

9th July 2009

Alcohol Strategy Unit
4th Floor Peel Building
Home Office
2 Marsham Street,
London SW1P 4DF

Dear Sir or Madam

Safe. Sensible. Social. Selling alcohol responsibly: A consultation on the new code of practice for alcohol retailers

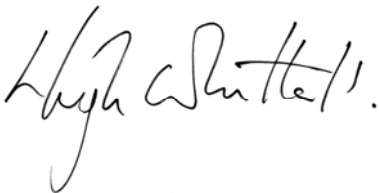
I am pleased to attach a response from the Nuffield Council on Bioethics to the above consultation.

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



Hugh Whittall
Director

Chair
Professor Albert Weale FBA

Deputy Chairman
Professor Hugh Perry FMedSci

Members
Professor Steve Brown FMedSci
Professor Roger Brownsword
Dr Amanda Burls
Professor Robin Gill
Professor Sian Harding FAHA FESC
Professor Peter Harper
Professor Ray Hill FMedSci
Professor Søren Holm
Professor Christopher Hood FBA
Professor Tony Hope
Dr Rhona Knight FRCGP
Professor Graeme Laurie FRSE
Dr Tim Lewens
Professor Ottoline Leyser CBE FRS
Professor Anneke Lucassen
Professor Alison Murdoch FRCOG
Dr Bronwyn Parry
Professor Nikolas Rose
Professor Jonathan Wolff

Director
Hugh Whittall

Assistant Directors
Harald Schmidt
Katharine Wright

Response by the Nuffield Council on Bioethics to the Home Office consultation: *Safe. Sensible. Social. Selling alcohol responsibly: A consultation on the new code of practice for alcohol retailers*

Summary

- 1 In its report *Public health: ethical issues*,¹ the Nuffield Council on Bioethics considers the role of the state and of other actors in relation to public health issues, and presents a 'stewardship model', which sets out guiding principles for making decisions about public health policies. In this response, the Council does not comment on the specific mandatory and discretionary licensing conditions proposed in the code of practice, but it does comment more generally on the underlying principles, drawing on the guidance set out in the stewardship model and international evidence in the effectiveness of interventions.
- 2 Given the health, social disorder, crime and associated policing costs of excessive alcohol consumption, there is a strong ethical justification for the state to intervene where the market fails to self-regulate. The Home Office has presented evidence that many retailers are not abiding by their own voluntary standards for responsible selling and marketing of alcohol.
- 3 International evidence suggests that coercive strategies to manage alcohol consumption, specifically in the areas of price, marketing and availability, are more effective than, for example, public information campaigns and voluntary labelling schemes. **The Council, therefore, supports the proposed code of practice in principle, as it seeks to put in place necessary and effective restrictions in the key areas of price, marketing and availability.** However, as price has been shown to be one of the main determinants of alcohol consumption, we would recommend a review of the decision not to introduce a minimum unit price.

Introduction

- 4 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

¹ Nuffield Council on Bioethics (2007) *Public health: ethical issues*. London: Nuffield Council on Bioethics. Available at: www.nuffieldbioethics.org/publichealth

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]

- 5 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

<p><i>Eliminate choice.</i> Regulate in such a way as to entirely eliminate choice, for example through compulsory isolation of patients with infectious diseases.</p>
<p><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.</p>
<p><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.</p>
<p><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.</p>
<p><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).</p>
<p><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.</p>
<p><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.</p>
<p><i>Do nothing or simply monitor the current situation</i></p>

Evidence and proportionality

- 6 Evidence about, first, causes of ill health and, secondly, the efficacy and effectiveness of interventions is important to public health policy. Selective use of evidence or 'policy-based evidence' that has been commissioned or interpreted to support existing or planned policies is unhelpful and can lead to confusion. In practice, evidence is often incomplete, or it may be ambiguous, and usually it will be contested. Although scientific experts may sometimes be tempted or pressured into offering precise answers to policy makers, the honest answer will

often be “we don’t know” or “we can only estimate the risk to within certain, sometimes wide, limits”. Claims of absolute safety or certainty should therefore generally be treated with great caution [paras 3.7–3.12, 8.19–8.23].

- 7 Whether an intervention is proportionate depends largely on: whether the public health objectives are sufficiently important to warrant particular laws, policies or interventions; how likely the intervention is to achieve certain ends; and whether the means chosen are the least intrusive and costly whilst still achieving their aims [paras 3.16–3.19]. The concept of proportionality is closely linked to the intervention ladder.

Harms caused by excessive alcohol consumption

- 8 Alcohol is associated with major health impacts and public order offences towards others, particularly through drink-driving, other accidents and violence. 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 consumption and, as a result, harm caused. The exact level of this wider burden is difficult to measure.
- 9 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 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. 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, 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 [paras 6.10–6.11].

Role of government

- 10 The use of alcohol 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.
- 11 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*² (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.
- 12 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 interventions aiming to reduce the overall consumption of alcohol is strong. Thus, the Government's failure

² Babor T, Caetano R, Casswell S *et al.* (2003) *Alcohol: No ordinary commodity – Research and public policy* (Oxford: Oxford University Press).

to take up the most effective strategies cannot be due to lack of evidence.

- 13 The stewardship model provides justification for the UK Government to introduce measures that are more coercive than those which featured in the National Alcohol Strategy (2004 and 2007). We therefore recommended 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 [paras 6.28-6.31].

Conclusions

- 14 The Council is unable to comment on the specific mandatory and discretionary licensing conditions proposed in the code of practice, but it can comment more generally on the underlying principles, drawing on the guidance set out in the stewardship model and international evidence on the effectiveness of interventions.
- 15 Given the health, social disorder, crime and associated policing costs of excessive alcohol consumption, there is a strong ethical justification for the state to intervene where the market fails to self-regulate. The Home Office has presented evidence that many retailers are not abiding by their own voluntary standards for responsible selling and marketing of alcohol.
- 16 International evidence suggests that coercive strategies to manage alcohol consumption, specifically in the areas of price, marketing and availability, are more effective than, for example, public information campaigns and voluntary labelling schemes. **The Council, therefore, supports the proposed code of practice in principle, as it seeks to put in place necessary and effective restrictions in the key areas of price, marketing and availability.** However, as price has been shown to be one of the main determinants of alcohol consumption, we would recommend a review of the decision not to introduce a minimum unit price.