

Nuffield Council on Bioethics

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Dr David Harrison
Clerk
Health Committee
7 Millbank
London SW1P 3JA

28 Bedford Square
London WC1B 3JS
Telephone 020 7681 9619
Fax 020 7637 1712
bioethics@nuffieldbioethics.org
www.nuffieldbioethics.org

Dear Dr Harrison

Health Committee inquiry into alcohol: call for evidence


I am pleased to attach a response from the Nuffield Council on Bioethics to the above call for evidence.

We focus in the response on relevant findings from the Council's report *Public health: ethical issues* (published in November 2007), a copy of which has been enclosed with this letter. The report included a case study on alcohol consumption and can be downloaded at: www.nuffieldbioethics.org/publichealth.

The report was prepared by a Working Party established in February 2006, which was chaired by Lord Krebs and included members with expertise in health economics, law, philosophy, public health policy, health promotion and social science. To inform discussions, the group held a public consultation and met with representatives from relevant organisations.

I hope that this is a helpful contribution to the inquiry. Please let us know if we can be of further assistance.

Yours sincerely



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Introduction

- 1 In its report *Public health: the ethical issues*, the Nuffield Council on Bioethics considers the responsibilities of governments, individuals and others in promoting the health of the population. It concluded that the state has a duty to help everyone lead a healthy life and reduce inequalities in health. Our 'stewardship model' sets out guiding principles for making decisions about public health policies.

The stewardship model

Concerning goals, public health programmes should:

- aim to reduce the risks of ill health that people might impose on each other;
- aim to reduce causes of ill health by regulations that ensure environmental conditions that sustain good health, such as the provision of clean air and water, safe food and decent housing;
- pay special attention to the health of children and other vulnerable people;
- promote health not only by providing information and advice, but also with programmes to help people to overcome addictions and other unhealthy behaviours;
- aim to ensure that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise;
- ensure that people have appropriate access to medical services; and
- aim to reduce unfair health inequalities.

In terms of constraints, such programmes should:

- not attempt to coerce adults to lead healthy lives;
- minimise interventions that are introduced without the individual consent of those affected, or without procedural justice arrangements (such as democratic decision-making procedures) which provide adequate mandate; and seek to minimise interventions that are perceived as unduly intrusive and in conflict with important personal values [para 2.44]

- 2 Complementary to the stewardship model, the Council has proposed an 'intervention ladder' as a method of thinking about the acceptability and justification of different public health policies. In general, the higher the rung on the ladder

at which the policy maker intervenes, the stronger the justification and the stronger the evidence has to be. A more intrusive policy initiative is likely to be publicly acceptable only if there is a clear indication that it will produce the desired effect, and that this can be weighed favourably against any loss of liberty that may result [para 3.37].

The intervention ladder

<i>Eliminate choice.</i> Regulate in such a way as to entirely eliminate choice, for example through compulsory isolation of patients with infectious diseases.
<i>Restrict choice.</i> Regulate in such a way as to restrict the options available to people with the aim of protecting them, for example removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants.
<i>Guide choice through disincentives.</i> Fiscal and other disincentives can be put in place to influence people not to pursue certain activities, for example through taxes on cigarettes, or by discouraging the use of cars in inner cities through charging schemes or limitations of parking spaces.
<i>Guide choices through incentives.</i> Regulations can be offered that guide choices by fiscal and other incentives, for example offering tax-breaks for the purchase of bicycles that are used as a means of travelling to work.
<i>Guide choices through changing the default policy.</i> For example, in a restaurant, instead of providing chips as a standard side dish (with healthier options available), menus could be changed to provide a more healthy option as standard (with chips as an option available).
<i>Enable choice.</i> Enable individuals to change their behaviours, for example by offering participation in a NHS 'stop smoking' programme, building cycle lanes, or providing free fruit in schools.
<i>Provide information.</i> Inform and educate the public, for example as part of campaigns to encourage people to walk more or eat five portions of fruit and vegetables per day.
<i>Do nothing or simply monitor the current situation</i>

The Council's recommendations on alcohol

- 3 The Council's recommendations on alcohol policy are outlined below. The full text and references can be found in Chapter 6 of *Public health: ethical issues*.

Role of government

- 4 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. 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.
- 5 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*. A comparison of the Government's Strategy with the findings of the evidence-based study *Alcohol: No ordinary commodity*¹ (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.
- 6 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. The evidence for the effectiveness of some of the

¹ Babor T, Caetano R, Casswell S *et al.* (2003) *Alcohol: No ordinary commodity – Research and public policy* (Oxford: Oxford University Press).

interventions aiming to reduce the overall consumption of alcohol is strong. Thus, the Government's failure to take up the most effective strategies cannot be due to lack of evidence.

- 7 **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 antisocial behaviour. [Paragraphs 6.28-6.31]**

Entitlement to treatment and costs to the NHS

- 8 Alcohol- and tobacco-related illnesses lead to financial cost to the public healthcare system 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 stigmatizing 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.
- 9 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. 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 to increase its clinical effectiveness, or could even make the transplant unnecessary.**

- 10 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.** [Paragraphs 6.16-6.17]

Protecting the vulnerable

- 11 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. 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.
- 12 **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. [Paragraphs 6.32-6.33]