/document/cm41/4177/contents.htm>.
⁶³ Royal College of Physicians (2005) *Going Smoke-free: The medical case for clean air in the home, at work and in public places*, p.142, available at: <http://www.rcplondon.ac.uk/pubs/contents/fe4ab715-2689-4a4a-b8c7-53e80386c893.pdf>.
⁶⁴ HM Revenue & Customs (2007) *2006-07 Accounts* (London: The Stationery Office), available at: <http://www.hmrc.gov.uk/about/hmrc-06-07-acc.pdf>.

to increase its clinical effectiveness, or could even make the transplant unnecessary. Generally, as in the case of obesity, we take the view that decisions about healthcare provision for people who smoke and/or drink alcohol excessively raise some valid considerations about the most efficient use of resources. In terms of public health policy, the focus of efforts should be on avoiding the need for treatment for alcohol- and tobacco-related conditions in the first place. This is a fairer approach, and also seems likely to be more effective in economic terms. **The UK health departments should further liaise with employers about how best to offer assistance with behaviour change programmes, such as smoking cessation, which could benefit the employer as well as employees** (see Box 6.7).

Obligations of the alcohol and tobacco industries

6.18 There are differing views on what responsibility industry should take for health problems caused by its products. Some examples from our consultation are:

“If companies are legally entitled to sell their products and the buyers are aware of the dangers to their health that may result, the companies cannot be expected to take responsibility for the illnesses they may cause.” *National Council of Women of Great Britain*

“The companies must ... take responsibility for selling hazardous known toxins to the public ... and ... compensation to the damaged people themselves, as well as to their health ‘care’ should be made available.” *Mrs Penny S Pullen*

6.19 For a variety of reasons, businesses have given increasing attention to corporate social responsibility (see paragraphs 2.47–2.50). The Working Party considers that when industry fails to behave responsibly, it is appropriate for government to impose more stringent regulations on the alcohol and tobacco industries to achieve a more effective reduction of the harms caused by their products (see paragraph 2.50). We explore some examples in the paragraphs that follow.

Advertising

6.20 Marketing is acknowledged to be powerful in manipulating people’s preferences between alcoholic and non-alcoholic drinks and of which type of drink to choose. For example, cider sales in the UK grew by 23% in 2006 following a widespread advertising campaign costing millions of pounds.⁶⁵ The advertising of alcohol is regulated and this could be further extended. For example, one respondent to our consultation proposed that:

“Manufacturers of products known to cause harm ... should not be able to advertise in a way that promotes the idea that their product improves the experience of life. ... they should not be able to sell in ways that take advantage of vulnerable people, including people with poor mental health or people under the influence of alcohol... should not be allowed to advertise unless those advertisements clearly set out the risks.” *Anon*

6.21 Companies are allowed to advertise alcoholic drinks much more freely in the UK than in some other countries such as France.⁶⁶ By contrast, advertising of tobacco products is almost entirely prohibited in the UK.⁶⁷ With certain exceptions (such as that of tobacco), the advertising industry in the UK is generally governed under self-regulation by codes of practice that “are designed to protect consumers and create a level playing field for advertisers”.⁶⁸ The codes are the responsibility of the Committee of Advertising Practice (CAP)

⁶⁵ Atkinson S (2007) Cider firms look to build on boom, available at: <http://news.bbc.co.uk/1/hi/business/6522855.stm>.

⁶⁶ See Institute of Alcohol Studies (2005) Fact Sheet *Alcohol and Advertising*, available at: <http://www.ias.org.uk/resources/factsheets/advertising.pdf>.

⁶⁷ Action on Smoking and Health (2006) *Tobacco Advertising and Promotion*, available at: <http://www.ash.org.uk/html/factsheets/html/fact19.html>.

⁶⁸ Committee of Advertising Practice, see <http://www.cap.org.uk/cap/>.

and are independently administered by the Advertising Standards Authority (ASA). Sanctions available to the ASA against advertisers whose material is in breach of the codes range from a warning to referral to the Office of Fair Trading with the possibility of legal proceedings. For broadcast media (television and radio), the regulator Ofcom can impose fines and withdraw broadcasting licences from those who run advertisements that breach the codes.⁶⁹

6.22 As an example, the *Non-Broadcast Code*⁷⁰ advises companies that promote alcoholic drinks that:

- Marketing communications should not be associated with people under 18 or reflect their culture. They should not feature or portray real or fictitious characters who are likely to appeal particularly to people under 18 in a way that might encourage them to drink.
- Marketing communications should not suggest that any alcoholic drink has therapeutic qualities (for example, stimulant or sedative qualities) or can change moods or enhance confidence, mental or physical capabilities or performance, popularity or sporting achievements. They should not link alcoholic drinks to illicit drugs.
- Marketing communications must neither link alcohol with seduction, sexual activity or sexual success nor imply that alcohol can enhance attractiveness, masculinity or femininity.

However, observation of advertisements of alcoholic drinks suggests that not all companies adhere to the ideal proposed in these guidelines.

The tobacco industry: harm reduction

6.23 In one of our fact-finding meetings it was reported to us that the tobacco industry has been aware of the harmful effects of tobacco and pursued a 'harm reduction strategy' since the 1970s (see Appendix 1). It was suggested that this strategy has included the development of regulations for the protection of vulnerable people, making it more difficult for people to take up smoking and easier for those who wanted to cease. We note that all major tobacco companies have corporate social responsibility policies, and although we see a contradiction in marketing very harmful and addictive products and seeking to play a role in reducing harms at the same time, it is clear that the industry does have a role to play in harm reduction (see paragraph 6.27).

6.24 The tobacco industry has recently been developing a form of smokeless tobacco called 'snus', apparently as a method of harm reduction and also as a response to the increasingly widespread bans on smoking in enclosed public places.⁷¹ Snus, which is placed underneath the lip, has been legally available in Sweden and some other countries for many years although it is banned in all other Member States of the European Union (Sweden has an exemption). It is addictive in the same way as cigarettes and has been found to increase the risk of some diseases but eliminates the risk of harm to third parties. The industry argues that there is epidemiological evidence that this form of tobacco presents considerably lower health risks than cigarette smoking⁷² and certain medical bodies and anti-smoking bodies agree.⁷³ Major tobacco companies have recently lobbied the European Union to change the legislation prohibiting it.⁷⁴

⁶⁹ Information obtained from the websites of these organisations.

⁷⁰ Advertising Standards Authority (2003) *The British Code of Advertising, Sales Promotion and Direct Marketing*, available at: http://www.asa.org.uk/NR/rdonlyres/A44808F1-1573-482A-A0E5-D8045943DA57/0/The_CAP_Code_Ed11_20060901.pdf.

⁷¹ See, for example, British American Tobacco *Selling Snus*, available at: http://www.bat.com/OneWeb/sites/uk__3mnfen.nsf/vwPagesWebLive/DO725M6L?opendocument&SID=&DTC=&TMP=1.

⁷² British American Tobacco *Regulation and Bans*, available at: http://www.bat.com/OneWeb/sites/uk__3mnfen.nsf/vwPagesWebLive/DO725MZF?opendocument&SID=&DTC=&TMP=1.

⁷³ See, for example, Royal College of Physicians *RCP Response to 'Choosing Health': Tobacco*, available at: http://www.rcplondon.ac.uk/college/statements/response_choosehealth_tobacco.asp; Action on Smoking and Health (2004) *Will Europe Lift the Ban on Oral Snuff?*, available at: <http://www.ash.org.uk/>.

⁷⁴ See, for example British American Tobacco *Regulation and Bans*, available at: http://www.bat.com/OneWeb/sites/uk__3mnfen.nsf/vwPagesWebLive/DO725MZF?opendocument&SID=&DTC=&TMP=1; Rose D (2007) Cigarette firms push for tobacco 'teabags' *The Times* 14 May, available at: http://www.timesonline.co.uk/tol/life_and_style/health/article1785028.ece.

6.25 Based on our considerations of the stewardship model, the Working Party is not persuaded that snus should be permitted. Although there may be evidence of lower overall health risks compared with cigarette smoking, there is still evidence of harm and addiction.⁷⁵ **In view of the health risks and the possibility that consumers may be led to believe they are using a relatively harmless product, we are not persuaded that permitting snus or conducting further research on the health risks is a helpful approach. Allowing snus might also carry the risk of increasing health inequalities in the UK as members of certain ethnic groups who already have a culture of chewing stimulants, such as betel nut, might more easily take up snus.**

The tobacco industry: international aspects

6.26 While, generally, we focus in this Report on the situation in the UK, in the case of tobacco it is relevant to consider the international context. Tobacco companies operate in many different countries, and increasingly in developing countries, many of which do not have in place stringent regulations on tobacco advertising and promotion. If tobacco companies are sincere in their harm reduction efforts, they are in a unique position to apply best practice that affords the higher level of protection available in some countries to people in countries with less developed regulations. Without this commitment, tobacco companies would be operating ‘double standards’ in terms of their corporate social responsibility and harm reduction strategies. Parties to the *WHO Framework Convention on Tobacco Control 2003*⁷⁶ were “seriously concerned about the increase in the worldwide consumption and production of cigarettes and other tobacco products, particularly in developing countries, as well as about the burden this places on families, on the poor, and on national health systems”. The UK has ratified this Convention and it came into force in 2005.

6.27 **It is ethically inconsistent for tobacco and alcohol companies advertising and selling their products in developed countries to claim corporate social responsibility, and yet apply different standards for protecting consumers in different countries, depending on local laws. Acting ethically exceeds simply complying with relevant laws and regulations. Policies on selling and advertising tobacco and alcohol that afford the greatest protection to consumers should be adopted worldwide. The members of the UK Tobacco Manufacturers’ Association and other companies that produce or market tobacco products should implement a voluntary code of practice that universalises best practice in terms of consumer protection. One example would be worldwide adherence to standards in advertising that have been developed and agreed by the industry in the EU, and particularly the UK.**

Role of government

6.28 The use of alcohol and tobacco has implications for nearly every government department in the UK. In some cases departments may support the alcohol and tobacco industries despite concerns about population health.⁷⁷ This may also be found in devolved administrations and regional and local government, for example where job losses might be caused in that area if sales of these products reduced.

⁷⁵ For a review article, see Gray N (2005) Mixed feelings on snus *Lancet* 366: 966–7.

⁷⁶ A framework convention is a binding international legal instrument that establishes broad commitments and a general system of governance for an issue area. The *WHO Framework Convention on Tobacco Control* addresses: elimination of illicit trade in tobacco products; banning tobacco sales to and by minors; agricultural diversification and the promotion of alternative livelihoods; and advertising, promotion and sponsorship. For further information see World Health Organization *Frequently asked questions on the WHO FCTC and the context in which it was negotiated*, available at: <http://www.who.int/tobacco/framework/faq/en/index.html>.

⁷⁷ Baggott R (2000) *Public Health: Policy and politics* (Basingstoke: Palgrave Macmillan), pp.196–220.

- 6.29 In 2004 the Government published its *Alcohol Harm Reduction Strategy for England* followed in 2007 by *Safe, Sensible, Social: The next steps in the National Alcohol Strategy*.⁷⁸ A comparison of the Government's Strategy with the findings of the evidence-based study *Alcohol: No ordinary commodity*⁷⁹ (sponsored by WHO) finds that there is little consensus. The latter emphasised the effectiveness of increasing taxes, restricting hours and days of sale and the density of outlets that sell alcohol, and possibly of banning advertising, whereas it found little evidence in support of the effectiveness of education about alcohol in schools, and evidence for a lack of effectiveness concerning public service messages and warning labels. The Government's original Strategy, however, concentrated on education and communication, reviewing the advertising of alcohol, enforcement of legal restrictions on selling to under-18s, and voluntary measures for the alcohol industry about labelling and manufacturing. The second part of the Strategy included further measures on guidance and public information campaigns and measures to try to promote a 'sensible drinking' culture. A review of the evidence and a consultation on the relationship between alcohol price, promotion and harm was also announced and the Government pledged to consider the need for regulatory change in the future. We draw attention to the fact that alcoholic drinks in the UK are now less expensive relative to disposable income than they were in the 1970s.⁸⁰
- 6.30 The areas where *No ordinary commodity* and the UK Government's strategies are in agreement include support for at-risk drinkers and treatment of people with alcohol problems and implementing rules about serving intoxicated people. The evidence presented in *No ordinary commodity* on the effectiveness of restricting the availability of alcohol stands in contrast to the Government's policy since November 2005 of allowing extended opening hours for pubs and bars.⁸¹ The evidence for the effectiveness of some of the interventions aiming to reduce the overall consumption of alcohol is strong.⁸² Thus, the Government's failure to take up the most effective strategies cannot be due to lack of evidence.
- 6.31 **The stewardship model provides justification for the UK Government to introduce measures that are more coercive than those which currently feature in the National Alcohol Strategy (2004 and 2007). We recommend that evidence-based measures judged effective in the WHO-sponsored analysis *Alcohol: No ordinary commodity* are implemented by the UK Government. These include coercive strategies to manage alcohol consumption, specifically in the areas of price, marketing and availability. For example, taxes on alcoholic beverages might be increased, which has been shown to be an effective strategy for reducing consumption. We also recommend that the Home Office, the UK health departments and the Department of Culture, Media and Sport analyse the effect of extended opening hours of licensed premises on levels of consumption, as well as on anti-social behaviour.**

⁷⁸ Prime Minister's Strategy Unit (2004) *Alcohol Harm Reduction Strategy for England*, available at: <http://www.cabinetoffice.gov.uk/strategy/downloads/su/alcohol/pdf/CabOffice%20AlcoholHar.pdf>; Department of Health, Home Office, Department for Education and Skills and Department for Culture, Media and Sport (2007) *Safe, Sensible, Social. The next steps in the National Alcohol Strategy* (London: Department of Health Publications). The original Strategy stated that the Government had consulted with the devolved administrations in Scotland, Northern Ireland and Wales in producing its analysis and would continue to do so as the strategy was implemented. All three devolved administrations produced their own strategies. The follow-up document was also prepared in discussion with the devolved administrations, and reflects programmes developed by each administration.

⁷⁹ Babor T, Caetano R, Casswell S *et al.* (2003) *Alcohol: No ordinary commodity – Research and public policy* (Oxford: Oxford University Press).

⁸⁰ Academy of Medical Sciences (2004) *Calling Time: The nation's drinking as a major health issue* (London: Academy of Medical Sciences).

⁸¹ See Department for Culture, Media and Sport *Licensing Act 2003 Explained*, available at: http://www.culture.gov.uk/what_we_do/Alcohol_entertainment/licensing_act_2003_explained/.

⁸² Academy of Medical Sciences (2004) *Calling Time: The nation's drinking as a major health issue* (London: Academy of Medical Sciences).

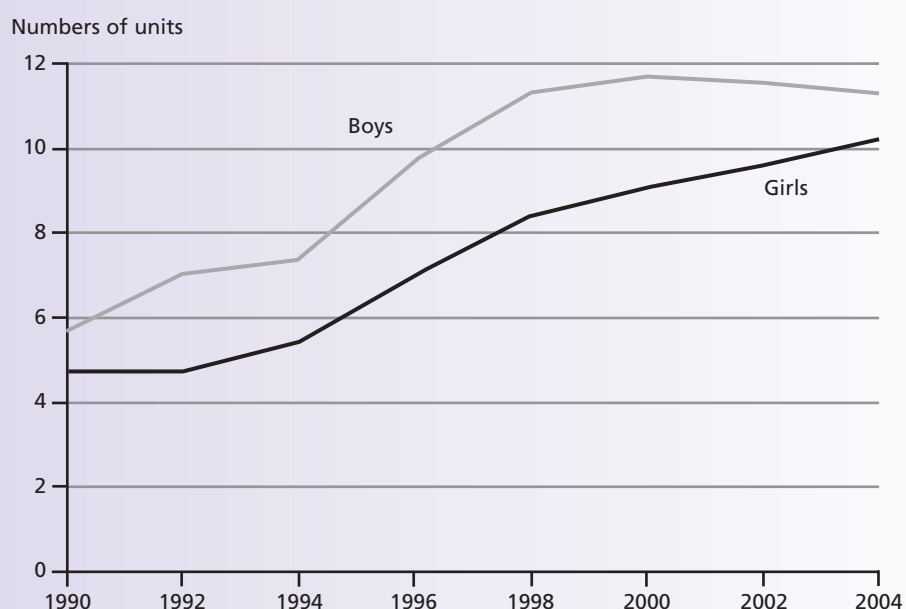
Protecting the vulnerable

6.32 Under our stewardship model, public health measures should pay special attention to the health of children (paragraphs 2.41–2.44). As both drinking alcohol and smoking are associated with dependence and harms, there has frequently been concern expressed about any use by children and adolescents (see Box 6.8 for details about consumption in this age group). A considerable number of respondents to our consultation called for vigorous action; for example: “[T]he State should do everything in its power to prevent children and teenagers from becoming addicted to smoking” (Dr V. Larcher). Young people often lack judgement about risk and are vulnerable to the influence of others. Additionally, if people start drinking alcohol and smoking as children and adolescents and continue into adulthood, they will have been exposed to these health harms over a longer period of time than if they had started as adults. Health and other harms (such as any effect on education) caused by misuse of these substances can be very serious for developing children and adolescents.

Box 6.8: Drinking and smoking among children

A national survey conducted in England in 2005 on smoking and drinking among schoolchildren aged 11–15 years suggests the numbers drinking and smoking between 1982 and 2005 had changed little or fallen, but the amount of alcohol consumed has shown a significant increase in recent years, particularly among girls, as illustrated in the figure below.⁸³ The survey found that 22% of boys and 23% of girls had drunk alcohol in the week prior to the survey. A quarter of all pupils who had drunk in the last week had consumed 14 or more units. The proportion of pupils who had drunk alcohol in the last week increased with age from 3% of 11 year olds to 46% of 15 year olds. The average alcohol consumption of pupils who had drunk alcohol had increased from 5.3 units per week in 1990 to 10.5 in 2005. The prevalence of regular smoking is higher among girls (10%) than boys (7%). Again, regular smoking increased with age, from 1% of 11 year olds to 20% of 15-year-olds (with regular smokers smoking an average of 42 cigarettes). Those who had recently smoked were also more likely to have consumed alcohol.

Mean alcohol consumption of children aged 11–15 who drank in the week prior to the survey, by sex, in England, 1990–2004*



*Source: National Statistics *Drinking*, available at:

<http://www.statistics.gov.uk/CCI/nugget.asp?ID=1328&Pos=4&ColRank=2&Rank=800>, Crown copyright material is reproduced with the permission of the Controller of HMSO under the terms of the Click-Use Licence.

⁸³ Fuller E (Editor) (2006) *Drug Use, Smoking and Drinking among Young People in England in 2005* (The Information Centre for Health and Social Care).

6.33 Producers, advertisers and vendors of alcohol and tobacco need to recognise more fully the vulnerability of children and young people, and take clearer responsibility for preventing harms to health. This would include refraining from understating risks, and from exploiting the apparent desirability of drinking alcohol and smoking, particularly in ways that appeal to children and young people. Furthermore, it would appear that whatever the legal position, these products are widely available to underage children, and existing law and policy need to be implemented more stringently. We welcome the raising of the minimum age for the purchase of tobacco from 16 to 18 years that has taken place throughout the UK as part of a strategy to protect vulnerable people. Although thought needs to be given to the way in which this measure can be implemented most effectively, it is an appropriate initiative in the context of the stewardship model, as the market has largely failed to self-regulate in this area.

Enabling people to live more healthily and make choices (provision of information)

6.34 It is widely recognised that the decrease since the 1970s both in the number of people who smoke and in the amount smoked are, at least in part, the result of an increase in people's knowledge about the dangers of smoking. However, in the case of alcohol, many heavy drinkers still underestimate the risks caused by their drinking and are reluctant or unable to associate their drinking with health risks or their poor health (see paragraph 6.4). Messages about the risks involved with smoking are easier to present, i.e. any amount of smoking is unhealthy and carries risk. Although no less significant, it is harder to present a straightforward picture of the risks associated with drinking alcohol, particularly as the health risks of light or moderate drinking are disputed (see Box 6.1).

6.35 We note that messages and warning notes have been used for several years on tobacco products although the evidence for their effectiveness is still limited. In the WHO-sponsored publication, *Alcohol: No ordinary commodity*, a review of the evidence about warning labels on containers of alcoholic drinks in the USA concludes that labels are not effective in producing a direct change in drinking behaviour although it is noted that the warning labels in the USA are small and relatively obscure. There was, however, evidence that labelling increased people's awareness of health risks.⁸⁴ In 2007, the UK Government reached a voluntary agreement with the alcohol industry about new labelling on alcohol containers and packaging bought or sold in the UK. From 2008, the labelling will show the Government's 'sensible drinking message' and the alcohol unit content of bottles, cans and, where practicable, standard glasses of wine and spirits. The Government has pledged to conduct a consultation in 2008 on the need for legislation in this area "depending on the implementation of the scheme".⁸⁵ We note that, despite the lack of evidence of effectiveness, legislation in this area would bring labelling alcoholic drinks into line with that for tobacco products and meet what we believe is the government's responsibility to promote health by providing information and advice under the stewardship model (paragraphs 2.41–2.44). Despite 'sensible drinking' messages being framed in terms of number of units (see Box 6.2), it has not often been clear how many units are contained in an alcoholic drink.

Summary

6.36 Alcohol and tobacco are both supported by major industries which have a role to play in reducing the harms caused by their products, both in the UK and around the world. The Working Party concludes that the Government has been justified in trying to reduce the

⁸⁴ Babor T, Caetano R, Casswell S et al. (2003) *Alcohol: No ordinary commodity – Research and public policy* (Oxford: Oxford University Press), pp.192–3.

⁸⁵ Department of Health, Home Office, Department for Education and Skills and Department for Culture, Media and Sport (2007) *Safe. Sensible. Social. The next steps in the National Alcohol Strategy* (London: Department of Health Publications).

harms caused to third parties by the introduction of bans on smoking in enclosed public places. However, given the level of harm caused, it would also be justified in taking further action to reduce the harms caused both to people who drink alcohol excessively and smoke tobacco themselves, and also to third parties affected by others' drinking and smoking. This is particularly true for alcohol; per capita consumption is rising and yet there have been few governmental measures to address the resulting consequences for health and public order.

- 6.37 Socio-economic groups with fewer resources are disproportionately affected by the harms caused by alcohol and tobacco. Therefore any public health policies in this area should aim to reduce health inequalities. Another special case is that of children, who are less able to judge risk to health, are vulnerable to the harms caused by alcohol and tobacco, and may become addicted to these substances at a young age. Promoters of alcohol and tobacco have a role to play in reducing the exposure of young people to harmful products.
- 6.38 There are a number of measures under the stewardship model that could be introduced and, based on the evidence presented above, could potentially reduce the harms caused by alcohol and tobacco. The Working Party reiterates the theme that if industries do not themselves make sufficient progress towards reducing harm when there is clear evidence that this is possible and desirable for public health, government should take regulatory measures aimed at reducing harm to health.