A new EU Alcohol Strategy?

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Advertising Association—Written Evidence

Introduction

The Advertising Association

The Advertising Association (AA) promotes the role, rights and responsibilities of advertising and its impact on individuals, the economy and society. We are the only organisation that brings together agencies, brands and media to combine strengths and seek consensus on the issues that affect them. Through wide-reaching engagement and evidence-based debate we aim to build trust and maximise the value of advertising for all concerned.

The AA’s core members are those trade associations and organisations with a stake in UK advertising and marketing. The AA enables its members to co-ordinate their activities and act collectively, providing the single voice for UK advertising activity. A full list of our members is available on our website.

The AA supports the alcohol industry’s right to market and advertise their products responsibly.

Submission overview

The AA welcomes the chance to offer its opinion on the EU Alcohol Strategy. Our submission includes an overview of alcohol advertising in the UK, followed by our response to some of the specific questions posed in the Committee’s Call for Evidence.

Alcohol advertising in the UK

Advertising is crucial to a competitive economy. It benefits consumers by increasing choice and driving competition. It also has an essential role in funding the media and creative industries. Alcohol advertising, like all advertising, helps fund investment in original UK content, culture and sport. In 2014 advertising spend is expected to exceed £18bn.

The UK has one of the most respected regulatory regimes for advertising in the world. Alcohol advertising, like all advertising, is controlled by a system of self- and co-regulation. The rules are written by the Committee of Advertising Practice (CAP) and Broadcast Committee of Advertising Practice (BCAP), and are enforced by the Advertising Standards Authority (ASA). Alcohol advertising has a 99% rate of compliance.

The rules control the content and the placement of ads and ensure that the young and vulnerable are protected. Alcohol advertisements on television and radio are also pre-

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1 http://www.adassoc.org.uk/Members
2 AA/Warc Expenditure Report, 2014
cleared before transmission. The guidance around how to apply scheduling restrictions was recently improved, and welcomed by Ofcom⁴.

The naming, packaging and merchandising of alcoholic drinks, including online, sponsorship, branding merchandise and sampling, are regulated by the Portman Group Code⁵.

The alcoholic drinks and advertising industries are keen to play a positive and active role, in partnership with the UK and European Governments, in helping to find long-term solutions to alcohol misuse. The alcoholic drinks industry recognises its special duty to ensure that its products are marketed responsibly, which is why alcohol companies originally set up the Portman Group, why they fund and promote the independent Drinkaware Trust, and why they support advertising self-regulation through the ASA.

Companies seek to promote their brands responsibly through commercial communications. There is no commercial value in being associated with encouraging irresponsible drinking. Alcohol misuse carries with it serious societal consequences and it is not in the interest of either the alcoholic drinks industry or the advertising industry to promote or condone it.

Everybody has a role to play in making sure that under-18s do not drink and that adults drink responsibly – parents, politicians, publicans, teachers, friends and advertisers. While we recognise that advertising has a part to play in addressing the issue of under-age drinking, there is no evidence that advertising per se is a root cause of alcohol abuse.

The EU Alcohol Strategy

The EU Alcohol Strategy was based around 5 priority themes. These are the protection of young people, children and the unborn child; the reduction of injuries and death from alcohol-related road accidents; the prevention of alcohol-related harm among adults and reduction of the negative impact on the workplace; to inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns; and to develop and maintain a common evidence base at EU level.

We welcome the multi-stakeholder approach of the Strategy, and would encourage any future strategy to take a similar approach.

We support the EU Strategy’s aim to encourage Member States to reduce alcohol related harm, as well as the 2012 assessment which indicated the continuing relevance of the strategy. While significant progress has been made in reducing harm, there is still much that can be done. To this end we advocate a holistic approach in which all stakeholders – including Member States, industry and NGOs – are encouraged to work together.

When considering the effect of EU alcohol policies on the UK it should be noted that drinking among young people in England has been in continual/constant decline since 2003, and that the proportion of school pupils who have drunk alcohol at least once is at its lowest level

⁴ http://www.asa.org.uk/News-resources/Media-Centre/2013/New-monitoring-programme.aspx#.U3HdeNdWZM
since 1988. When questioned by the Health and Social Care Information Centre (HSCIC), 39% of pupils said that they have drunk alcohol at least once in 2013, compared to 61% in 2003.6

Answers to specific questions

1. Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

We believe the Alcohol Strategy worked well, and understand the preference for an consistent approach across the continent.

However, trends in alcohol consumption and harm are asymmetrical across Member States, and so coordinated policy direction should take account of this and not aim for complete harmonisation. As detailed above, in the UK alcohol consumption – as well as many of the associated harms – is in long-term decline.7 It is crucial, therefore, that when direction is set across the EU, safeguards are put in place to ensure that those Member States in which measures to avoid alcohol-related harm are effective are not subject to over-regulation. The EU should be particularly careful that policies which are proving effective in the UK are not superseded by less effective policy in the interests of harmonisation.

The content, focus and purpose of the next Alcohol Strategy – if indeed one is deemed necessary – must be on reducing alcohol-related harms, rather than on curbing drinking among willing and responsible adults. This applies to the strategy’s approach to marketing and advertising, but also to other policies and should be firmly codified in any Alcohol Strategy.

Specifically with regards to alcohol advertising and marketing, the focus must be on the harm that one is seeking to avoid – it is often assumed that reducing alcohol marketing will reduce harms. In fact, the assumption that advertising exposure is even relevant to harm should be challenged – in recent years, there has been an inverse correlation between advertising exposure and levels of consumption.

A Strategy should ensure consistency and alignment with other EU policies and objectives, specifically Europe 2020 and a commitment to economic growth. In line with the Digital Agenda for Europe and Audiovisual Media Services Directive8 it must respect the Country of Origin Principle, and should acknowledge self-regulation as an effective means of regulating media and advertising, where media and advertising regulation is referred to.

Finally, the Strategy must recognise the balance of competences between the EU and individual member states. In particular, that Member States retain competence for health policy, and that the primary role of the EU is to supplement the action of individual states.

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6 http://www.hscic.gov.uk/catalogue/PUB14579
7 BBPA – Analysis of HMRC customs clearance
8 Opinions and Lifestyle Survey, Drinking Habits Amongst Adults, 2012
2. Are the EU’s alcohol policies underpinned by a sound scientific base?

A sound scientific base is a key part of effective, evidence-based policy making. Generally, we are confident that the European Commission understands this.

In the pursuit of evidence-based policy, the Commission has funded a number of pieces of research throughout the course of the Strategy, some of which pertain to advertising and marketing. One such piece was an ‘Assessment of young people’s exposure to alcohol marketing in audiovisual and online media’ conducted by RAND Europe\(^{10}\). The Commission instructed RAND to explore ‘novel’ approaches to exposure measurement. As a result, RAND’s finding was itself ‘novel’.

The study’s headline finding, which has been uncritically repeated by a number of commentators in academic papers and in the press, was that “Young people in the UK (ages 10–15 years) ... were exposed to 11 per cent more alcohol advertising than adults (aged 25 years and older)”. The implication being that alcohol advertisers are either intentionally making 10-15s their prime target (thus breaching the guidelines within UK advertising codes), or displaying low competence in planning their campaigns to cost-efficiently reach their intended, adult target groups. At first reading we considered this claim to be extremely unlikely. It runs contrary to how we know advertising campaigns to be planned and targeted, as it found higher exposure among a group advertisers do not target than a group they typically do target.

We undertook our own analysis of their research and found a number of specific problems. Their methodology, most commonly used in epidemiology, was unnecessarily convoluted and complex. Among the numerous technical flaws which result in RAND’s misleading findings are:

- The RAND measure of exposure does not take account of the fact that young people watch less TV than adults;
- RAND’s lack of knowledge of the regional nature of advertising spot buying in the UK has led to misinterpretation of data fundamental to their model; they report 2.5 times more UK spots than the actual number that appeared nationally;
- RAND’s analysis of alcohol advertising is limited as it only covers 10 TV channels;
- RAND’s reported general viewership data for UK channels is inaccurate. The average viewership by age by channel is too low for ITV and Channel 5, and too high for the other channels. This calls into question the other viewing data upon which the whole analysis rests;
- RAND’s approach introduces potential biases and inaccuracies by averaging viewing across different sections of the “TV day”, not making allowance for instance that weekend audience patterns are very different from weekdays.

The concerns set out above led us to conduct our own analysis of the same time period and age group definitions as studied by RAND Europe. Our research found exposure of 10-15s in the UK to alcohol advertisements on TV to be 53% lower than that for adults. Despite active

dialogue, and similar complaints from the Netherlands and Germany (the other Member States referenced in RAND Europe’s report), the Commission were unwilling to amend or retract the claims, to remove the RAND Report from their website, or to list industry’s response to the report alongside it. Part of our response to RAND, which was submitted to the Commission, is available in Appendix 1.

Following the process of evaluating and rebutting the RAND Europe study, the need for a common, agreed methodology for media analysis was discussed. As research is one of the few EU competences in alcohol policy, an explicitly stated commitment to a methodology which is deemed acceptable by all stakeholders would be a positive step. To this end, a recent review of the effect of gambling advertising on harmful behaviours recognised the important role industry plays in research of this kind, noting “full scale media tracking across many media channels requires large resources and is best done by professional enterprises.”

In the pursuit of the best, evidence-based policy, and in the spirit of co-operation which runs through the Alcohol Strategy, all interested parties, including industry, should be consulted when extensive research projects such as these are undertaken. We feel it would also be appropriate to allow interested parties a right of reply to major research projects such as these. In the first instance, this would have ensured a better process, reduced costs for the Commission, and ultimately led to a more robust scientific base on which for policy to have been based.

4. Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

We consider the European Alcohol and Health Forum to be an extremely important mechanism for dialogue between industry, the NGO community and the European Commission. The Forum embodies the multi-stakeholder approach, which is crucial to an effective Strategy. It, or an equivalent channel for this dialogue, must be retained in any future Strategy.

However, we are concerned about repeated complaints from the NGO community about the extent of industry’s representation in the EAHF. A working group has been established to discuss the governance of the forum in response to growing pressure to exclude the private sector from policy discussion. This is consistent with public health lobbyists’ general suspicion of co- and self-regulation.

The Committee on National Alcohol Policy and Action (CNAPA) brings together representatives from Member States’ governments to share information, knowledge and

13 http://www.eurocare.org/resources/policy_issues/eu_alcohol_strategy/eurocare_papers/eurocare_suggestions_for_changes_to_the_eu_alcohol_and_health_forum_march_2014
good practice on reducing harmful alcohol consumption. They have been responsible for the production of an Action Plan on Youth Drinking and on Heavy Episodic Drinking which runs between the previous EU Alcohol Strategy and the next Alcohol Strategy.

We recognise the independent evaluation of the Strategy which found that the function of and interaction between both the EAHF and CNAPA must be improved. The AA supports this finding – we would certainly call for a more transparent process from CNAPA, especially if it continues to develop policy, as it has been doing, rather than focusing on specific national actions. Furthermore, we feel a more balanced Forum might include commitments from every organisation (both industry and civil society) represented in membership. Dialogue between the two bodies must be improved.

Finally, the precise role of CNAPA does not seem to be clear, even within CNAPA itself. For example, CNAPA Chair Phillipe Roux has described the CNAPA Action Plan as a “Member States’ Action Plan”, when in fact it had not been endorsed, and the role of CNAPA as speaking for all Member States is unclear. We understand that some Member States send representatives to CNAPA who do not speak for government departments. It is vital that the role, remit and mandate of all mechanisms created in the last Strategy are codified and that these bodies are held to these mandates.

Other observations

In line with previous documents, the Strategy is likely to include specific reference to any of “young people”, “youth” and “minors”. We would ask that these definitions not be used interchangeably, as for the purposes of marketing and advertising the distinction between a person of, say, 24 years old, as opposed to a person under the Legal Purchasing Age (LPA) in their country is extremely important. This would also ensure consistency with the AVMSD.

APPENDIX 1
RESPONSE TO THE RAND EUROPE ANALYSIS ON YOUNG PEOPLE’S EXPOSURE TO ALCOHOL MARKETING IN THE UK (TV) – 19th April 2013

Our dialogue with RAND

Following the November meeting of the EU Alcohol and Health Forum, the UK Advertising Association, on behalf of the tripartite interests of the different parts of the advertising industry (advertisers, agencies and media), has followed up the invitation by the European Commission to submit comments on the RAND research. In December, we sent detailed comments to DG Sanco, DG Connect and RAND. Since then, we have had a constructive dialogue with RAND, enhancing our understanding of their approach, and we have also analysed the data on alcohol advertising on TV, for the same periods covered by RAND, using the standard approach applied to measuring all viewership of TV programmes and commercials.

In this short follow-up paper, we summarise the result of this detailed data analysis, which contrasts significantly with the findings of RAND, and we also set out the reasons why there are fundamental discrepancies in the two analyses.

We offer this to the Commission and the Forum in the spirit of cooperation proposed at the meeting last November. Alcohol advertising on UK television has long been subject to strict scheduling restrictions to ensure that alcohol is not advertised in or around programmes of direct appeal to children and this reflects the fact that the product is targeted at adults, and not children. Content and scheduling restrictions are periodically reviewed by the regulators and the broadcasters take a responsible and cautious precautionary approach in scheduling alcohol advertisements.

Current scheduling restrictions operate on the principle of proportionality. Young people do see some alcohol advertising on TV, but it is not targeted at them. Underage consumption amongst UK teenagers is in long-term decline, with the number of 11-15s drinking alcohol having more than halved since 2001. This demonstrates that the proportionate approach works and that there is a lack of direct causal relationship between advertising and young people’s drinking levels.

**Fundamental discrepancies between RAND’s and the industry’s analysis**

RAND concludes that: “In the UK, this age group (10-15s) was exposed to 11 per cent more alcohol advertising than adults (aged 25 years and older)”.

However, our detailed analysis of standard data in the same time periods on all UK TV channels shows that, in contrast:

- **10-15s** see 53% less alcohol advertising on TV than adults
- **4-9s** see 70% less alcohol advertising on TV than adults
- **16-24s** see 26% less alcohol advertising on TV than adults

In summary, RAND’s headlines do not accurately portray the actual situation in the UK. There are various reasons for this, including a misunderstanding of regional and network TV data. Importantly, the RAND measure of exposure does not take account of the fact that young people watch less TV than adults, thus greatly over-estimating their actual exposure to alcohol advertising.

**Our measurement of actual exposure**

In this analysis of young people’s exposure to TV alcohol advertising, we have used the standard audience measurement metrics and approach used worldwide for 50+ years. By contrast, RAND has used a theoretical and highly complex academic model. To ensure direct comparability we have:

- taken the same (standard) data source as RAND (BARB data)
- cover the same 6-month data period (Dec. 2010 – May 2011)
- use the same age group definitions.

Whereas RAND looked at the most-viewed ten TV channels in the UK, we looked at all alcohol advertising on all TV channels in this period, to ensure the most accurate measure of exposure available. (See appendix for details).

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16 See the publically-available GGTAM global guidelines developed under the sponsorship of the European Broadcasting Union.
The much lower exposure of young people to alcohol advertising shown by this new analysis is the product of three main factors:

Commercial intention: alcohol advertisers market to adults, who account for the great majority of their sales; they do not target underage consumers as this would not make business sense.

Viewing patterns by young people: they watch less TV which automatically helps limit commercial exposure.

Current rules that prevent the placement of alcohol advertising in programmes with particular appeal to young people.

For broadly similar reasons, data showing relatively low exposure of young people to alcohol advertising are seen across EU countries.

It should also be noted that in the UK alcohol advertising accounts for just 1.9% of all UK TV advertising expenditure during the periods examined by RAND.

While RAND’s aim was to provide an objective measurement of young people’s exposure relative to adults, their findings on exposure are the polar opposite to any other data we have seen. No one would expect different approaches to produce identical estimates, but one would expect results to be directionally similar.

Several concerns about RAND’s data analysis were highlighted in our initial response last December, but have become more apparent as a result of our recent dialogue with RAND. We have issues with the approach used, and their understanding and use of the base data. Furthermore, their headline conclusions have been presented (and uncritically repeated in the UK media) in a misleading way.

Some background to the RAND Europe report

RAND responded to a tender from DG SANCO and have said that they viewed the report’s primary audiences to be EU institutions and health professionals. DG SANCO sought ‘novel’ approaches to exposure measurement (as referred to in the RAND report p.xiii). The industry was not consulted at any stage.

The statistical modeling approach adopted by RAND (Negative Binomial Regression) is based on one widely used in medical fields such as epidemiology – in this case alcohol advertising spots were treated as the dependent variable (in epidemiological terms ‘the disease’). It is highly ‘novel’ in the context – it is not a model used by any media practitioner for measuring or understanding advertising exposure (for any category), and the only reference to its use in the media sphere is an obscure piece of academic research in the USA. It is not ‘fit for purpose’ for the analysis of media data where there are more straightforward, tried and trusted ways of directly and accurately measuring viewership (covering both programmes and advertising).

Advertising exposure amongst a given target group is usually measured through GRPs (Gross Rating Points), which are calculated by dividing the total number of times an advertisement has been seen (number seeing x how many times = ‘total impressions’) by the number of people in the target group concerned.

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17 For instance the 2012 AMMIE Report (commissioned by the EU) found exposure ratios for young people well below 1.0 in the 5 countries covered; recent analyses by broadcasters in Germany and the Netherlands have shown a similar picture.

18 Source Nielsen; period Dec. 2010 – May 2011
RAND informed us that a GRP-based approach (i.e., similar in nature to that followed in our own analyses) was in fact presented as an option in their initial proposal to DG SANCO, but that they were directed to follow the alternative ‘novel’ approach. RAND were unable to provide reasons for this choice and have directed us to DG SANCO for clarification.

RAND have further stated that they do not regard a more straightforward GRP-based approach as ‘not good’ and do not regard their approach as superior, just different. The original report (p.8) notes ‘commercial data on viewership and advert placements are very expensive, therefore requiring an approach to data acquisition that is highly selective with regard to level of detail and coverage’. This implies that the RAND approach may have been driven by budget which is why they have used averaged rather than the detailed data used in the more ‘fit for purpose’ GRP-based approach.

It is apparent from our discussions with RAND that their team comprises academics and statisticians who have had no practical experience of how UK media (and media data) works. Their report refers to the contribution of Ebiquity, a company with media expertise. However we understand that, while Ebiquity provided data to a specification, they had no involvement in the analysis or reporting, and did not have sight of the final report pre-publication.

RAND does not see their lack of media knowledge as a problem, but it is at the root of many of the flaws of the research. The UK TV landscape is complex in terms of the buying and reporting of spots and impacts or impressions (much at a regional level). Without specific UK media expertise—which RAND lacks—it is very easy to make errors, particularly given their need to deal with budget-imposed data restrictions and manipulate it to fit their model.

**Technical flaws with the RAND approach**

The RAND approach is complex and inaccessible to a non-technical audience, many of whom will not have looked beyond the headline conclusions.

Over and above a lack of clarity in terms of what they are actually measuring, we have found many apparent technical flaws that further undermine confidence in the RAND findings:

- The RAND measure of exposure does not take account of the fact that young people watch less TV than adults, thus greatly over-estimating their actual exposure to alcohol advertising;
- RAND’s lack of knowledge of the regional nature of advertising spot buying in the UK has led to misinterpretation of data fundamental to their model; they report 2.5 times more UK spots than the actual number that appeared nationally across the network;
- RAND’s analysis of alcohol advertising is limited as it only covers 10 TV channels (our analysis is more complete as it covers all TV channels to provide a complete picture of young people’s exposure);
- RAND’s reported general viewership data for UK channels is inaccurate. The average viewership by age by channel is too low for ITV and Channel 5, and too high for the other channels. This calls into question the other viewing data upon which the whole analysis rests;
- RAND’s approach introduces potential biases and inaccuracies by averaging viewing across different sections of the “TV day,” not making allowance for instance that weekend audience patterns are very different from weekdays. Data for the
audiences of each individual advertising spot (which we have used) is available and provides the most accurate assessment.

Leaving aside the shortcomings of their model, the RAND team’s poor understanding of the base data also means that inputs to their model are inaccurate. It is regrettable but not surprising that their findings are so out of line with those derived from straightforward analyses of actual viewing data.

In conclusion
The RAND report’s findings run counter to how TV campaigns run by alcohol advertisers are planned, placed, controlled and measured. They are based on a theoretical approach that does not produce a true measure of real exposure (the actual number of alcohol advertisements young people see relative to adults), further undermined by technical data flaws in its execution.

Their headline finding that 10-15s in the UK are exposed to 11% more alcohol advertising than adults aged 25+ is the polar opposite of the true picture. Our analyses, which could easily be repeated by any independent media researcher, show that the real exposure of 10-15s in the UK to alcohol advertisements on TV is 53% lower than that for adults.

We would ask DG SANCO to withdraw RAND’s misleading report and, should they wish, commission independent research via a third party with specific media research expertise, using standard and well-tried data and analysis techniques similar to those employed in our own analysis.

TECHNICAL APPENDIX – OUR APPROACH TO DATA ANALYSIS
To ensure direct comparability we have taken the same (standard) data source as RAND (BARB), cover the same 6-month data period (Dec. 2010 – May 2011) and age group definitions.

We have looked at all alcohol advertising on TV in this period, across all UK channels.19 We cumulated all alcohol advertising impressions20 for this period, split by age. We next calculated the total number of impressions per head22 for each age group – in simple terms this is the average number of times an age group member saw a TV ad for alcohol. We then calculated a simple Exposure Ratio for each age group: Exposure Ratio = total alcohol ad impressions per head for (given age group) divided by total alcohol ad impressions per head for all adults aged 25+ (the reference group chosen by RAND).

Thus a ratio of 1.0 for a given age group denotes exactly the same level of exposure as for all adults 25+, <1.0 = less exposure, >1.0 = more exposure. This ratio is equivalent to RAND’s reporting of exposure via their Incidence Rate Ratios, where for instance an IRR of 1.11 for 10-15s was equated by RAND with ‘10-15s being exposed to 11% more alcohol advertising than adults 25+’.

19 RAND restricted their analysis to the Top 10 viewed UK commercial channels – we have taken all channels to ensure the most accurate measure of exposure available.
20 One advertising ‘impression’ (also known as an ‘impact’) equates to one member of the target audience viewing one advert. Impressions are summed to give, for example, the total impacts delivered by a particular spot, by an overall campaign or the total supplied by a given channel. A total of ten impacts could correspond to ten people viewing a single advert; one person seeing the advert ten times; or five people seeing the advert twice, etc.
21 Alcohol advertising was identified via The Nielsen Media Research Monitor, and then data on exposure by age group extracted via DDS (Donavon Data System).
22 In media industry jargon ‘impressions per head’ x 100 is used a standard ‘currency’ termed as Gross Ratings Points (or GRPs)
Comparison of exposure measures based on BARB data for Dec. 2010 – May 2011
(in both cases taking the same reference group as RAND - All Adults aged 25 and over = Ratio of 1.0)

<table>
<thead>
<tr>
<th>Age Group²³</th>
<th>Exposure Ratio (Industry Analysis)</th>
<th>Incidence Rate Ratio (RAND)</th>
</tr>
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<tbody>
<tr>
<td>4-9</td>
<td>0.30 (70% less exposure)</td>
<td>0.83 (17% less exposure)</td>
</tr>
<tr>
<td>10-15</td>
<td>0.47 (53% less exposure)</td>
<td>1.11 (11% more exposure)</td>
</tr>
<tr>
<td>16-24</td>
<td>0.74 (26% less exposure)</td>
<td>1.02 (2% more exposure)</td>
</tr>
</tbody>
</table>

19 September 2014

²³ RAND did not do this but we have also looked at Exposure Ratios above and below the legal drinking age of 18. The equivalent Exposure Ratio for 10-17s is 0.55 (45% less than adults 25+); for 18-24s it is 0.74 (26% less).
Advertising Association and Portman Group—Oral Evidence (QQ 200-216)

Evidence Session No. 13

Heard in Public

Questions 200 - 216

WEDNESDAY 3 DECEMBER 2014

Members present

Baroness Prashar (Chairman)
Baroness Benjamin
Lord Blencathra
Viscount Bridgeman
Lord Faulkner of Worcester
Lord Jay of Ewelme
Lord Morris of Handsworth
Lord Sharkey
Earl of Stair
Lord Wasserman

Examination of Witnesses

Henry Ashworth, Chief Executive, Portman Group, and Sue Eustace, Director of Public Affairs, Advertising Association

Q200 The Chairman: Welcome to both of you this morning and thank you for your time. As you know, this session is open to the public. A webcast of the session goes out live as a video transmission and is subsequently accessible via the parliamentary website. A verbatim transcript will be taken and will be put on the parliamentary website. A few days after the session, you will be sent a copy of the transcript to check it for accuracy, and it would be helpful if you could advise us of any corrections as soon as possible. If, after the evidence session, you wish to clarify or amplify any points that you have made during the session, or you have any additional points to make, you are welcome to submit those to us. Before I start, I would just like to say that, if there are any conflicts of interest for anybody asking questions, can you please declare them? Would you like to make any introductory statement and just briefly introduce yourselves, please?

Sue Eustace: Thank you. I am Sue Eustace, director of public affairs at the Advertising Association. We represent the whole advertising industry: the advertisers that advertise, the agencies that create their campaigns and the media in which they advertise. We think that advertising is crucial to growing companies’ brand share and the value of the brand, and we support the right of alcohol companies to advertise in accordance with the advertising codes of practice. We are separate to the Advertising Standards Authority, from which you took evidence from the other week. The ASA judges against the codes of practice and can name and shame companies that breach the codes. We are not a member of the EU Alcohol and
Health Forum. The European industry associations attend that, along with the drinks companies and many other stakeholders. However, I have personally attended some of the public meetings over the years. We believe that the current EU alcohol strategy is basically a sensible approach. It is multi-stakeholder, partnership approach and is about sharing best practice. We believe this has been very important and that it is important to have a long-term approach as the best way to tackle alcohol consumption harm. Thank you.

**Henry Ashworth:** Good morning. My name is Henry Ashworth. I am the chief executive of the Portman Group. First, a little about the Portman Group: the Portman Group works both nationally and locally. Nationally we regulate marketing for alcohol alongside the Advertising Standards Authority. Our remit is pretty much to pick up anything it does not, particularly around products, packaging and promotions. We lead social responsibility for the wider drinks industry. At a national level this is through the Government’s responsibility deal alcohol network, which I also chair. We challenge the industry to be the best that it can be to tackle alcohol misuse and harms. You may recall that the Portman Group set up the proof-of-age scheme in its early days. It also established what is now Drinkaware, which is now an independent charity. Locally, the Portman Group co-ordinates partnership working. There are many partnership schemes funded by industry, and our role is to both facilitate and co-ordinate these schemes so that they are targeted in the areas that need them the most.

Our evidence will focus on the UK. We are not EU experts, but we may be able to help you with your inquiry in terms of how the UK operates within the EU. I will only be using government statistics. I know you have heard much evidence from many people. I will only use official statistics from the Government, and I will not be able to help you on minimum unit pricing. I understand you have been looking at this. I cannot regulate it. I cannot lead a voluntary partnership solution. Both of those would be illegal, so I cannot really help with that. As I said in respect of the EU strategy, we are not EU experts, but we absolutely believe that an EU strategy should be an enabling mechanism, helping to remove barriers for member states to support partnership working and to support innovation.

Q201 **The Chairman:** Thank you very much for that and the very clear indication of what you will not be able to answer. May I start by asking you, in particular, whether there should be a new alcohol strategy?

**Sue Eustace:** We believe that the current alcohol strategy is still fit for purpose. As I said in my opening statement, we believe that it has focused on some sensible broad areas and that there has been a broad stakeholder approach, including all partners: the public health sector, the European Commission, member states, regulators and the industry. We believe the approach has been helpful because it has stimulated best practice and co-ordinated work across the EU, which has raised the bar through the public debate and so put pressure on industry to do better.

**Henry Ashworth:** From my perspective, the continuation of the EU strategy is really important; certainly the emphasis on children, drink-driving, alcohol in the workplace, education and data collection. We fully support all of that. One of the things the strategy really can deliver and support is better bottom-up government data collection, ensuring that national Governments are collecting the same data so that they are comparable and can therefore be collated at a European level.
The other thing that we feel strongly is that the strategy can help to facilitate better partnership working, both at a national and local level, although we must recognise that every country will have a different set of challenges and that even within countries there are very disparate challenges and harms. As an example, within the UK, alcohol-related admission rates in Sunderland are 69% higher than the national average. The alcoholic liver disease mortality rate in Blackpool is five times higher than that in Hackney, for example. There are very disparate harms both at a local level and a national level.

**The Chairman:** Are you suggesting that action at EU level is not as effective at addressing alcohol harm as it would be at a local level, or are you suggesting that you need a connection between top-down and bottom-up?

**Henry Ashworth:** A connection between top-down and bottom-up is incredibly helpful. Within the UK, we have a national framework with the responsibility deal, where companies are collectively making public pledges. By making a public pledge at a national level, companies are having to go through a due diligence process; they are having to ensure that it is legal for them to make the public commitments, particularly in terms of competition law. But delivering those at a local level, where they are needed the most, is vitally important. As The Government has set out 20 local alcohol action areas. These are areas suffering disproportionate harms. It is clear that delivering to each area what they most need is vital, but having a national framework, supported by a European framework, is obviously helpful. The best example may be alcohol in the workplace, where a piece of work was carried out through the European Alcohol and Health Forum, chaired by Sir Ian Gilmore. That has resulted in a pledge being made within the responsibility deal at a national level, delivering workplace alcohol policies at a local level, so that all employers at a local level suffering disproportionate harms are actively working together. That is the best way of delivering it, in our view.

**The Chairman:** What do you think? Do you think this is an effective way of dealing with alcohol harm?

**Sue Eustace:** As I said, we believe that the current approach that the EU is taking has been pretty constructive on the whole. There are certain angles or routes that have been taken that we would not necessarily think of as valuable, but we think it is really important the EU does not impose a European-wide mandated, single approach. We believe that alcohol harms vary, as Mr Ashworth has said, from country to country and region to region, and therefore we need a facilitating mechanism where we share best practice, ideally looking at things that work well and sharing what works well with other countries and across the EU. If you have a top-down approach through European legislation, for example, we do not believe that will necessarily be well adapted to member state situations.

**Q202 Lord Wasserman:** I am not clear about all this. I see you saying that, across the board, it is useful having an EU strategy, but I am really concerned about this country and the situation here. Would things be much worse or a little worse if there were no EU alcohol strategy? We have the Portman Group. We have all these other people doing the work for the Government. What are we getting from the EU strategy we would not otherwise have, and how bad would the situation be if they decided we were not having an EU strategy?

**Henry Ashworth:** From my perspective, there are two very valuable elements. One is the European Alcohol and Health Forum, which is a partnership framework and absolutely
supports the way we work here, which is helpful both at a national and local level. The other thing is being able to have a reliable set of data across Europe based on comparable official government statistics so that we can understand how different approaches in different countries—approaches that are relevant and suitable to those particular countries—are making a difference.

**Q203 Baroness Benjamin:** Both of you said that alcohol-related problems differ from region to region, here in this country especially. Have you done any research into why this is? Have you done any studies on this at all?

**Henry Ashworth:** The figures I was giving you are from Public Health England. They show very disparate sets of harms. We would welcome more research into understanding why we have such disparate relationships with alcohol in different parts of the country. Certainly there are factors that were raised, for example, by Sir Michael Marmot: “People of lower socioeconomic position are more vulnerable to the effects of alcohol, perhaps because of poor nutrition or less resilience in other ways. Some of that could be psychosocial—it could be the obvious thing of who you hang out with would be associated with alcohol-associated violence ... It’s a mixture of alcohol and other things that make individuals and groups more vulnerable to the effects of alcohol ... people of low socioeconomic position are vulnerable to a whole range of different disorders ... alcohol interacts with this vulnerability”.²⁴ Maybe that goes some way, but I think much more research is needed.

**Baroness Benjamin:** What I was getting at is that you are promoting the sale of alcohol and you know that, in some regions, people drink more than in other regions. You mentioned “responsibility” several times in your opening speeches. Do you have some sort of responsibility as well to look into the fact of why the people are doing so in the various regions?

**Henry Ashworth:** If the drinks industry were to do research, the public health community would not accept that research. I would strongly advocate for—and we would fully support—a better understanding, led by Public Health England and government statistics, that we can all rely on. I have been advocating that as the approach we should be taking across the EU so that we can understand the regional disparities within countries and the different patterns of drinking. Consumption is a very easy metric, but it is actually the patterns of harmful consumption and the harms related to alcohol misuse that are most important. Broadly, poorer people drink less and suffer more harms in this country.

**Q204 Lord Faulkner of Worcester:** This is really a question for Ms Eustace, although I am happy to hear from Mr Ashworth as well. I am trying to get to the bottom of the value of advertising. What is the correlation between alcohol marketing—including advertising, promotions, sponsorship and packaging—and, first, the overall levels of alcohol consumption and then the harm that alcohol can cause?

**Sue Eustace:** We do not think one can make direct links between the two. There are lots of academic studies out there, including those published as a result of the Commission commissioning reports, that show there is some relationship or some very small relationship, and there are others that show there is not. It is useful to look at what is happening on the ground. In this country we allow alcohol advertising within rules that are aimed at providing

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protection both for young people and, in fact, for all people. We have detailed rules around
the content and what you can say in an ad, and that dictates how alcohol companies or any
other companies communicate with their audience. We also have placement rules to ensure
that the ads are appropriately targeted and offer proportionate and appropriate protections.

Obviously, advertising is incredibly important to companies in terms of the promotion of
brand share. If you are launching a new low-alcohol product, for example, you will be trying
to gain market share against other similar products in that sector. You are not looking at
growing total consumption. That is not your goal as the company. You are looking at brand
share, and you are also looking at promoting the reputation and the value of the brand.

Henry Ashworth: Within the UK, there is no correlation. The UK government data show no
correlation. There has been a 19% drop in alcohol consumption in the last ten years, while
the opportunities to view marketing have increased. Having said that, we need to get below
consumption data and start looking at patterns of consumption and harms. Often the charge
against alcohol marketing is that it is encouraging young people to drink. In fact, harms are
falling among children and young people. The Health and Social Care Information Service
measures 11 to 15 year-olds as a cohort, and has done since 2001. The proportion of
children drinking has dropped by 34% in the last 10 years. Children’s alcohol admissions have
dropped by 34% in the last five years, but there are no comparable data before that. Binge
drinking is down 20% since 2005 and falling fastest among the 16 to 24 year-old age group. If
you are looking at patterns of drinking and harms, there is no clear correlation. Also, in the
academic community, in November this year a Cochrane review said, “There is a lack of
robust evidence for or against recommending the implementation of alcohol advertising
restrictions”.

Q205 Lord Faulkner of Worcester: I am very puzzled, I must say. We had some evidence
from Thomas Gault, who I think works for the Advertising Association. He wrote and said
that “the assumption that advertising exposure is even relevant to harm should be
challenged—in recent years, there has been an inverse correlation between advertising
exposure and levels of consumption”, which is more or less what you are saying. Do you not
ever consider that you must be wasting millions and millions on advertising that is
completely pointless if the effect of it is to drive down consumption?

Sue Eustace: As I said in my statement just now, brands are looking at growing brand share
within their particular category, and a tiny shift or a tiny gain in brand share can lead to
considerable additional value for the company concerned. That is what they are aiming to
do. They are not aiming to increase total consumption at a population level, and that is why
we think a population-level restriction or approach, beyond the controls that are already in
place, would be misguided and would not tackle the problem that needs to be tackled,
which is alcohol harm.

Lord Faulkner of Worcester: Do you ever feel a little uneasy that those are exactly the
arguments the tobacco manufacturers used about restrictions on cigarette advertising—that
it is all about brand loyalty and not about increasing consumption?

Henry Ashworth: We would strongly advocate for restricting irresponsible marketing. I
spend my entire day implementing the Portman Group’s code of practice on responsible
naming, packaging and promotion, protecting young people and ensuring that there are very
clear, very strict and very robust rules, with very strict sanctions. We can have products
taken off the shelves if they breach the rules. The retail community are partners with the producers to ensure that, if we uphold a complaint against a product, it is taken off the shelves. I make a distinction between restricting irresponsible marketing, which we do in a very strict and thorough manner, with restricting marketing per se.

Sue Eustace: It might be quite interesting also to look at the example of other countries. For example, in France there has been an alcohol advertising ban since 1991. There have been recently considerable increases in binge drinking among young people in their early 20s. Initially, where advertising is allowed, there do not seem to be the same problems of consumption harm, so there seems to be a disparate picture across member states, which I think is quite useful to look at and reflect on.

Q206 Lord Wasserman: I have two points. One is that every industry wants volume to grow: of course you do not want irresponsible drinking, but volume growth is key to profitability, and everybody must want that. The other point is about correlation. When you said, Mr Ashworth, that there was no correlation between advertising and total consumption, surely there are other factors. We cannot know; it is not a one-to-one correlation. We are talking about a regression analysis of one against another, and there are other factors that could be brought in. You have no idea, for example—nor does anyone—what would have happened had there been no advertising or what other factors exist. No advertising and strong pressure against binge drinking and drink-driving may have driven down consumption more than it otherwise would have done. To say there is just no correlation between one and the other, ignoring all the other factors—holding everything else as equal—is simply not legitimate, is it?

Henry Ashworth: I completely agree that it is a very complex picture. If I want to stress one thing, it is that it is a very complex picture. Is there a direct correlation in the UK from the government statistics? I would say no, on this one measure. However, there is a comparable country that went down a very different route: in France, as Sue said, the proportion of 12 to 18 year-olds drinking alcohol increased from 47% to 65% in the four years following the ban. In the UK, we have seen trends going in the right direction with a strict self-regulatory regime. Every country has a different set of challenges, a different set of harms and a different set of drivers.

Q207 Viscount Bridgeman: On Lord Faulkner’s paradox—that there is reducing consumption of alcohol but competition within the brands for the advertising—has it ever occurred to the advertisers they may be wasting their money, or is it just that they are struggling for a bigger share of a diminishing pot?

Sue Eustace: I do not think they regard it as a waste of money. They think it is incredibly important to, as I said, increase brand share within the category that they are marketing in, therefore creating real value and profits for the company but also increasing brand reputation. That links us back to the overall aims of the big global companies. Most alcohol producers do not have any interest in encouraging and promoting consumption harms or alcohol abuse, because it diminishes the reputation around the brand and the company.

Henry Ashworth: With the work that I have been doing through the responsibility deal there has been a commitment to remove 1 billion units from the market by growing the market for lower alcohol products. Some of the biggest brands in the market have been growing brand extensions, if you like, using marketing as their tool, for beers at 2% or 2.8%, working in line
with government incentives in that area such as tax breaks at 2.8%. On the suggestion that alcohol is just one category—in my experience the competition between the beer community, the wine community, the spirits community and the cider community—it is about getting one of your loyal customers to drink my product. It is a much more complex picture than whether alcohol marketing increases overall consumption or not. It is competition between brands and competition between categories.

Q208 Lord Sharkey: I ought to declare a kind of interest, having worked from time to time over the last 10 years with the Advertising Association and occasionally spoken at its conferences. My question is about the WHO. The WHO names measures restricting the marketing of alcohol as one of the three most cost-effective policies for reducing alcohol-related harm. Do you agree with that, and should a new EU alcohol strategy encourage such policies?

Sue Eustace: The World Health Organization has indeed stated that it would be cost-effective to ban marketing or introduce restrictions on exposure, particularly on television and in digital media. We have already set out why we think that a top-down approach is not the best way of tackling individual member state issues. Aside from that, to address your question about cost effectiveness, surely a system where the industry itself funds the self-regulatory system is the more cost-effective approach, as long as you have checks and balances in place to ensure that the self-regulatory system—in our case, the Advertising Standards Authority—operates independently and separately from the industry, in a very robust way, and stands the test of public scrutiny. That is especially the case if you look at the fact that, on television in this country, Ofcom is the backstop regulator that can hold the ASA to account. It can look, for example, at whether exposure, for example, on television by children is fit for purpose. We have a lot of scrutiny, and we think that it is a sensible and proportionate approach that provides good protections but is also the most cost-effective approach, because there is no money being put in from the public purse.

Henry Ashworth: I would add that I think the premise of the World Health Organization, in this case is to restrict marketing in order to restrict population-level consumption. We have to acknowledge in this country that alcohol-related harms in some areas are reducing, and noticeably, and in other areas are not. Alcohol-related hospital admissions have risen 37% since 2004 (according to the latest figures from HSCIC and the Public Health Outcomes Framework). Deaths due to alcoholic liver disease have risen 26% since 2004 according to Public Health England. In exactly that same period, consumption at a population level has reduced 19%. I would be completely support the WHO if it added one word into its statement, which is “irresponsible”. We would absolutely advocate restricting irresponsible marketing, because we think that is bad for business.

Lord Sharkey: One of the reasons the WHO gave for reducing tobacco marketing and trying to restrict it was to reduce the socialisation of tobacco usage. Do you think that would be a reasonable aim for the restrictions on alcohol marketing?

Sue Eustace: We think that tobacco is a different product from alcohol. If you consume one cigarette, that is damaging, albeit not as bad as 60 a day. Drinking in a sensible way is not harmful. Drinking in an irresponsible way is harmful, and in that context we believe that a separate and different approach is merited.
Henry Ashworth: More than that, I would add that 70% of adults are drinking within government guidelines on their heaviest drinking day in the week, while smoking is bad for you full stop. Government guidelines are very clear: the Chief Medical Officer is advising people they should drink within recommended daily and weekly guidelines. Brands can absolutely support that message, and I would argue that it is in the long-term interests of the drinks industry that more people are drinking within those guidelines. That is exactly why we support the responsibility deal and why we have been actively putting pledges on the table to help more people know about how many units there are in a product, and what the Chief Medical Officer’s guidelines are, as well as to give very clear messages on not drinking during pregnancy, for example, 80% of products on shelves now carry those messages. This has been done voluntarily, and I think it just shows that the drinks industry absolutely recognises that we do have harms related to alcohol misuse in this country. Those harms are disparate, but the drinks industry is a committed and willing partner to tackling them.

Q209 Lord Blencathra: You and others have told us that despite increased advertising in the UK, consumption is down. Yet the EU AMPHORA research project determined that the greater the exposure of 13 to 16 year-olds to online alcohol marketing and alcohol-branded sports sponsorship, the greater the likelihood that they will consume alcohol 14 to 15 months later. I have no idea of where that research was done, whether in the UK or other European countries. We have also heard that a lot of EU research has been a bit dodgy, to say the least. But assuming this research is correct, how are such findings taken into account by the alcohol and advertising industries? I will add a supplementary for Mr Ashworth. I am a tremendous fan of the nudge unit. Despite original derision, it has done a fantastic job changing attitudes. Do you see a role for the nudge unit in changing some of the attitudes in dealing with irresponsible drinking?

Sue Eustace: We are obviously aware of the AMPHORA group findings that argue that alcohol advertising and marketing are encouraging teenagers to drink, and drink more. As I have said before, there are lots of different pieces of research out there, and most recently the Cochrane review has argued that the evidence is not as clear-cut as that. That aside, we are very concerned in the advertising industry as a whole to take a sensible, proportionate and tough approach, and we believe that the advertising codes of practice are the most effective tool. They are more robust and more flexible, and we can change them more quickly than legislation. We believe that we do take a preventive approach, if you like, by having a lot of content restrictions and placement restrictions around alcohol advertising, because it is an adult product and the companies concerned want to aim their advertising space or time at adults, not children.

It is a mixed picture if you look at what is happening on the ground as well. We have already heard some statistics from Mr Ashworth, that teenage drinking is going down in this country and yet there is still advertising. In France there seems to be the reverse going on, so there is a very mixed set of influences—a lot of different factors—that we have to look at, and there is some academic evidence looking at the different factors, particularly issues around family and peer pressure.

Henry Ashworth: There are several questions in there. The evidence from UK government statistics is that children are drinking less, that harms related to children’s drinking, such as hospital admissions, are reducing and that binge drinking is down. That would tend not to
support the AMPHORA findings you are referring to. AMPHORA also clearly said that it is the complex social determinants that are far and away the strongest driver of consumption variability, which would support the fact that each region within a country and each country within the European Union has a very separate set of social responses to drinking alcohol. To give you a specific example, last year the Portman Group introduced a new Code of Practice on sponsorship, which has been signed up to by all the sports governing bodies, major venues, music promoters and of course drinks producers. One of the key requirements in the code makes is that all alcohol sponsorship agreements must have a recognisable commitment to responsible drinking. An example of responsible alcohol sponsorship would be Budweiser’s sponsorship of the FA Cup, because it used the perimeter boards around the pitch simply to promote Drinkaware, which is the education and information charity, the Drinkaware website saw a 58% increase in unique visitors as a result. Budweiser did not use it for its brand purposes; it used it to promote responsible drinking.

One of the areas that needs more research is the link between smartphone usage, social media usage and gaming as a reason for young people turning away from drinking. When we talk about online space, the growth of social media and smartphone use since 2005 is exactly the same time period in which we have seen young people drinking less and harms going down. I think we should be exploring that as possibly an important factor.

Can I just answer your question on nudge? I was in the nudge team for a while.

**Lord Blencathra**: That is right. That is why I asked it.

**Henry Ashworth**: Let us be clear: I do not think there is a silver bullet to any of this. It is a complex area. But I will give you a couple of examples. Within the commitment to take 1 billion units of alcohol out of the market, there is a very specific piece of work going on to ensure that house wine has an alcohol content of less than 12.5%. House wine is when you walk into a bar or a restaurant, or a supermarket, and simply order their own-brand wine. There is a commitment through the responsibility deal that more and more companies are signing up to. Without people asking, you can give somebody a drink full of flavour and taste with over 20% less alcohol in it if you bring the wine down from 14% to 12%. That would be an example of this. It is good for consumers, public health and the business community.

The other example would be that the drinks industry have just made a pledge to neither produce nor sell more than four units of alcohol in a single-serve can. That takes nearly 15% of the alcohol out of every can of, for example, high-strength products in the market. This is in its early stages, but it is an example of where the drinks industry can step forward and do things using behavioural economics and the environment.

The final area is to say we have some very strong social norms developing, particularly around young people, which we are not using but which we should be using much more. When 90% of young people have not had a drink in the last week, it is empowering to their parents and to them to be able to be more resilient and say, “No, it is not the norm to go out drinking any more”.

**Q210 Lord Morris of Handsworth**: Could you tell us, please, your view on the new EU alcohol strategy? That strategy was built on regulations and voluntary commitment. It is a balanced approach. What is your view in terms of the implementation, monitoring and evaluation of voluntary commitments in the 2006 to 2012 strategy, and can you give us some examples of any measurable benefits that have resulted from such commitments?
**Sue Eustace:** There are a lot of questions in that one question. On whether there should be a new strategy, which I think was the first part of your question, when I said we support the current one, I was referring to the one that officially ran out in 2012 but, because there is no new one at the moment, is continuing. We would support the 2006 to 2012 strategy, because it is based on a partnership approach and sharing the best practice. We do not see why there is a need for a complete change of strategy, because we believe there is a lot of merit in the previous one, which is continuing at the moment. If it is a question of developing a long-term approach to tackling alcohol harms, it would seem to us that continuity is better than change. As I have said before, we do not think the top-down approach of introducing EU-wide legislation is either in the EU’s competence or in the best interests of member states wanting to tackle the problems in their countries in their own way. I think you asked me for some examples—

**The Chairman:** This question really is about the balance between regulation and voluntary commitments in the strategy.

**Henry Ashworth:** It is absolutely right that there should be a balance between regulation and voluntary commitments. The example from the UK would be around the responsibility deal, the best being the labelling pledge: we made a commitment, through the responsibility deal, to get 80% of products on shelves to include agreed key health information. The monitoring and evaluation was agreed between the Department of Health and the drinks industry. The commitment was agreed between the Department of Health, the public health community and the drinks industry, so that it is measurable, so that it can be evaluated, and everybody knows what is being evaluated. As I said, we have achieved the 80% commitment that we made, which has been independently evaluated by Campden BRI. This pledge has resulted in Unit information on products increasing by 46% since 2008, and ninety-one per cent of products in this country now carry an alcohol and pregnancy warning on them. This has been done voluntarily. To try to achieve this through regulation at a European level would require, first of all, all countries to agree on what an alcohol unit is, which would require 28 member states to agree, because this is a European competency. Delivery through a voluntary agreement at national level will get us much further and faster and, I would say, get us to a similar level to that you would achieve with regulation.

**Lord Morris of Handsworth:** Your position is: no change.

**Henry Ashworth:** No. We have strict regulation in this country. We have a Licensing Act, which is strict. Selling to under-18s is a key element of the Licensing Act. The industry has absolutely embraced it and taken that further with, for example, Challenge 25 schemes—where you cannot sell to somebody if they look under 25 unless they produce ID—Challenge 21, bar-server training and so on, which are there and designed to support the Licensing Act. We now see that under-18s are not getting alcohol from shops and bars, by and large. Ninety-five per cent of them are getting it either from their friends and family or from strangers. That is how those two might work together.

I would say that smart regulation is incredibly helpful. The EU strategy, however, should be an enabling mechanism and should not be acting as a barrier to this partnership working. When we have taxation start to encourage innovation, that is incredibly helpful, as we have seen with the growth in lower-alcohol products in the beer sector, for example. Growth is good and important, at the same time as reducing harms. To look at this at a local level,
Durham has had an 87% drop in violent crime and a 57% drop in violence against the person, and yet licensees are seeing a 50% increase in footfall at the same time, all through the implementation of the Best Bar None partnership scheme.

**Viscount Bridgeman:** You mentioned labelling of low-alcohol beer. I am not quite sure of the details of this, but I think we have been given to believe that there is a deficiency in the information given on the low-alcohol beer labels, as between different strengths of low-alcohol beer.

**Henry Ashworth:** The information on labels will tell people how many units there are in the product and the Chief Medical Officer’s guidelines. That is all clear and being delivered voluntarily. I think, what you may be referring to is that the Department of Health is unsure whether it is legal or not to make claims about reducing alcohol and therefore promote lower-alcohol products. On the issue of promoting lower-alcohol products, there is a perception that the EU is acting as a barrier to growth where producers are trying to grow a market for lower-alcohol products. With wine, it is illegal to call wine under 8% “wine”, and therefore growing a market for low-alcohol wine is much tougher, because it cannot even be called wine.

**Lord Wasserman:** Is that an EU regulation?

**Henry Ashworth:** Yes. Understanding where the EU creates barriers is important, I think, to enabling innovation and growth in an area that is good for public health and good for business.

**Q211 Baroness Benjamin:** As we know and have to accept, we live in a commercially led world, and the advertising industry leads on this. As you said several times, the emphasis is on branding and growth, growth, growth. Several witnesses in earlier evidence sessions have said to us that the alcohol industry’s primary responsibility is towards its shareholders, and that this disproportionately influences the companies’ involvement in the formulation of alcohol policies. Is this a fair criticism? How do you think your involvement can be beneficial to the public health, crime and alcohol-abuse related issues?

**Sue Eustace:** Of course, alcohol companies are answerable to their shareholders, and of course they are interested in profits and so on, but they are also very interested in their responsibilities in society. Working with many different sectors in advertising as I do, I would say that the alcohol industry is right up there in terms of its sense of responsibility. They founded the Portman Group, for example, in 1989 to deal with marketing more broadly, as well as just advertising, and to ensure high standards and the ability to take products off shelves. There is a self-denying approach. All the big global players have a lot of their own responsibility schemes looking at different areas, whether it is funding pregnancy advice—but through third parties such trusts or whatever—or lots of different on-the-ground stuff that Mr Ashworth will know about better than I do, because of his involvement in the responsibility deal process. Of course, they also fund Drinkaware to the tune of many millions a year.

To look at what is happening on the ground in the EU alcohol forum, it has been incredibly useful and important that these big companies, which have a longstanding interest—and have shown it—in responsible drinking and disassociating their brand from irresponsible drinking and alcohol abuse, have been involved in the policy debates. They have an important contribution to make, and it is also a good way of holding them to account and...
pushing them to better practice. In my experience through the EU alcohol forum, there have been numerous examples of industry developing lots of pledges that they then push out throughout the member states, and we have heard in the UK a similar approach. I ask myself whether all that would have happened if the industry had been excluded from the discussions. I do not think it would have.

**Henry Ashworth:** The drinks industry is trying to optimise value and profit for the long term. The real key to this is whether you are looking at the way you operate your business for the long term or the short term. The problem of alcohol misuse and harms is probably the single most damaging thing for the drinks industry for the long term. It is absolutely in our interests as an industry to be committed and willing partners of Government in reducing alcohol misuse and associated harms. As we have seen, many of the social determinants are completely outside of the control of the drinks industry. What we must do is ensure that we are marketing our products responsibly, which is why we have very strong codes, that consumers are informed and educated and that children are protected.

We work very closely with Government, as you would expect, because we are key delivery partners for government policy. It is for Government to set policy, but it is absolutely right to say that, of the issues within the Licensing Act relating to selling to under-18s or to drunks, one of those is not particularly working. There were five prosecutions last year for selling to drunks, but the industry has been working very closely with the Government around underage drinking. We are actively participating, with voluntary schemes that go over and above what Government require. We are absolutely essential delivery partners, both at a national and local level. There is not a single local authority that I speak to that does not want to see its night-time economy thrive and grow, and they all recognise that they want that at the same time as they want to see the harms and the costs associated with alcohol misuse drop. We think this is absolutely achievable, and we want to be committed partners, which is why we support local partnership schemes, Drinkaware and a self-regulatory model.

**Baroness Benjamin:** What do you think you can do then to dispel this myth that people have that you should not be part of the discussion?

**Henry Ashworth:** I think this comes out of the tobacco framework, and we need a recognition that tobacco is a totally different product from alcohol. The Chief Medical Officer has set responsible drinking guidelines, and the vast majority of people in every community up and down the country are drinking responsibly within the guidelines. The vast majority of businesses are operating their businesses responsibly, and the likes of the Best Bar None scheme, which has awards up and down the country, are celebrating pubs and bars that have fantastic management schemes in place. Sometimes it is worth looking at the frontline staff, whether line managers in companies, bar staff or convenience store owners, as being at the vulnerable front end and being key partners in tackling misuse and harms, rather than necessarily being the problem. Sometimes it is easy to say, “You, the drinks industry, are the problem”, rather than, “You are partners in the solution, and you are key delivery partners”.

**The Chairman:** We have not much time left. We need to move on.

**Q212 Earl of Stair:** Can I turn, please, to the public health responsibility deal alcohol network? I notice that two of your best-supported pledges cover alcohol labelling and advertising and marketing. I appreciate the point you made, Mr Ashworth, at the beginning about not being an EU expert, but do you feel that our United Kingdom network could serve
as a model for co-operation between the alcohol industry and the public health sector at the EU level?

**Henry Ashworth:** At some level, we have had fantastic success with the Public Health Responsibility Deal Alcohol Network; as a framework for partnership working, it has been successful. At the beginning, I was co-chairing with a colleague from the public health community, ensuring that the pledges that are made, such as labelling, unit reduction or supporting local alcohol action areas, are measurable. These are really important, as is setting the monitoring and evaluation and the methodology upfront so that everybody can agree what we are trying to measure in a co-operative way. It was regrettable that the public health community walked out by and large en masse due to something that was outside of the responsibility deal. It was to do with plain packaging of cigarettes and minimum pricing, both of which were outside of the responsibility deal.

We have to be able to park things we cannot agree on and continue to work in partnership on the things we can, so that we continue to make progress rather than for everything to stall. Organisations such as Addaction that stayed inside the responsibility deal and continued to challenge and engage, need crediting for things like the pledge of four units in a can, for which they have been campaigning for years. I think that is a great credit to their staying inside the tent. There are two sides to that argument. We need to work in partnership, and to find a mechanism for parking the things we cannot agree on and move forward, but we can learn things from many other countries as well. The Scottish Government Alcohol Industry Partnership (SGAIP) is a good model, and I believe they are doing some fascinating things in Spain to shape the market to grow, for example, low-alcohol beer to 15% of the market, which is fantastic.

**Earl of Stair:** You think we could integrate into the European policy as well.

**Henry Ashworth:** The EU Alcohol and Health Forum is a partnership. It is a partnership that both industry and the public health community sit at. It is really important that dialogue continues, and I think it would be damaging to progress in reducing harms in this country to have a stand-off between the drinks industry and the public health community. At a local level, nobody believes that a standoff is a sensible approach. The harms are at a local level—on the high street, in A&E and in the local community—and at a local level people realise you have to work together and in fact broaden the partnership.

**Q213 Viscount Bridgeman:** I think this question has largely been answered by your answer to Lord Stair’s question. Incidentally, I was going to ask you about the countries that could serve as sympathique partners in this. I would just mention that there is this difference in practice you found between young people drinking in France and in England. That must be a factor that you bear in mind when you are seeking to transpose best practices at the bottom-up level to other countries.

**Henry Ashworth:** As I said, I focus on the UK, because we have really strong, robust government data going back over many years, both around consumption and consumption and harm patterns. It is not the same across EU member states. I would go back to my previous answer, which is that to have comparable government statistics across member states will really help us, as an EU community, to understand which countries are addressing harms in different ways. Every country has a different relationship with alcohol, and within countries there are regions and towns that have different relationships with alcohol, as I
have tried to explain. Therefore building from the bottom up rather than trying to take a top-down approach is by far and away the most beneficial way to develop it. Does that answer your question?

**Viscount Bridgeman:** Yes, it really does. Thank you very much.

**Q214 The Chairman:** Could we say a little more about the responsibility deal? Can that be transposed across to other national Governments?

**Henry Ashworth:** I think it works for us. It is not as simple as saying you can take a pledge from here and it will work elsewhere without understanding why the pledge was made, because we are trying to encourage more people to drink within government guidelines. If you are not measuring how many people drink within government guidelines, there is no point in making a pledge to increase that number. We are trying to ensure that we are targeting those parts of the country that are suffering disproportionately from alcohol harms. If that is not being measured, it is impossible to translate that to another country. Where it is possible, I think we have a very good framework and mechanism that we would love to be able to share with other countries in terms of public commitments signed off by chief executives collectively, in a way that is not anti-competitive, which is a key part of that. Yes, we would be delighted to share that progress.

**The Chairman:** Am I right in thinking the responsibility deal has been evaluated?

**Henry Ashworth:** It is in the process of being evaluated as a whole across all of the networks by the London School of Hygiene and Tropical Medicine. Each pledge is evaluated separately. The labelling pledge has been evaluated independently by Campden BRI, and the methodology for that was agreed upfront and with the Department of Health. The 1 billion unit reduction pledge is being evaluated on an annual basis. In the first nine months of the four-year programme, we achieved 253 million units net, which means that the active contribution of the drinks industry to take units out of the market was 253 million, and that is measured by sales data from Nielsen and CGA Strategy. The methodology for that was agreed with the public health community upfront. I come back to the point that it is really important to have that agreement upfront, to avoid disagreements later on.

**Q215 Lord Wasserman:** I am professionally concerned with crime and public and community safety locally. I am not really interested in national figures; I am much more interested in local figures. I was fascinated by your reference to these local partnerships. Can you tell us a little more about the partnerships? Do they involve the local police and crime commissioners in each of these areas?

**Henry Ashworth:** In terms of who sits around the table, apart from having key fundamental leadership, it is essential that there are people who really want to make a difference leading the partnership. It is really important to have the local authority—and the director of public health now sits in the local authority—the police and local businesses, both those that are involved with the alcohol industry and those that are not. Big local employers who care about the city or town in which they are operating as a great place to live and work and play have an interest as well. The make-up of the partnership is crucial.

Our role is to ensure that industry-funded partnership schemes are available in the areas that need them the most. That is, schemes such as Best Bar None for the night-time economy; the Pubwatch scheme; Purple Flag, which is about safer town-centre
management; Community Alcohol Partnership, that ensure young people are not drinking underage in public places; community alcohol partnerships or business improvement districts—there are many partnership schemes. My role has been to say, “Government, you set out where you think the areas that need the most support are, and we will ensure that industry supports that”, and we have made a pledge to that effect. The make-up of the partnership is crucial. I used the figures from Durham, but in fact the community alcohol partnership in Islington is being credited with a 50% decrease in ambulance call-outs for intoxicated children, and the Nottingham business improvement district and Purple Flag have achieved a 24% reduction in violence in a single year and a 38% reduction over the last five years. At a local level, these partnerships really work, and the most important part of course is people pulling together and recognising they all have a role to play.

**Lord Wasserman:** How many of these partnerships are there?

**Henry Ashworth:** It varies. Different schemes have different numbers of partnerships. I could provide you with that information for each scheme, if you would like me to.

**Lord Wasserman:** That would be useful. Could we have a map of where we do and do not have them? If I am the police and crime commissioner for, say, Bristol and there is not one, how do I go about getting one?

**Henry Ashworth:** My contact details are on the Portman Group website, www—sorry, this was not supposed to be an advert, was it?

**Lord Wasserman:** No, that is very good. Some colleagues want to ask questions about whether this should be a European issue. I do not see the point, personally. Do you think it would be useful to have that in the strategy?

**Henry Ashworth:** Again, I have to come back to this point: I do not know about other European countries, but I would be hugely surprised if every country does not have disproportionate harms in different parts of their country. A partnership approach, where the local authority, the police, the industry and the local employers come together has to be good for everybody.

**Q216 Lord Jay of Ewelme:** We have touched on this once or twice already during the evidence this morning. We have had evidence from the Wine and Spirit Trade Association that says that the “quality of the research in a number of projects funded by the European Commission has been poor” and that “the same researchers seem to get funded time and again”. What do you think about that, and about the quality of EU research? In particular, are there areas not covered by research that you think should be? I was struck by what Mr Ashworth was saying earlier on about the importance of research and the effect of social media, for example.

**Sue Eustace:** We certainly think there has been a flawed approach to the commissioning of research. It is usually commissioned behind closed doors, and we think that there would be a lot of value in having broad objectives and terms of reference agreed among all stakeholders. Previous witnesses have said it would be helpful to have more data provided by the industry. In the context of the RAND research, for example, the industry was not asked for any data. We did not even know here in the UK that research was coming out until I saw it a week before an EU Alcohol and Health Forum, by which time it had been published. The EU Alcohol and Health Forum held a debate all about the detail of that research, which we had not had an opportunity to study properly. It would be very helpful to agree broad
objectives among all stakeholders and to agree some sharing of data and data analysis. My observation from the RAND research was that it was given to RAND, an agency, and they bought research data from Ebiquity, which provides this sort of thing on a regular basis to industry. They rather overegged in the report the extent to which they had relied on Ebiquity to interpret the data. Ebiquity had not explained how the data should be interpreted, so there were some misassumptions and so on, which led to a flawed analysis. If we contrast that with the review by Ofcom in the UK, an independent regulator looking at alcohol advertising exposure over some years, there is a stark contrast in the results. Something must be wrong somewhere, and it seems to be very unconstructive to have a lot of money spent on big research projects, and then, when it is published, a lot of stakeholders disagree with it all. What are we achieving by that? It would be perhaps better to look at what is working in member states and to research those points so that we could share and move forward.

**Lord Jay of Ewelme:** Yes—particularly that last point about what areas you might focus on.

**Henry Ashworth:** I think there are some significant gaps at an EU level. There is no comparable alcohol-related crime data, such as government statistics comparing one country to another in terms of alcohol-related crime. We know in the UK that violent crimes related to alcohol have decreased 32% since 2004 and 47% since 1995. Are we doing better or worse than other countries, and why would that be? There is incomplete data on underage drinking. Protecting young people is at the heart of the EU strategy, and yet there is no comparable data.

I would just like to give one example. We were talking about the labelling commitment through the responsibility deal. A very reputable organisation, GfK, was commissioned by the European Commission to look at health labelling. In the UK, it picked four retail outlets: three supermarkets in London and one local store in Birmingham. It took no account of product market share, so it did not differentiate between popular brands and isolated examples of bad practice, and it assumed that leading brands have no health information if a product was not picked up. It came up with a result that said the UK had 7% of products with health information. The Campden BRI research, developed from the bottom up in the UK, picked out more than 500 products from across the market. It was based on the latest off-trade market share data, so it knew exactly which of the biggest brands were market leaders. It purchased from a wide range of outlets and was market weighted, and the result came back at 79.3%.

**Lord Jay of Ewelme:** It was 7% versus 79.3%.

**Henry Ashworth:** Yes. My strong assertion is that, if you want to get strong data at a European level, it must be built from the ground up through the member states, and I think the European strategy should be really supporting that. My final point is we know that there are strong trends among, for example, 11 to 15 year-olds. These trends are comparable to the very successful drink-driving trends we have seen in this country. We need to be researching why we are seeing the difference and what is working. Something is working; we can see it. We need to be researching why, and then we need to build that up to a European level.

**The Chairman:** Can I say thank you very much indeed to both of you for a very helpful session this morning? As I said at the outset, if there are any supplementary points that you wish to make, please do send us your remarks. Mr Ashworth, it would be useful to have
some information about the local partnerships but also any information you have about the evaluation of the responsibility deal, because I think that is quite important. I am also struck by the areas where you indicate you think further data and research might be necessary, so if you can list those for us, that would be helpful too. That said, thank you very much indeed.
1. The Advertising Standards Authority (ASA) is the UK’s independent regulator for ensuring that advertising in all media is legal, decent, honest and truthful, for the benefit of consumers, business and society. Our ambition is to make every UK ad a responsible ad.

2. The ASA administers the UK Advertising Codes (the Codes) that are written and maintained by two industry bodies, the Committee of Advertising Practice (CAP) and the Broadcast Committee of Advertising Practice (BCAP).

3. The ASA system recognises the important role that advertising regulation has to play in ensuring that advertisements are responsible and do not encourage or condone irresponsible drinking.

4. In 2013 complaints about alcohol ads constituted little over 1% of the total complaints received by the ASA. Whilst we do, of course, have to enforce the rules against alcohol advertisers from time to time, we’ve seen no evidence of a systemic compliance problem with alcohol advertising; the overwhelming majority of ads, and advertisers, are responsible. We also regulate in an environment where, as well as through our own proactive work, anti-alcohol campaign groups and individuals helpfully contact us if they see something untoward — a practice that has helped us establish, for example, useful precedents in how we apply the rules in social media and online.

5. **Ensuring the rules remain robust**

6. The alcohol ad rules are exceptionally robust, especially in relation to the protection of young people and vulnerable groups.

7. The current alcohol advertising rules were tightened significantly in October 2005, and reviewed again, in full, in 2009 taking account of the latest Department of Health commissioned evidence. In 2013 Ofcom reviewed exposure to alcohol ads on TV, resulting in enforcement work by the ASA and strengthened guidance from BCAP. The rules are developed in line with better regulation principles, and are a proportionate response to the best available evidence on the relationship between alcohol advertising and attitudes to alcohol.

8. **The rules**

9. The Codes contain robust alcohol rules that sit on top of other general provisions that require ads not to mislead, harm or cause serious or widespread offence. In summary, the rules state that alcohol ads must not:

   - link alcohol with daring, antisocial, aggressive or irresponsible behaviour
   - link alcohol with seduction, sex or social success
   - show alcohol being handled or served irresponsibly
show people drinking or behaving in an adolescent or juvenile way or reflecting the culture of people under 18 years of age
• depict people who are, or appear to be, under the age of 25.

10. In non-broadcast media (including online and in the cinema) no medium can be used to advertise alcoholic drinks if more than 25% of its audience is under 18 years of age.

11. The ASA actively checks ads for compliance with the rules. Our most recent survey revealed a compliance rate of 99.7%.

12. Alcohol scheduling rules on TV

13. Alcohol ads are banned from appearing in and around programmes which are made for, or likely to appeal to those under the age of 18 and are subject to strict rules about their content.

14. In 2013, the UK’s communications regulator, Ofcom, published research into children’s exposure to alcohol advertising on TV. In response to the findings BCAP published a new, strengthened guidance note on the scheduling of TV advertisements to help broadcasters identify which television programmes should exclude ads for alcohol and other age restricted products.

15. The ASA will make sure the guidance is being followed by conducting a monitoring and enforcement exercise later this year.

16. Online regulation and media convergence

17. In March 2011 the ASA’s remit was extended to cover marketing communications on companies’ own websites and in other non-paid-for space under an advertiser’s own control, such as social media sites Twitter and Facebook.

18. The ASA is vigilant to the challenges of new media and ensuring that ads are responsible, no matter what media they appear in. In 2013 the ASA published the results of a survey it commissioned to find out what ads young people see and engage with in social media. Encouragingly, the results showed that 98.4% of the ads young people see stick to the rules. Of the 427 ads that were served, two ads were for alcohol products, delivered to two children who’d given a false age.

19. The ASA recognises the importance of advertising regulation being able to respond to a changing media landscape. We believe that our principles-based, media neutral approach has enabled us to adapt to deal with changes in the marketplace more quickly and flexibly than if changes to laws were required.

20. Summary

21. The ASA has been regulating UK advertising for over 50 years. The robust alcohol rules in place today are the result of sustained engagement by the ASA system in the
alcohol debate, resulting in a set of protections that are proportionate to the best available evidence of the potential risk of harm. We are not, however, resting on our laurels, and as shown by our recent and ongoing action, we are committed to ensuring that alcohol advertising remains responsible in a changing technological and media landscape.

18 September 2014
WEDNESDAY 5 NOVEMBER 2014

Members present

Baroness Prashar (Chairman)
Baroness Benjamin
Lord Blencathra
Viscount Bridgeman
Lord Faulkner of Worcester
Lord Jay of Ewelme
Lord Judd
Lord Morris of Handsworth
Lord Sharkey
Lord Tomlinson
Lord Wasserman

Examination of Witness

Guy Parker, Chief Executive, Advertising Standards Authority

Q52 The Chairman: Good morning, Mr Parker, and thank you very much indeed for your time. As you are aware, this session is open to the public and is being webcast live as a video transmission. A transcript of the session will be accessible via the parliamentary website, and in a few days’ time you will be sent a copy of the transcript to check for accuracy. It would be helpful if you could advise us of any corrections as quickly as possible. If, after the evidence session, you wish to amplify your evidence or make additional points, you are welcome to submit supplementary evidence. Before we start asking questions, do you want to say anything by way of a general introduction?

Guy Parker: It may be helpful if I give a brief overview of the Advertising Standards Authority and the European Advertising Standards Alliance. The ASA system has been around for 52 years. We are a mixture of self-regulation and co-regulation on the non-broadcast side. We have been regulating TV and radio adverts since 2004 in a co-regulatory relationship with Ofcom. We now regulate all UK advertising, including since 2011 companies’ advertising claims on their own websites and on other social media spaces under their control—Facebook, Twitter et cetera. We do so through the UK advertising codes, which require adverts to be legal, decent, honest and truthful. The codes also include specific sections on alcohol advertising that state that alcohol adverts must not be targeted at under-18s through their placement, scheduling or content. I will not go into all the rules but a couple of them are relevant. People should not appear in alcohol adverts if they are or they look under
the age of 25, so there is a seven-year legal buffer between the legal purchase age of 18 and the age at which people can appear in alcohol adverts. You must not link alcohol with tough, daring or aggressive behaviour in adverts. You must not link alcohol with sexual or social success. That is a snapshot of the rules that are set out in the codes.

We handle complaints from people, including members of the public. Most of the complaints that we receive are from members of the public and last year we received 30,000, around 400 of which were about alcohol adverts, so that is quite a small proportion. I would argue that it is a smaller proportion than the importance of alcohol as an issue in our society. We also conduct monitoring on our own initiative to pick up on dodgy adverts that people might not have spotted and complained to us about, and very importantly last year we delivered 160,000 pieces of advice and training to organisations in the industry to help them get it right in the first place. That is a much larger figure than the complaints that we receive. I do not have figures on how many of those pieces of advice and training related to alcohol adverts, but my estimate would be that it is some thousands because alcohol is quite a controversial area and it is our experience that advertisers and their agencies often come to us for advice and help on getting it right.

We are part of the European Advertising Standards Alliance, whose members are the equivalents of the ASA—we call them self-regulatory organisations—in 22 of the 28 EU member states. We almost have full coverage in Europe. Another 12 self-regulatory organisations from outside Europe are members of the alliance, as well as industry associations. Its mission is to promote responsible advertising in and increasingly beyond Europe. Specifically, it acts as the expert voice on effective advertising self-regulation. It was an expert witness—I think that is the phrase but I might be wrong—on the EU Alcohol and Health Forum, which was a big part of the last EU strategy, so it played a significant role in that. It also liaises with the EU institutions on European consumer protection, which is covered by the AVMS directive.

EASA promotes the development and strengthening of advertising self-regulatory organisations in Europe and beyond. We are constantly trying to improve our capabilities and our capacity. Importantly, it co-ordinates pan-European monitoring projects, in particular on issues such as alcohol, where it will oversee monitoring in several different countries by looking at adverts over a period of time. It also oversees a cross-border complaints process that ensures that for example people in the UK who have a problem with an advert that originated somewhere else can complain to us. Using an EASA mechanism we will make sure it gets to the right ASA equivalent so that a decision can be reached that is then communicated back. We always deal with people in their own language.

Q53 The Chairman: Thank you very much indeed for that explanation of the way you work. Did the previous EU strategy have any effect on advertising regulation either at the national or the European level?

Guy Parker: The short answer is yes. At the UK level, alcohol advertising has been high on the public policy agenda for a long time, for obvious reasons. We saw increasing alcohol consumption in the 1980s and 1990s that peaked in 2004, but it has declined significantly among both adults and young people over the 10 years since then. That has obviously meant that alcohol has been a significant issue and people want to address it. It has not had a major impact at the UK level, but it has had a positive effect because the issues that were discussed between 2006 and 2012 as part of the last EU alcohol strategy had already been on the table.
in the UK for quite a long time. At the European level, again it had a positive effect because it brought people together and put them into the same room to talk about this important issue.

I think that it also helped to promote action, in particular through the EU Alcohol and Health Forum, which as you will know was one bit of the strategy. It helped to encourage the setting up of at least one ASA in Bulgaria. The driving force behind the establishment, quite recently, of that advertising self-regulatory organisation was a desire to ensure that alcohol advertising in particular but not exclusively was responsible. It also contributed to the strengthening of at least two other national advertising self-regulatory systems in Portugal and Hungary. It was not the sole reason for that strengthening and creation of those agencies, but it helped. It worked when it was open and inclusive. The best bit of the EU alcohol strategy 2006-12 was the forum, because it encouraged people to engage with the facts. It worked when it focused on the objective arguments and evidence and the counterarguments and counterevidence. It persuaded and encouraged participants to stick to debating, arguing and discussing issues at that level and thus it made progress. It worked when it recognised the role that advertising self-regulation can play in the policy mix.

Advertising self-regulation is not the answer to every problem, but we believe passionately that it can play a very important role in the policy mix. The forum has been good for that. It recognises the role that advertising self-regulation can play, but quite reasonably it has also challenged it when appropriate, and that is as it should be. It also works when it recognises that despite us having a single market, there are still some really quite significant cultural and legal differences between the member states. You have to work with those because you cannot ignore them. Those are the ways in which I see the strategy having helped.

The Chairman: You have spelt out fully the position at the European level, but can you amplify on what has happened here in the UK in terms of a positive impact?

Guy Parker: Its success has been in getting people around the table. Many of the discussions and liaison between NGOs, government, business and the ASA system were already happening before, so I would not want to overestimate or exaggerate the impact of the EU strategy on the UK specifically.

Viscount Bridgeman: Perhaps I may make a general point. Do the 12 members that are outside the European Union have a positive input into the forum?

Guy Parker: I suppose they would have the opportunity through their membership of the European Advertising Standards Alliance more broadly.

Viscount Bridgeman: Presumably those members include the United States.

Guy Parker: No, the United States is not a member. The legal and cultural traditions of the United States are very different from the UK and Europe, and indeed from quite a few other countries. You have a lot more state-based legislation. There is a body in the US that is similar to the ASA, but whereas we deal with around 18,500 cases a year as a result of people complaining, it deals with a couple of hundred—and those are mostly from competitors. It might be Proctor & Gamble complaining about another company on nappy performance.

Q54 Lord Blencathra: Mr Parker, given that you have told us that all these things are working quite well, should there be a new EU strategy to address advertising?
Guy Parker: I would give a qualified yes, but it rather depends on what the strategy is. I am in danger of repeating some of the points I have made, but if it is open and inclusive, if it recognises the role that advertising self-regulation can play—without accepting it uncritically, of course—if it encourages everyone to stick to the facts and the arguments rather than engage in stone throwing, and if it recognises and tries to work with the differences between countries it can only be a good thing at the European level. It would not solve every problem. You cannot do that at the European level precisely because of the differences between countries, not the least of which are the different patterns of consumption. In countries like Italy and France, alcohol consumption has been in decline from a very high starting point for some 40 to 50 years. In other countries such as the UK we have gone up and now we are coming down again. These statistics and demographics obviously have a big impact on the extent to which there are concerns in different countries about alcohol.

Q55 Lord Tomlinson: What is the relationship between alcohol marketing and levels of consumption? Is there sufficient evidence and data to establish such a relationship? You spoke earlier about the need for objective facts and evidence. Can you tell us what the evidence is in that area?

Guy Parker: Again, the short answer is yes, there is a relationship, but it can be misunderstood. I have made the point that official statistics show that in the UK, our consumption rose in the 1980s and 1990s, hit a peak in 2004, and has been declining significantly since then. That is the consumption backdrop at the national level.

If you look beneath the surface at what is going on at the regional level, different pictures emerge depending on where you are talking about. In 2004 the UK Government—when consumption had reached its peak although that was not known then—produced an alcohol harm reduction strategy. It looked at all the evidence that was available then, which identified a possible link between younger people’s awareness and appreciation of alcohol adverts and their propensity to drink. In a nutshell, that is a summary of what the evidence was saying about alcohol advertising at that point.

In response to that, a year later in 2005 the UK advertising codes that we administer were strengthened with tougher rules on avoiding appeal to under 18 year-olds and linking alcohol with sexual success. Another important report commissioned by the Department of Health, the SchHARR report—I think you may have had evidence from Petra Meier about it—was produced. It found that alcohol advertising had a small but consistent effect on alcohol consumption, including by young people. Again, I am trying to encapsulate in a nutshell a meta review of the various studies that were made at the time. It also, interestingly, revealed disagreement in academic research circles over whether advertising bans reduced or increased consumption by having the unintended consequence of increasing price competition and driving down prices, but that is a slightly different matter.

At around the same time, the science group of the EU Alcohol and Health Forum came to some similar conclusions as those in the SchHARR report but put it slightly differently. It said that, “Although the findings confirm an impact of some forms of alcohol marketing on drinking onset, frequency, quantity of alcohol consumed and alcohol problems, the size of the impact, even though statistically significant, is on average not large”. I think that all those three things say the same thing in a different way. The ASA system is required to be evidence based in its regulation. If we are not evidence based, we risk having either our rules
or our decisions under those rules overturned by judicial review in the High Court. We think that the strengthening of the rules in 2005 was the right response to the evidence base as it was then and as it still is, but we are always open to new arguments and new evidence that is put to us, obviously based on new studies that show something different.

Q56 Lord Tomlinson: After the 2004 peak we have seen a decline in alcohol consumption. What, following that peak, was the pattern of alcohol advertising? Did the industry, for example, increase advertising budgets in order to mitigate declining sales?

Guy Parker: I cannot give you a precise answer, but I can follow up with one. I think that advertising spend has remained relatively stable, although there have been other significant changes over the period. One example is the massively greater impact that changing technology has had on all our lives but particularly on the lives of younger people. The internet is now part of all our lives. That does not seem to have had an impact on rates of consumption at the national level. However, the short answer to your question is that I think it has remained relatively stable, but I would have to go away and find out.

Lord Tomlinson: If you could do that, I would appreciate it.

The Chairman: Lord Jay, would you like to come in with a supplementary question?

Lord Jay of Ewelme: Following on from the question put by Lord Tomlinson, I notice that the Advertising Association’s response to the RAND report states that underage consumption among UK teenagers is in long-term decline, with the number of 11 to 15 year-olds drinking alcohol having more than halved since 2001. Do you agree? Is it specific to the UK or are there similar trends elsewhere? What conclusions, if any, did you draw on the link between advertising and consumption if there has been such a very steep fall in underage drinking over the past 10 years or so?

Guy Parker: I do not know about the specific figure, but it is in line with other statistical data that we have seen over the last few years that confirm a significant decline in consumption among both the adult population and among teenagers. Why that might be is a really difficult question to answer, and other people who I know will be giving evidence to your inquiry are probably better placed to do so. My instinct is that it is the combination of a number of factors, including the changing way in which we regard alcohol, particularly among the younger age groups. I suspect that changing demographics have had a small but probably significant impact; that is, the demographic make-up of the nation. I would cite the focus on health consciousness. That has shown up in at least one good study as being a significant factor in young people’s attitudes to alcohol. We would not say that the strengthening of the rules in 2005, for example, has had a significant impact on national consumption levels. It might have had a small impact, but we cannot say for sure.

The point of strengthening the rules was to make sure that adverts are not targeted at children either through scheduling or through their placement and number across media. If children do see them, as they are inevitably going to, we want to make sure that they do not contain any content that is likely to appeal to them. That is not all that the rules seek to achieve because they are not just about protecting children, but when we talk about young people and alcohol advertising, that is the purpose of the rules. We measure the success of the rules and our regulation by looking at the extent to which we think they are achieving that purpose.
**Lord Jay of Ewelme:** I have just one follow-up question. You said that a reason for the decline could be changing attitudes to health and so on. Is that in part a response to advertising on health matters? In other words, is there a sort of advertising content in the area?

**Guy Parker:** I suppose there could be, but it is more likely to be all the media coverage that has been around for quite a long time now about harmful drinking and the effect that drinking too much can have on your health. I think it would probably be a mistake to think that these changes have been brought about by the content of adverts. Advertising should not undermine those messages, but I am not sure that they should be delivering them—unless we are talking about public health advertising by the Government, Drinkaware and so on. I am not talking about those, but about companies’ adverts for their alcoholic drinks.

**Q57 Lord Morris of Handsworth:** Mr Parker, in your opening statement you gave us an impressive list of stakeholders both here at home and in Europe. Can you tell us, therefore, what is the added value of the European Advertising Standards Alliance? What are the specific issues regarding the regulation of alcohol advertising in the EU context?

**Guy Parker:** Thank you for the question. In my opening statement I explained what the European Advertising Standards Alliance tries to do and how it works. Specifically in the context of alcohol, the alliance has played an active role at the EU Alcohol and Health Forum table. Indeed, it has been responsible for helping to implement some of the actions that have come out of the forum discussions.

In terms of other advertising self-regulatory organisations that are members of the alliance, particularly the European ones, there are 22 of them out of the 28 countries. All 22 have advertising codes that cover alcohol advertising. All have rules within those codes that seek to prevent alcohol adverts being targeted at minors either through scheduling and placement or through content. They all contain similar rules around social and sexual success, tough and daring behaviour and, crucially, avoiding anything that encourages immoderate consumption. The alliance is a very important issue brief at the European level, and for the majority of European countries that are members of the alliance, it is a really important issue at the national level. I would not say that is the case for all of them, but the majority. The alliance co-ordinates pan-European research, and here I should say that I am currently the chair. We are in the middle of organising a significant piece of research that is going to be conducted in a number of countries. It will look at the primary appeal: that is, whether or not adverts are primarily appealing to minors. They should not be, but we will conduct this own-initiative monitoring in a number of countries, including the UK, to see whether they are. The research will include looking at online areas such as companies’ own websites and social spaces. The point about online areas is really important, because in 2008 only two out of the 22 countries I am talking about had in place advertising codes that covered companies advertising on their own websites, their Facebook pages and so on. A lot of work was done because we knew that we needed to change that situation, and now all 22 countries have codes to cover those areas.

**Lord Morris of Handsworth:** How does the alliance measure success?

**Guy Parker:** We look at the compliance rate of the adverts. A period of time has been chosen for the monitoring project on primary appeal that is coming up, which I think is October, November and December of this year. All the ads that appear in the specified
media—TV, online, print and poster—will be collected together by a media agency in each of the countries. Those ads will be provided to the ASAs of those countries, where they will be assessed against the rules. They will then provide reports on the compliance rates of the ads and undertake any necessary follow-up action. The European Advertising Standards Alliance co-ordinates all that information and ensures that there is an independent reviewer who is not a part of the system to act as a further check just to make sure that corners are not being cut and everything is being done properly. The reviewer will check on a sample basis the work that is done by the individual ASAs. The product, the output of all this, will be a report that will give us an invaluable insight into the state of play. If there are weaknesses that are sometimes shown up by these reports—they do not always give us a 100% clean bill of health—we are able to respond to them. This is not as a result of members of the public complaining to one national self-regulatory organisation, it is the result of the own-initiative action that we have taken.

Q58 Lord Faulkner of Worcester: Following on from Lord Morris’s question, how would you say our oversight of alcohol advertising compares with that in other member states? If you put it on a scale of one to 10, from liberality to strength, where is Britain and where are the others?

Guy Parker: That is a good question. We have one of the strictest regimes but no absolute bans on alcohol advertising. I think that in around a third of the 22 countries out of the 28 where there is an ASA, there are partial bans of some types of advertising in some media. The way it tends to work is by taking the bans into account when deciding what additional regulation is necessary through the advertising self-regulatory organisations, so you end up with a specific mix that suits the legal and cultural traditions of a particular country. We have a very good reputation for administering the codes strictly. I think that quite a few companies would say that we that are too strict, but obviously the battle we have to fight is impressing on them the importance of being thorough in our administration of the code. Moreover, it is a self-regulatory system, so we are talking about companies that at the general level support advertising self-regulation but by no means always agree with us on the individual decisions we take, and I dare say it is the same in Europe. I am not going to pretend that there is no work for us to do on advertising self-regulation at the European level and beyond. I think we have a good story to tell about the contribution that we can and do make to improving advertising regulation, including the regulation of alcohol advertising. I mentioned earlier that it was only recently that a self-regulatory organisation was set up in Bulgaria. It is a developing organisation that does not do everything we do and it is not as well known among Bulgarians as we are by the UK population. There is always room for improvement.

Lord Faulkner of Worcester: How many other countries in Europe are effectively controlled by the state in terms of alcohol advertising? How much of it is real self-regulation and how much is state controlled?

Guy Parker: Self-regulation has an important role to play in all 22 countries, but as I said earlier, around a third impose partial bans. For example, alcohol advertising in cinemas might not be allowed before 6 pm. I think that it is illegal to advertise any alcohol except beer in Poland. Legislation has evolved to suit the particular situation of the country: the demographics, drinking behaviours and harms that result are different in each country.
Q59 Lord Sharkey: I should declare a kind of interest, having spent 30 years in the advertising industry. Mr Parker, could I ask you about self-regulation? Do you think that self-regulation is equally suited to all forms of media? Do particular issues arise, for example, with regard to online and digital media?

Guy Parker: Advertising self-regulation is particularly suited to responding quickly to what we are experiencing now, which is a bit of an upheaval in the media landscape—I am putting it lightly. We are seeing major changes in the way people consume media, particularly online. We are able to respond quickly and flexibly. I mentioned that in 2008, two out of 22 countries had codes that covered companies’ claims on their own websites, Facebook, Twitter and so on, and now it is 22 countries out of 22. In European terms that is a rapid response. The speed of the evolution/revolution of technology argues for more rather than less self-regulation because it is best able to keep up with that speed of development. That does not mean that there are not real challenges in regulating the online world; there are, and they are obvious. The online world is not a great respecter of borders, so you must have good arrangements in place to identify who has jurisdiction for a case if people in more than one country are being targeted with advertising. How do you decide that? What is the country of origin of the advert in order to determine which advertising self-regulatory organisation, or statutory authority for that matter, should have jurisdiction.

There are issues around determining what advertising content is online. Obviously we stop short of saying that we regulate the internet. We say that we regulate UK advertising online—the internet, mobile, social network spaces—including advertising that masquerades as blogs by members of the public et cetera. However, distinguishing between advertising content and other content is not always easy. That was one of the things that caused us to scratch our heads when we were planning the extension of the advertising codes in 2011. Actually it has not turned out to be as big a deal as we feared, but it is an issue. We have no desire to regulate genuine editorial material.

There are particular issues around the way people, and particularly young people, behave online, but advertising self-regulation neither can nor should respond to them all. However, they have an impact on the way young people engage with alcohol. Quite a lot of concern has been expressed about young people posting pictures of themselves on social media sites while drunk on a night out and normalising those sorts of behaviours. That might well be a problem in our society at the moment, but it is not one that an advertising regulator, whether statutory or self, should be responding to. We need to focus on genuine alcohol ads to make sure that they are not targeted at minors either through their placement or their content. The rules that we apply online are basically exactly the same.

Online does allow for more precise targeting. Last summer, we carried out a small study that looked at 24 11 to 15 year-olds. The agency we had commissioned videoed them online because we were trying to have as small an impact as possible on their normal behaviour. I am sure that there was a bit of an impact, but we were trying to achieve the minimum. We recorded every advert they watched. The young people were spending a lot of their time on Facebook. Of the 427 ads they saw, three were for alcohol, and they saw them because they had said that they were 18 or over, although none of them was. The age-inappropriate ads they watched they were able to see only because they had registered saying that they were 18 years old or over. Happily, none of the ads contained content that was likely to appeal to children. So they had got around the scheduling rules by putting in a false age, but the
second barrier—the second line of defence—in the form of the content rules, ensured that at least the ads were not primarily appealing to them.

This piece of research was comforting in one sense because it told us that no ads were being shown by companies to people who they thought were under 18 and the content of the ads was okay under the codes. In other sense, however, it raised issues that go wider than those around alcohol, and specifically about what is known as age-gating: age verification systems and the reliance that the digital ecosystem places on people self-declaring their age. There is evidence that children are very good at accessing the content they want to get to, even if it is behind an age gate.

Lord Sharkey: That suggests a supplementary question. Do you think that your oversight of online and digital media is comprehensive? For example, what percentage of the complaints that you handle relate to digital and online media?

Guy Parker: A very high percentage. We extended our remit to online in 2011 for two reasons. The first was public demand. We were having to turn away a lot of complaints that were being made by people who wanted us to apply the codes to advertising content on companies’ own websites. We had to say, “Sorry, we do not cover that”. The other reason was our own realisation, resulting from the pushback from people, that there was a gap in the regulation. I would estimate that 40% of all our work now covers advertising online, but before 2011 it was not within our remit. It comprises around 35% of the complaints we receive, but it makes up a higher proportion of the cases we investigate, which would be in the low 40% area. It is responsible for around 40% of the 160,000 pieces of advice and training we delivered last year, and a similar chunk of the own-initiative monitoring that we do, and again a similar proportion of the regulatory policy work, public affairs work and research that we undertake.

Lord Faulkner of Worcester: I also have a supplementary question. Does the ASA cover advertising in unsolicited e-mails or is it just advertising on websites?

Guy Parker: Yes, we do.

Lord Faulkner of Worcester: So if one gets an e-mail that does not comply with your standards, one can complain.

Guy Parker: Yes. I would just add that we do not profess to be the solution to spam e-mail or spam texts. These are global, awful problems involving fraud. We do what we can to help, but we are not saying that we can solve this problem.

Q60 Lord Judd: How important do you judge self-regulation to be? Is it working and how can it be made to work more effectively? When it gets to the level of Europe, what do you see as the strongest part of the role played the European Advertising Standards Alliance in monitoring compliance?

Guy Parker: I think that it is working effectively and is an important part of the policy mix. We are always trying to do more and improve the performance—that is not a very nice word—of advertising self-regulation at both the European and the global level. There are no advertising self-regulatory bodies in quite a few countries around the world. We have pretty much got Europe covered with one or two omissions, but there is a lot of work to do beyond. The European Advertising Standards Alliance is increasingly acting at the international level. Actually it is one of the challenges we face: at what stage do we need to
set up an international alliance? That is because the European Advertising Standards Alliance is easily the predominant regional body and there are no other regional equivalents. Increasingly, the problems that are affecting people are global: problems with obesity, concerns about harmful drinking, problems around privacy, concerns about sustainability, and the impact of advertising encouraging unsustainable consumption—or greenwashing, as people call it. At the strategic level, we feel that the changes that have taken place in recent decades whereby the problems that affect us are going to affect you too means that we need an increasingly international response. The European Advertising Standards Alliance is outstandingly placed to step up to the plate and respond to that. I do not know whether I have answered your question.

**Lord Judd:** Do you think that these standards that you all strive for can be or are being effectively enforced?

**Guy Parker:** Yes, they can be, and they generally are being. If they always were, you would not need an advertising self-regulating organisation to do the policing. You do need an advertising self-regulating organisation like the ASA to do the policing, because there will always be some that intentionally or otherwise push their advertising beyond the codes. It is very important in these systems to have an independent part of the self-regulating organisation that is administering the code and making sure that it is working, but unashamedly I am a believer in the importance of industry buy-in. You have to stand up to individual companies when they are producing ads that you think break the rules, of course, and you have to be prepared, as we are, to fight that in the High Court. We have just concluded a High Court judicial review where Sainsbury’s has been taking us to task.

You have to be prepared to do that, but at a general level it is better to work with an industry that buy into the longer-term view that if they comply with rules there will be a level playing field and they will preserve, to their best ability, people’s trust in advertising. If it all goes to pot and everyone is saying anything and statutory regulation is failing to tackle that, then from their point of view all that is happening is that they are diluting the usefulness and the power of something that is incredibly useful to them in drawing people’s attention to new products, services, improvements and so on.

**Lord Judd:** If the Chairman will permit me, there are two points arising from or ancillary to what you have just been saying. First of all, would you say in your work with the people that you are monitoring that there is any kind of internalised value system that really recognises the importance or is it simply a matter of, “What do we do to”—

**Guy Parker:** Get round it.

**Lord Judd:** You have put the words more bluntly than perhaps I would have done, but exactly. The other point that arises out of this is: how narrowly focused is your concern? I am very interested by the whole interplay between alcohol and the lifestyle advertising, tourist advertising and the rest, which it seems to me may be having a huge impact on the level of consumption. I mean youngsters getting the impression that you go off to the Greek islands and get drunk.

**Guy Parker:** In answer to your first question, most companies think of themselves as being responsible, and they try to be responsible. I think they succeed most of the time, but not always. There will always be a tension in business between the bottom line and being a responsible company. There will always be a tension between hitting your targets and the
pressure you are under to hit your targets and your company’s corporate social responsibility commitments, and how that tension resolves itself within individual companies will depend on where that company is. It will depend on the moment in time as well, and it will depend on the leadership and the culture of the company.

The advertising code that we administer and the equivalent for the other members of the European Advertising Standards Alliance contain general social responsibility clauses. I am not talking here about the rules that apply to alcoholic drinks; I am talking about rules that apply to anything. In an ad encouraging people to go to Ibiza, you are not allowed to imply that they should do so to get off their face on alcohol. That would be an irresponsible ad and we would seek to stop that. Honestly, I do not see a lot of that around, and when we do see it we stamp it out. I wonder whether you are thinking of TV programmes that concentrate on this sort of area of young people having a very good time on holiday islands. That is not something that we regulate, obviously, because it is not advertising, but it might be contributing to how society feels about that.

Q61 Baroness Benjamin: It is great to see and hear from you today how much has been done over the years to protect children from being targeted through advertising—alcopops et cetera—but there have been conflicting reports about the amount of advertising seen by children and young people. RAND claims that 10 to 15 year-olds see 11% more than adults, yet the Advertising Association says that 10 to 15 year-olds see 53% less than adults. Bearing in mind that children and young people also see alcohol imagery on YouTube, social media and online, so they are being exposed to it from all quarters, what is being done at the EU level to prevent alcohol advertisements from targeting minors and young people? Do you agree with the RAND report that there is a direct correlation between the level of advertising and consumption by young people?

Guy Parker: Okay, so there are a number of important points to make there. I have talked quite a lot about what has been happening at EU level as far as the European Advertising Standards Alliance is concerned—that everyone’s code contains important rules on alcohol. I have talked about the evidence base for advertising and consumption in the UK. I do not think that was the interesting thing in the RAND report. The interesting thing in the RAND report was what you touched on just before you made that point, and that is what it seemed to say about the exposure of 11 to 15 year-olds to TV ads. I cannot comment on the Advertising Association’s response to that and its 53% figure, but I think you have someone who is going to be giving you evidence on that. What I can say is that we obviously read the RAND report with interest when it came out. We thought a bit about the very novel and theoretical methodology that they had applied, but this came out at exactly the same time.
as Ofcom, who we work in a co-regulatory relationship with—the UK Office of Communications—published its own report. Ofcom came out with a major study on the exposure of young people to TV alcohol ads. It came out just after RAND published its report.

The Ofcom study took a three-month time period—October, November, December, the lead-up to Christmas, which is when quite a lot of alcohol ads appear—and looked at the alcohol ads appearing on all UK TV channels. It looked at what is called the BARB data. Lord Sharkey will know all about this. The BARB data comes from the Broadcast Audience Research Board. It has a panel of 5,000 or so households and, through that panel, the broadcasting industry gets a very consistent, thorough and regular set of data on who is watching which TV programmes, and it breaks it down by demographic, including young people.

Ofcom published its report, which showed that between 2007 and 2011 there had been a small increase in the average number of alcohol ads that children had seen, from 2.7 ads per week to 3.2, but that was still around 40% of the ads that were seen by adults. The figures between 2007 and 2011—the same period of time—for adults were 6.6 to 8.1 average ads per week. Actually, in 2012, we did another cut of the data with Ofcom and it had gone back down to 2.8; so for children it went 2.7 to 3.2 then down to 2.8, and for adults it was 6.6 to 8.1 and I cannot remember what the figure was for adults for 2012, but it was similar. So those findings show that children saw, in that period of time, around 40% of alcohol TV spots.

It was a very thorough and authoritative study. I cannot reconcile those results with the results in RAND, and I will not seek to. There were some interesting things that came out of that Ofcom study that we responded to—that we needed to respond to. It showed quite significant changes in the way people, particularly young people, are watching TV. They are watching a lot more of what are called portfolio channels, which are HD versions of the channels and plus-one versions of the channels, and they are watching fewer of ITV, Channel 4 and Channel 5. It showed that they are watching slightly later in the evening, and it also showed a number of incidences that raised a query as to whether or not alcohol ads should have appeared, because the scheduling index might have been breached. We had to look into those and work out what to do. The result of that was that we then published beefed-up guidance that better reflected the changing way people watch TV. We also—

The Chairman: Mr Parker, we are a bit pressed for time. You can submit some of this in writing if you think it is relevant; that would be helpful.

Guy Parker: I was pretty well there.

Q62 Viscount Bridgeman: Mr Parker, you have referred to the EU’s audio-visual media services directive, and you mentioned that it had some national statutory content in it, I think. The question is: do you reckon that this is up to date in the context of the development of social media, because several stakeholders appear to have considered that that was due to “prevent cross-border discrepancies that can undermine national policies in Member States”?

Guy Parker: I think that it is still up to date. Media convergence means that people will have to keep looking at the AVMS directive to make sure that it stays up to date, but people are still watching a lot of TV. Even young people are still watching a lot of TV. Because AVMS does not cover any advertising on things like social media sites, because they does not fall
under the definition of audio-visual media services, does not mean that there is not really substantial self-regulation that is seeking to make sure that advertising is responsible in those areas. I have explained how we are seeking to do that in a number of the answers to previous questions.

The Chairman: Thank you very much indeed for your comprehensive answers. They were very helpful. As I said, if there is anything you want to supplement by giving us written evidence on, we would be very grateful to receive that. Thank you very much indeed for your time this morning.
About the Alcohol Health Alliance UK
The Alcohol Health Alliance (AHA) welcomes the opportunity to contribute to the House of Lords inquiry into the future of the EU Alcohol Strategy and to respond to the call for evidence.

The AHA is an alliance of organisations whose mission is to reduce the damage caused to health by alcohol misuse. The AHA works to:

- highlight the rising levels of alcohol-related health harm
- propose evidence-based solutions to reduce this harm
- influence decision makers to take positive action to address the damage caused by alcohol misuse.

The members of the AHA are: Academy of Medical Royal Colleges, Action on Addiction, alcoHELP, Alcohol Concern, Alcohol Focus Scotland, Balance North East, Beating Bowel Cancer, British Association for the Study of the Liver, British Liver Trust, British Medical Association, British Society of Gastroenterology, Centre for Mental Health, College for Emergency Medicine, DrinkWise North West, Faculty of Dental Surgery, Faculty of Occupational Medicine, Faculty of Public Health, Institute of Alcohol Studies, Medical Council on Alcohol National Addiction Centre, National Organisation for Fetal Alcohol Syndrome UK, Our Life, Royal College of Anaesthetists, Royal College of General Practitioners, Royal College of Nursing, Royal College of Physicians London, Royal College of Physicians and Surgeons, Glasgow, Royal College of Psychiatrists, Royal College of Surgeons of England, Royal College of Surgeons of Glasgow, Royal Pharmaceutical Society, Royal Society for Public Health, Scottish Health Action on Alcohol Problems, Scottish Intercollegiate Group on Alcohol, SHAAP (Scottish Health Action on Alcohol Problems), Society for the study of addiction, Turning Point, UK Centre for Alcohol and Tobacco Studies, and UK Health Forum.

Response to call for evidence
1. Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

The AHA is a strong supporter of effective alcohol policy and several of its members, most notably the Institute of Alcohol Studies, Alcohol Focus Scotland, Scottish Health Action on Alcohol Problems and the BMA have been calling for a renewed EU Alcohol Strategy since 2010, when the previous Strategy was approaching its expiration date. This submission supports the evidence contributed to this inquiry by the aforementioned AHA members.

The AHA believes the next EU Strategy should be based on the evidence-based framework for effective alcohol policies outlined in the World Health Organisation (WHO) Global Strategy to reduce harmful use of alcohol (2010) and, more specifically, the WHO European Action Plan to reduce the harmful use of alcohol 2012-2020 (2011). Both of these strategies have received unanimous endorsement by all EU Member States and are based on the best available scientific evidence of policy effectiveness. The ten policy areas for action outlined in these two strategies are:
Alcohol Health Alliance—Written Evidence

1. Leadership, awareness and commitment
2. Health services’ response
3. Community action
4. Drink-driving policies and countermeasures
5. **Availability of alcohol***
6. **Marketing of alcoholic beverages***
7. **Pricing policies***
8. Reducing the negative consequences of drinking and alcohol intoxication
9. Reducing the public health impact of illicit alcohol and informally produced alcohol
10. Monitoring and surveillance

*denotes a “best buy” policy: The WHO has identified, in line with the international evidence, the three “best buy” policy interventions that are most cost-effective in reducing harmful consumption of alcohol are controls on price, availability and promotion of alcoholic beverages.

The AHA acknowledges that the responsibility for delivering public health policy lies primarily with individual member states. Each country in the EU has different requirements and cultural backgrounds and there is no one-size-fits-all strategy that can be applied. The EU Alcohol Strategy should therefore seek to support and complement comprehensive national alcohol strategies by focusing on policy areas where the EU mandate can add value, for example in relation to trade and cross border issues. It should also provide Member States with the freedom to implement national policies that prioritise the health and wellbeing of their citizens.

A primary aim of an EU Alcohol Strategy must be to ensure that a Health in All Policies approach is taken with decisions at the EU level, and that the health and wellbeing of EU citizens is prioritized over trade and economic operator interests. An important objective within this aim must be to address the health inequalities, both within and between Member States, which are exacerbated by harmful alcohol use.

2. Are the EU’s alcohol policies underpinned by a sound scientific base?

There are many elements of the previous EU Alcohol Strategy that were underpinned by a strong evidence base of effectiveness. The comprehensive framework of policies outlined acknowledged the breadth of scope required in order to reduce alcohol harm across the EU population. Similarly, funding streams were established to advance the work of alcohol researchers and develop the evidence base for effective policies, through projects such as AMPHORA and ALICE RAP. Funding was also allocated to NGOs in order to build capacity amongst civil society actors, thus following an evidence-based approach of good governance in policymaking.

However, the previous EU Alcohol Strategy could have been more ambitious in its objectives to be more in line with evidence of effectiveness, and its expiration in 2012 presents a real threat that EU alcohol policies are not currently being prioritised according to the scientific evidence of the burden of disease in the region. The Europe is the heaviest
drinking region in the world and a significant proportion of alcohol harm is experienced by adults of working age through chronic health conditions including liver cirrhosis, cancer, stroke, heart disease and also mental illness and dependency (WHO EU Alcohol Action Plan, 2011). The focus of the current (draft) EU Alcohol Action Plan is on young people and binge drinking, and whilst the latter will capture the adult population to some extent, the Plan does not include recommendations for interventions aimed at reducing health problems caused by regular heavy consumption amongst middle-aged adults, who have the absolute highest rates of disability and premature death due to alcohol.

The Science Group of the EU Alcohol and Health Forum was established in 2008 to provide scientific guidance to the Forum. Since its inception the Group has produced two reports, relating to adolescent exposure to alcohol marketing and alcohol policies in the workplace. However, as outlined below, the function and role of the Science Group could be improved upon in order to ensure that EU alcohol policies are underpinned by an up to date evidence base of effectiveness moving forward, and that the evidence advising such policies is independently verified and free from commercial vested interests.

3. Are the EU’s alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?

The absence of a current EU Alcohol Strategy means that there is no comprehensive policy framework in existence at the EU level that can be compared to the WHO Global Alcohol Strategy or WHO EU Alcohol Action Plan.

A key omission from the EU alcohol policies at present is a set of specific, measurable and timely targets or indicators, outlining the EU ambitions for reducing alcohol harm. This is in contrast to current WHO strategies that include the following goals:

- To achieve a 10% relative reduction in the harmful use of alcohol, as appropriate in the national context, by 2025 (WHO Global Action Plan for Prevention and Control of Non Communicable Diseases 2013-2020 – baseline data from 2010)
- Offer brief advice programmes to 30% of the population at risk of hazardous or harmful alcohol consumption; or offering early identification and brief advice to 60% of the population at risk (WHO European Alcohol Action Plan)
- To achieve a 25% global reduction in premature mortality from non-communicable diseases (NCDs) by 2025 (World Health Assembly Political Declaration, May 2012)

The AHA believes that a new EU Alcohol Strategy should compliment existing WHO strategies by including targets and indicators that have been endorsed by Member States.

4. Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

The mechanisms created in the previous EU Alcohol Strategy still have an important role to play in working to reduce alcohol harm in Europe, however the roles of the Committee on
National Alcohol Policy and Action (CNAPA) and the EU Alcohol and Health Forum (EUAHF) need to be revised to reflect the requirements of a new, more ambitious strategy that puts Health in All Policies at the heart of it focus.

As CNAPA is the body representing Member States, it is essential that its role be strengthened to reflect its position as the driving force for the design and implementation of a new EU Alcohol Strategy. Conversely, the EUAHF has been awarded greater priority in the EU alcohol policy process that its remit requires. The AHA believes that the role and function of the Forum should be guided by the WHO guidance, which states alcohol industry activities should be restricted to their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages and that they should have no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests.

The function of the Science Group of the EUAHF would be better placed if it reported directly to CNAPA. This would enable policy discussions on the evidence to support interventions to reduce alcohol harm to be free from commercial conflicts of interest. It is not appropriate that economic operators with pecuniary interests in policy areas such as price and marketing should be involved in the presentation of scientific evidence to policy makers. The Science Group of the EUAHF should therefore be re-established as an independent expert group, free from membership from economic operators.

5. Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?

The previous strategy established funding streams for alcohol research, including the Alice Rap and AMPHORA projects, however the absence of an EU Alcohol Strategy presents the threat that research grants will not be made available to investigate alcohol harm.

Whilst there are funding streams available within EU programmes for alcohol research, there is an urgent need for better data on alcohol in Europe and coordination of alcohol research, both of which should be addressed in a new EU Alcohol Strategy. The European Commission’s evaluation of the Alcohol Strategy to 2012 highlighted that less than 3% of the total budget of the Health Programme for 2008-2013 and less than 1% of the budget for health under the Seventh Research Programme were allocated to alcohol. This is not sufficient given the harm caused by alcohol.

At present several Member States collect relevant data on alcohol harm and consumption, however there are many countries where sufficient data is not routinely available. We recommend that an EU Alcohol Strategy includes funding mechanisms for data collection, so that alcohol harm and policy progress can be monitored and evaluated across the EU.

6. Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?
Tensions exist between the promotion of free trade and the protection of public health through fiscal measures for alcohol within the EU. Current EU regulations have the ability to undermine Member States’ efforts to implement pricing policies designed to protect public health, and Scotland’s plans to introduce minimum unit pricing for alcohol could potentially be thwarted by a legal decision made in the European Court of Justice.

In 2012, the legal challenge to Scotland’s plans to introduce minimum unit pricing, launched by the Scotch Whisky Association and Spirits Europe, generated an unfavourable and ill-informed opinion from the European Commission. This did not correctly differentiate between the roles of minimum unit pricing and taxation, and recommended that taxation alone could achieve the same objective of reducing consumption of cheap, strong alcohol amongst harmful drinkers. However, the EU Directive on alcohol taxation actually prohibits the implementation of a taxation system for all beverages based on their alcoholic strength. Indeed, this is one of the many reasons why the Scottish Government turned to minimum unit pricing as a policy solution to the problems caused by cheap, strong drink in Scotland. Minimum pricing and taxation are complementary policies and are not mutually exclusive.

Questions have been referred to the European Court of Justice (CJEU) for clarification by the Scottish Courts in the legal challenge. If the CJEU finds against minimum unit price, a policy that has been judged by the Scottish Court of Session as a reasonable and proportionate response to a public health need, this will raise a key issue regarding the role of the European Courts in re-assessing evidence considered by elected legislatures within Member States. This would raise questions about subsidiarity and the margin of appreciation between Member States and the EU and could potentially have adverse consequences for wider public health policies than alcohol.

19 September 2014
WEDNESDAY 29 OCTOBER 2014

Members present

Baroness Prashar (Chairman)
Baroness Benjamin
Lord Blencathra
Viscount Bridgeman
Lord Judd
Lord Morris of Handsworth
Lord Sharkey
Earl of Stair
Lord Tomlinson
Lord Wasserman

Examination of Witnesses

Dr Evelyn Gillan, Chief Executive, Alcohol Focus Scotland, Professor Nick Sheron, Senior Lecturer and Head of Clinical Hepatology, University of Southampton, and Katherine Brown, Director of the Institute of Alcohol Studies.

Q33 The Chairman: Dr Gillan, Professor Sheron, Ms Brown, welcome. Is it my time to congratulate you that you were made a professor recently?

Professor Nick Sheron: Yes, I have—they made a terrible mistake.

Q34 The Chairman: Thank you very much for your time this morning. As you will be aware, this is a public session; the webcast of the session goes out live as an audio transmission and is subsequently accessible via the parliamentary website. A verbatim transcript will be taken of the evidence, which will be put on the parliamentary website. I see, Professor Sheron, that you have provided us with some charts. Obviously, if you prefer to use them, it would be very helpful if you can do so in a way that will be understood by people who are reading the transcript. I do not know how you will manage that, but I wanted to make you aware that it has to be done in such a way that it can be understood.

Professor Nick Sheron: I submitted the digital copy, so you are very welcome to use those in the transcript.
Oral Evidence (QQ 33-51)

The Chairman: Yes, we have those, but it is not us; it is the people reading the transcript who will need to know when you are referring to the charts. A few days after this session, you will be sent a copy of the transcript to check it for accuracy. It would be helpful if you could advise of any corrections as quickly as possible. If, after the session, you wish to clarify or amplify any points that you made during the evidence, or if you have any additional points to make, you are welcome to submit those to us, as you wish. Do you wish to make any introductory comments, or shall we go straight into the questions?

Professor Nick Sheron: Yes, the questions will be fine.

Q35 The Chairman: I would like to start by asking you what, from your point of view, were the key achievements of the EU alcohol strategy in 2006-12. Did it achieve the overall objective of reducing alcohol-related harm, and did it achieve its aims in any or all of its five priority areas? It would be useful if you could be a bit more specific about oral harm and refer to the specific priorities and what you think has been achieved in each of them.

Katherine Brown: I will begin by giving more of an overview of the situation before I hand over to my colleagues. The EU alcohol strategy was a very useful tool in that it provided a very helpful focus and a collective response to alcohol across member states, which has been very helpful and has raised the profile of alcohol in the European political arena. There have been some specific improvements; for example, some member states have lowered their blood alcohol limit for the legal limit for drink driving, with the comment that at the moment the UK and Malta remain the only countries with the highest legal limit that is above the recommended European Commission limit; although Scotland has been making plans to introduce a lower limit before Christmas. However, we need to remember that Europe remains the heaviest-drinking region in the world, and we have not seen an overall huge reduction in rates of alcohol-related harm, both in the health and the social contexts. I would also like to comment on the fact that it is quite difficult to measure the success of the EU alcohol strategy, because the strategy itself did not have any measurable targets or indicators. So it is quite difficult to discuss success when we do not really know what it would look like, because it was not laid down from the outset. I will hand over to my colleagues now to comment on anything more specific.

Professor Nick Sheron: Just to split it down, if you look at protecting young people, children and the unborn first of all, I would say that arguably the most important driver for alcohol-consumption—alcohol-related harm—in young people is probably alcohol marketing. Price is very important as well. I can support that statement with a couple of charts, which you may be interested in. It will be very quick. PowerPoint slide 20 shows the increase in alcohol consumption at a population level—this is UK data. The black line on this chart, incidentally, is the increase in relative mortality of liver disease. I want you to look at the data in the green circle. Slide 21 on the right-hand side shows the changing consumption of spirits in the UK. That is interesting, because whisky consumption has gradually declined as a generation of whisky consumers has disappeared and has not been replaced by new whisky consumers. However, look at the huge increase in vodka consumption in the early 1990s. When I was a child or was at university I never drank vodka—none of my colleagues drank it. I suspect that the same is the case for you. I am interested to know why that happened and why that huge increase happened in such a short space of time. In fact, in the 1990s the drinks industry was in a bit of a state, because with the rise of the rave culture there was a generation of young people who stopped drinking alcohol, quite briefly. The response from the drinks industry
was twofold. First, it increased the volume of its marketing, but more importantly, it changed the target of its marketing. I have given you a couple of examples of a representative selection of alcohol adverts in the 1980s, and subsequent to that in the late 1990s (slides 22 and 23). Alcohol adverts in the 1980s were characterised by Leonard Rossiter tipping a glass of Cinzano down Joan Collins’ cleavage, and were aimed at people my age. Post the early 1990s they were very clearly aimed at 18 year-olds; and adverts that are aimed at 18 year-olds also apply to younger children. The data are in PowerPoint slide 24 in the blue and green blocked areas. What we have here is data from the regular survey of smoking, alcohol and drug use in schoolchildren aged 10 to 15. In 1992 less than a unit a week of spirits was consumed by schoolchildren. By 2000, the amount of alcohol consumed either as spirits or as alcopops had increased fivefold. That is in direct response to that marketing and also to the introduction of a type of alcohol aimed at children—alcopops. It was phenomenally successful. The red lines there show the timescale of the increase in population-level alcohol consumption. You can make of those data what you will—I am not suggesting that I can prove a causative effect. Nevertheless, it is interesting, and marketing is very important. One of the major achievements of the alcohol strategy are two pieces of work, the first is the report by the Science Committee on alcohol marketing, which drew together all the evidence and essentially showed that marketing was important in initiating alcohol consumption and increasing the consumption of alcohol by children. The second report, which followed on from that report, was a report commissioned by the EU alcohol forum—the RAND report. When we talk about data on advertising I will talk to you about that as well, but for the time being I will leave that there.

My second point—Katherine has already mentioned reducing injuries on roads and drink-driving, so I will not say anything about that—is on alcohol-related harm among adults. I think it is quite difficult for people to get a handle on this. I am a liver disease doctor, so this is what I see—it is my day-to-day existence. PowerPoint slides 1 to 4 are there purely to tell you that liver disease causes about three-quarters of wholly-attributable alcohol-related deaths, and three-quarters of all liver disease is because of alcohol. Therefore liver mortality rates are a very good cipher for what is happening in terms of alcohol-related harm, and are a very good cipher for the effectiveness or otherwise of alcohol policy. I can show you what has been happening in Europe. In slides 5 and 6 I have split the European member states into three groups. There is a group of green countries, which have always had low levels of liver disease and alcohol consumption. Another group of countries—which is very interesting—is the amber group, which are countries such as France, Spain and Italy, which historically have had very, very high levels of alcohol consumption, liver mortality and alcohol-related harm. Alcohol consumption has been in freefall in those countries, and liver mortality has followed it almost exactly. You can see the two graphs there; I hope you can see the linkage. There is a third group—and unfortunately the UK is a member of that group—of countries which have high or increasing alcohol consumption. A lot of those countries are the new EU member states in eastern Europe.

So I think you can see that there is a long way to go. You can see that since the start of the alcohol strategy there has been a decline. Things are slowly improving, and alcohol consumption is also dropping. I just want to make the point that liver mortality is closely related to population-level alcohol consumption. If you look at all the parameters of alcohol-related harm, they are all dose dependent, whether you look at liver disease, cancer, hypertensive disease, it is a dose-dependent relationship—exactly the same as the one you
get with smoking. At a national level, there is also a dose-dependent relationship. The more a country drinks, the more alcohol-related harm people develop. Slide 7 shows you that relationship. Here I have the four countries with the biggest change—either an increase or a decrease—in alcohol consumption and liver disease mortality. Again, I hope that I can convince you that there is a relationship between the two, because on the vertical axis we have liver death rates, while on the horizontal axis we have alcohol consumption at a population level. That is critical. As Katherine said, we cannot ascribe that more recent improvement to anything in the alcohol strategy, but particularly the work of CNAPA has been important, particularly in the eastern European member states, where there is now a much greater awareness of alcohol than there was in previous years. I suspect that a lot of that is related to the efforts of the EU and the alcohol strategy.

Q36 The Chairman: Why has there been a decrease in France and an increase in the UK?

Lord Blencathra: And in Finland.

Professor Nick Sheron: That is a very good question. Finland has gone up, like the UK, because of the cross-border trade with Estonia. I can explain that one. I have asked this question to every global alcohol expert that I meet—Professor Thom, your specialist adviser, may have a view on this as well—and I get a different answer every time. My considered position is that in the early 1960s people were not aware at all of the health-harms of alcohol. In fact, people thought that alcoholic liver disease was a nutritional deficiency—they did not think that it was a dose-dependent relationship. So in those countries that have very high levels of drinking and high levels of cirrhosis and alcohol dependency, there has been a natural progression to drinking less. A lot of that is due to health awareness; some of it may be due to alcohol policy. For example, in France they introduced the loi Evin, which is a very effective control on alcohol marketing. However, I cannot prove that, and neither can anyone else. There has been a real change in drinking culture in those Mediterranean countries; for example, the death of the long lunch, the movement from a rural existence to an urban existence, and globalisation of drinking cultures. All those add together to cause a steady decline in alcohol consumption. We are now starting to see the same decline in alcohol consumption in the eastern European countries, and with that decline in alcohol consumption we get a decline in alcohol-related mortality and liver disease mortality.

The Chairman: But what about the UK? Why is there an increase?

Professor Nick Sheron: The UK is a perfect example of how not to do alcohol policy. I can talk about that now as well, if you like.

The Chairman: Yes please; it would be very helpful.

Professor Nick Sheron: Those are PowerPoint slides 8 to 11. In slide 8, with a red line going into the sky and the various blue lines, the blue lines are mortality rates normalised to 100% in 1970. You can see that mortality rates from every disease—so we have circulatory disease, cancer, respiratory disease, ischemic heart disease—have decreased. The red line is liver disease mortality, which has gone up between 400% and 500%. Why has that happened? If you look at slide 9, my thesis is that this is entirely related to changes in alcohol consumption. However, if you just look at crude overall consumption, you do not see a relationship—not a strong one—because there have been very significant changes in the alcohol market in the UK. We have shifted from the 1970s, when we drank most of our alcohol in pubs, to 2014, when we buy most of our alcohol in supermarkets and off-licences.
and drink it at home. The type of alcohol we drink has changed. We no longer drink as much alcohol in the form of weak beer—3.4%; very few of my patients get liver disease from drinking beer with 3.4% alcohol because the volume is just too great. We are drinking a lot more alcohol as wine and as spirits. If you look at the different coloured lines in slide 9, the green line going up into the sky represents consumption of strong lager; then we have consumption of wine, spirits and cider—cider in particular, because it is so cheap, because the duty on it is so small. My patients with cirrhosis drink a huge amount of that—it is the tipple of choice for a lot of them. Again, I hope that I can convince you that there is a relationship with the black line, which represents liver mortality. However, slide 10 is more important: changes in affordability of alcohol. Again, we have a black line which represents the change in liver disease mortality, then coloured lines which represent the change in the affordability of spirits, wine, beer and cider. There is a very close relationship between the affordability of alcohol and deaths from liver disease. The reason for that is quite simple. My patients with cirrhosis drink a vast quantity of alcohol. The average consumption of my patients with alcoholic cirrhosis is between 120 units, the median, and 150 units, the mean, per week. That is four or five bottles of vodka a week.

As a result, they are paying the minimum they possibly can. We have studied this and have data. I can give you the paper: they are paying an average of 33 pence per unit. Low-risk drinkers do not buy the cheapest alcohol they possibly can, they buy alcohol in pubs and they treat themselves. So the behaviour of very, very heavy drinkers is exquisitely sensitive to the price of alcohol. That becomes very important when you start to talk about effective policies, as we perhaps will later on. If you have a policy that specifically targets cheap booze, that becomes very targeted at where the problem is.

To move on to the final two points, “Inform, educate and raise awareness” was the other component of the alcohol strategy. The strategy has done quite a bit to do that, and the research projects funded by the strategy, such as the ALICE RAP project, have also contributed. However, we have real problems with the evidence base. It is the World Health Organization that has led with regard to the evidence base, while the EU Commission is lagging behind. All the European data that I have presented to you comes from the World Health Organization Health for All database, which is publicly accessible. I will stop there and pass this on to Evelyn.

Dr Evelyn Gillan: I think Nick has answered extremely comprehensively and I am happy not to add to that.

Q37 The Chairman: Can I just ask you another question? Are there any ways in which the strategy has influenced the UK’s national policy and practice? Where has the specific impact been on our own policy and practice?

Dr Evelyn Gillan: My colleagues may come in on this, but I can talk for Scotland. The strategy has provided a useful benchmark, but Scotland has quite a different alcohol strategy from England. Our alcohol strategy is much more based on the recommended, good-practice and evidence-based policies that the World Health Organization identifies and on where the evidence is strongest as to the policies that are going to be effective in reducing both consumption and harm. Certainly, the strategy in Scotland is to have alcohol policies which

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aim to reduce overall alcohol consumption in the population. That is quite significant, given alcohol policies in the UK up until now. I think Nick made this point, but if you want to look at how not to do alcohol policy, look at the UK. We have not based our alcohol policies in the past on the best scientific evidence but have tended to go for those policies which have the least evidence base. Scotland has taken a different road over the last couple of years, in part because of the increasing evidence that Nick talked you through. The health evidence is now becoming so overwhelming that it becomes untenable to continue on the path that we were on in the face of such clear evidence. People often think that the UK has always had this heavy drinking culture, but in 1960 the UK had one of the lowest liver cirrhosis mortality rates in western Europe. That coincided with a time when alcohol was very expensive and was hard to get. I am old enough to remember when pubs closed in the middle of the day. Alcohol only became available in supermarkets in 1960, I think. We have moved from a position of having one of the lowest liver cirrhosis rates in western Europe to having one of the highest. If we chart the alcohol policies that have been put in place, you can almost see a direct correlation between when alcohol became more affordable and more available and when we liberalised and deregulated licensing. All that is very much linked to increasing alcohol consumption, which leads to the kind of harm that Nick is talking about.

**The Chairman:** Can I just ask another question? You said that one effect of the alcohol strategy has been raising awareness, but that awareness-raising has not had an impact and that the outcomes are still quite negative in that sense. Why is that?

**Dr Evelyn Gillan:** Just quickly, what is really important about awareness-raising is how you can encourage people to be responsible when they live in an environment that promotes both access and excess—for example, if it is cheaper to buy a unit of alcohol than to buy a bottle of water. Some of our schoolkids in Scotland were fed up with being lectured by adults about being responsible drinkers and said, “How can we be responsible?” They went to a local supermarket, did a survey and came back and presented a petition to the Scottish Parliament, saying, “Our alcohol is being sold more cheaply than a bottle of water”. Education has a place but it is virtually a waste of time unless you also have policies in place that seek to change the environment. Environments can enable drinking and they can constrain it. If alcohol is very affordable, very available and very heavily marketed, it becomes very difficult, through persuasion only, to encourage people to drink responsibly.

**Professor Nick Sheron:** Just to add to that, there is a paradox here. We are going to come on to something later that really exposes that paradox and it is best to get it out into the open. When the World Health Organization analysed the effectiveness of different health policies, it came to the conclusion that education and information campaigns on the whole do not change behaviour—they prepare people for effective health policies but do not change behaviour on their own. That is fine. The health community says that education and information do not work, but at the same time we also say that marketing by the drinks industry does change behaviour—I have just said as much in that it changes children’s behaviour. There is clearly a paradox there. What is the solution to that paradox? I was a founding trustee of the Drinkaware Trust, which is a body that takes drinks industry money and puts it into health education. I think it is a basic human right for people to have that information. The Drinkaware Trust’s funding is about £3 million a year. We do not know how much the drinks industry spends on alcohol marketing—according to the last information we had, it was round about £250 million a year in direct advertising and perhaps £750 million in total marketing spend. There is a massive mismatch between the amounts of finance going
into those different education arms. The other thing is that despite all that money going into marketing, it is quite difficult to prove that it changes behaviour. The industry knows very well what the impact of its advertising campaigns is, but those data are not in the public domain—they never are. For example, the science committee report looked at 10 longitudinal studies and lots of other studies, and brought them all together in a meta-analysis. It was able to show an impact from alcohol marketing, but that is not an easy thing to do. My personal feeling is that we perhaps underestimate the importance of education and information.

**Q38 Lord Tomlinson:** You said early on that there had been some benefit from the EU strategy. You then showed us very clearly your view that the World Health Organization is a much more important player in this regard than the EU strategy. Should there be a new EU strategy or should we try to beef up the work of the World Health Organization? If there is a new EU strategy, should it be built on the principles of the previous strategy? If not, should more emphasis be placed on a Health in All Policies approach—that sort of mainstreaming approach?

**Katherine Brown:** I will begin to answer that before I hand over to colleagues to follow up. Absolutely, there should be an EU strategy. That is something that the public health community across the European region is very supportive of, because we need this focus and collective action to come together to reduce rates of alcohol harm. In association with a new EU strategy, funding needs to be made available for both research and implementation programmes and for civil society support. We would say that there definitely needs to be some leadership from the European Union on alcohol harm reduction across the region. There are also very important things which the EU can do within its mandate that the WHO cannot do. The European Union is a trading region and there are many elements where collective action is going to be stronger than member states or nation states trying to implement policies on their own. In areas such as pricing, marketing and indeed labelling of alcoholic beverages—going back to Nick’s mention of the consumer right to information—there is no European directive at the moment to list the ingredients of alcohol containers or indeed any of the health harms. I will get back to the point, but as an aside, alcohol is classified as a type 1 carcinogen by the World Health Organization, but there is no mandate to label this as a risk to consumers on alcohol containers. These are areas where the European Union could enact its mandate in order to ensure that the policies are implemented across the region and are not undermined by cross-border issues that could be introduced by individual member states. Sweden, for example, has tried to introduce greater restrictions on marketing with regard to broadcast advertisements, but these restrictions have been undermined by neighbouring member states broadcasting television programmes into Sweden. There are certainly areas where having an EU strategy can strengthen action within a specific mandate.

**Lord Tomlinson:** Just to interrupt you, Sweden does not follow any EU strategy, does it? When it went to join the EU all those years ago, it negotiated a complete derogation from the need to liberalise the sale and distribution of alcohol.

**Katherine Brown:** There are areas where Sweden has been a very supportive partner with regard to reducing alcohol harm; certainly in terms of research and offering support in the Committee on National Alcohol Policy and Action. Sweden, Ireland and the UK put together a joint position paper calling on the Commission to renew the EU alcohol strategy and
outlining the principles that they would like to see within a new EU alcohol strategy. So I would not say that Sweden has completely ignored the alcohol issue or refused to play ball within Europe when it comes to collectively reducing alcohol harm, but I acknowledge the points that you make regarding wider EU positions.

To just mention one thing on your question regarding the Health in All Policy approach, that is absolutely something that we really need to see strengthened within the next EU alcohol strategy—if indeed we have one, which has not yet been confirmed. We need to have an awareness that alcohol is everybody’s business: it crosses all the Directorates-General across Europe and is not just an issue for DG SANCO. We need to have an education process whereby colleagues in DG Tax, DG Info and DG Trade understand the impact that alcohol has across their policy briefs and that alcohol harm has in general across society. Indeed, that harm is not just experienced by drinkers themselves. There are enormous volumes of third-party harms: alcohol-related accidents, drink-driving incidents, domestic abuse and child abuse are some of the issues that I am sure we will be following up in some detail further on. I would say that absolutely we need to see a Health in All Policies approach taken at the population level to get real collective buy-in on action together.

Dr Evelyn Gillan: In answer to your question, I would say, no, we should not just leave it to the World Health Organization. I agree completely with Katherine, for the reasons that she outlined, that the EU has a very strategically important role to play, particularly in relation to EU directives on price, taxation, labelling and all the stuff that Katherine mentioned. But what would be very helpful for a future EU strategy would be to ensure the difference between a strategy and an action plan: a strategy is a coherent, strategic approach that is informed by the evidence, not just a set of actions. What would be very useful for any strategy would be for it to be, first, informed by the evidence and, secondly, informed by the World Health Organization frameworks that are currently in place. We need to work together and the World Health Organization, for example, has done very good work. We have already said that one of the problems with the EU strategy was that it had no indicators and no clear outcomes. The work the WHO has been doing on non-communicable diseases has set clear targets such as a 10% reduction in harmful use of alcohol by 2025 and a 25% reduction in preventable mortality from non-communicable diseases. So it is not either/or; they need to work together. The EU definitely has an important strategic role to play in this but it needs to link with the World Health Organization.

Professor Nick Sheron: I absolutely agree with what my colleagues have said here. I will just give you a quick thumbnail of the sorts of benefits that could ensue in Europe if we got the alcohol strategy right. The European population is about 500 million; the liver death rate is 13 per 100,000. The best liver death rate—the best, green countries on slides 5 and 6—is 4 per 100,000. At the moment there are 65,000 liver deaths in the EU; it ought to be 20,000. That is what we should be aiming for. That is a difference of 45,000. Liver deaths are about a quarter of alcohol-related deaths, so if you multiply that by four, you have 180,000 avoidable deaths per year. That is the best possible outcome. It is entirely realistic to think that an effective alcohol strategy could probably prevent a million deaths in Europe over a 10-year period. That is a pretty good reason for the EU being involved in an alcohol strategy.

I will very briefly add to what Katherine said about Health for All. I will just give you three examples of the sorts of things that the EU could do if it was able to get its act together—I guess that that is one of the issues. For example, taxation: beer is taxed on the basis of the alcohol within the beer, as are spirits, but wine is taxed in bands. There is a band at 7.5% and
at 15%, so there is no financial incentive for manufacturers to make weaker wines, which, given the population-level link, would be much healthier—and that would be a good thing. There should be a tax advantage for doing that. Secondly, there is VAT. At the moment, alcohol has two taxes: alcohol duty, but also VAT, which is related to the price that you pay. If you buy alcohol in a supermarket, you pay a lot less tax than if you buy alcohol in a pub, because of all the added costs that pubs have. So really it is unfair on pubs and bars—this is unfair, double taxation. However, we are not allowed to take VAT off alcohol; if we were allowed to do that, you could have a purely volumetric tax. You could equal the playing field between pubs and bars and supermarkets, and by the way, you could achieve a minimum unit price where all the money would go to the Exchequer, not to the retailers—but that is a separate issue.

Finally, I will mention the Common Agricultural Policy. I will say something nice about it—I bet that does not happen very often in this Committee. If you look at the declining alcohol consumption in France, that led to the wine lakes and a policy by the European Commission to protect the incomes of farmers by taking alcohol out of the system by distilling it into agricultural alcohol, by grubbing up vineyards, by pushing the wine industry to develop a business model based on quality, not quantity. The impact of that has been very interesting; I have another couple of slides, numbers 18 and 19, with a black dotted line going down, which represents liver deaths, and a fainter black line which represents overall wine consumption. Next to that there are a lot of squiggly lines. What are they? That decrease in wine consumption was almost all decrease of cheap plonk—big containers of plastic bottles of cheap wine. At the same time, because the French wine industry moved its business model to one based on quality, there was an increase in sales of appellation contrôlée wines in glass bottles with corks. Therefore liver mortality has dramatically decreased, as has alcohol-related harm, but because of the shift in the business model to quality, the value of the French wine industry has increased. That is a win-win for the drinks industry, for health and for society. It is an example of how, although the health community and the drinks industry are essentially diametrically opposed, there are ways in which that need not necessarily be the case, and this is an example of that. The Common Agricultural Policy is not the reason for this, but it has been a beneficial factor. If that message got through to the European Commission, it might be a little more open to alcohol policy.

Katherine Brown: I will make one final comment on the question of whether there should be an EU strategy with a health in all policies approach. I want to clarify that EU action can enable effective alcohol policy and reduce alcohol harm, but action at the EU level can also work to obstruct or undermine effective alcohol policy. Therefore, for example, we could see an incidence whereby minimum unit pricing was given an unfavourable opinion from the European courts, which may obstruct the Scottish Government from implementing a policy that they see as in the best interests of their citizens. We have also seen examples of EU action undermining effective alcohol policies—for example, the abolition of the duty-paid allowances system, which effectively undermines countries or nation states that had introduced higher taxation on alcohol to lower alcohol harm. I just wanted to stress the importance of action at the EU level over and above the WHO, because of the EU’s mandate.

Lord Tomlinson: Can I just ask one small question directed at Katherine? She referred to the benefits of EU research. The evidence we have seen so far seems to indicate that we are not

26 Sheron, N. Vary VAT on alcohol to achieve minimum pricing. BMJ 2011; 341:1105
getting best value for money from that research, because the research is not directed
towards filling gaps in our knowledge about the European Union, but is much more demand-
led by the research bodies that are bidding for funds. Should that not change?

**Katherine Brown:** Absolutely—that should change. The research agenda as regards public
health-driven research should reflect the burden of disease and the burden of harm that we
experience in Europe at the moment. It is my understanding that less than 3% of the total
budget of the health programme between 2008 and 2013 and less than 1% of the budget for
health under the seventh research programme were allocated to alcohol, when we know
that the burden of disease is 7% of the burden of disease across the European Union—
although I may have to check that statistic—and is around 4% worldwide. This goes back to
setting indicators and objectives and trying to see what success might look like. Any research
programme that comes out from an EU strategy should be mapped against the work plan
within that strategy and against the targets and objectives of that strategy. Therefore if we
want to see a European-wide reduction in deaths from liver d
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**Viscount Bridgeman:** On the French success story that you were talking about, does
not poor old monsieur Évin with his loi get some credit for all that?

**Professor Nick Sheron:** I would like to be able to say yes to that question, but I do not have
the data to be able to do that. If you look at the decline in mortality, I would love to say that
there was a big inflection and that it went down much further when the loi Évin was
introduced, but that is not the case. So I am not able to ascribe a causative relationship with
the loi Évin. It probably has had an impact in protecting young people, however, because we
have not seen the increase in young drinking and young alcohol-related harm in France to
anything like the same extent as we have in the UK. Bear in mind that alcohol is now the
leading cause of death in young people. Between the ages of 18 and 29, alcohol causes 26%
of deaths in young men and 15% of deaths in young girls.**28** That is more than meningitis,
leukaemia and all the things that parents are worried about.

**Viscount Bridgeman:** Thank you. I have another quick question. On slide 5—the country
distribution—what was the spike in 2006 in the red group?

**Professor Nick Sheron:** I cannot say anything about that spike as these data were
accumulated from lots of different countries, so I cannot answer that question. However, the
general increase was as a result of eastern European countries joining the EU and an
increase in living standards. What happened was that their alcohol consumption went up
and then slowly drift back down again. By the way, the other interesting point—and this is
fascinating—is that it takes probably a minimum of 10 years to develop cirrhosis and then
liver failure from the start of heavy drinking. However, if you look at liver mortality, it follows
changes in alcohol policy very quickly indeed. The best example is Russia in 1985, when
Gorbachev introduced his alcohol reforms.**29** There was a big reduction in alcohol

**Notes:**

28 Jones L, Bellis M. A., Dedman, D, Sumnall, H, and Tocque, K. *Alcohol attributable fractions for England; alcohol
attributable mortality and hospital admissions.* North-West Public Health Observatory and Dept of Health; 2008.
consumption in Russia and an immediate reduction in mortality from all causes: homicide, liver disease—everything. The reason is that people die of liver disease from acute or chronic liver failure as a result of their recent drinking. As soon as you get over that recent drinking episode, the mortality rates flatten out. There is some data from Canada which we might have time to look at later on. You see this whenever there has been an effective alcohol policy intervention; you see an immediate readout within 12 to 18 months as regard liver disease mortality. The message for policymakers is very important. If you introduce effective alcohol policy measures, you will see an improvement in mortality within that term of administration. It is very unusual for public health measures.

Q40 Baroness Benjamin: The question we need to ask ourselves is, why do people need to drink? With the education policy there should be a strategy of willpower, discretion, how to deal with temptation, especially among children. The message you are giving me is becoming clearer and clearer—we should be concentrating on that. Several stakeholders have expressed concerns that health inequalities were increasing both within and between member states. There are concerns that a one-size-fits-all approach would undermine the ability of member states to address specific issues around the national context; also health problems among middle-aged drinkers and young people—teenagers—are quite different. What do you think is the relationship between alcohol and health inequalities, and in what way can an alcohol policy address health inequalities? Secondly, how should a new strategy—if we get one, as Katherine was saying—address health inequalities, both within member states and across Europe?

Dr Evelyn Gillan: On the question of health inequalities, there is a social gradient to alcohol-related mortality. For example, we know that in Scotland death rates from alcohol-related mortality are seven times higher in areas that we describe as deprived than anywhere else. So we know that that happens. However, people often do not appreciate that that is not because everybody on lower incomes is drinking more—that is not the case. In fact, people on lower incomes on average drink less than people on higher incomes, but those who do drink, drink much more harmfully. Therefore alcohol is a real driver for health inequalities. Obviously, the harm that is caused by increased consumption is then compounded by other, broader health inequalities. However, we know that if you had effective alcohol policies in place, the biggest beneficiaries of those policies would be poorer people, because they are suffering under this burden of harm at the moment. It is about what Nick was saying: good alcohol policy is a matter of life and death, not just a philosophical question. If you have good alcohol policies, you will save lives. If you have bad alcohol policies, people die.

Dr Evelyn Gillan: The evidence is undisputed, that consumption is linked to harm. So your alcohol policies must be designed to reduce overall alcohol consumption in the population. Nobody disputes the link between consumption and harm, but we also know, from over three decades of evidence, what works to reduce consumption. If you want to reduce harm, you need to reduce consumption. You cannot do it without reducing overall consumption. So what are the policies that are most effective in reducing—

Baroness Benjamin: But do you not think that the first statement I made asking why people need to drink is part of that as well?

Dr Evelyn Gillan: Yes; of course there is always an element of individual choice, but we know that price, availability and marketing are the policies that are most effective in reducing
alcohol consumption. So if you have higher prices, less availability and it is less heavily marketed, people will drink less, and if they drink less, they will suffer much less harm.

**Professor Nick Sheron:** It is almost in the British DNA to drink alcohol. We have been feast-drinking for—

**Dr Evelyn Gillan:** Not if you go back to 1930; people drank much less then.

**Professor Nick Sheron:** I will come on to that in a second. But for hundreds of years, if not millennia—the Romans and Greeks described the difference between the feast-drinking culture of northern and western Europe compared to the steady drinking with meals culture of southern Mediterranean Europe, and those differences still persist. So there is an underlying tendency to drink in different ways, and the Scandinavians and Celts drink differently to Mediterranean people. However, the personalities of British people have not changed over the last 30 years. The reason that liver disease has gone up 500% is because of their drinking environment, not because of their essential personality. With regard to the link to inequalities, Evelyn is absolutely right: there is a paradox there, because poor people on the whole drink less, but suffer very disparate levels of alcohol-related harm. I have some data from Wales, which is slide 11. I gave a talk at the Welsh Assembly a few months ago, which is when I drew these data. There is a ten-fold difference in alcohol-related mortality between the highest and lowest social classes in Wales. However, there is another very interesting thing, which is on slide 12. I had to go to the bowels of the Office for National Statistics in Newport to get this data. Every 10 years it issues statistics on the link between liver mortality and social class. We start in the 1920s, then go through the 1930s, 40s, 50s, 60s, 70s, 80s and onwards. Liver disease now is a disease of the poor, but in the 1920s it was a disease of the rich. The transition was in the 1980s, when alcohol got dramatically cheaper. The explanation for this is the one that I gave you earlier, which is the impact of very cheap alcohol on very heavy drinkers. That is what has ramped up in response to changes in affordability. Therefore alcohol-related harm was not always associated with deprivation; it has been associated with deprivation only since drinking a lot of strong alcohol became very affordable.

As regards solutions, I had the privilege of being the adviser to the House of Commons Alcohol Select Committee a few years back. I did a survey of the written submissions from the health community and from industry. It was very interesting, because the top, number one priority for industry was an alcohol policy targeted at very heavy consumers. There is such a policy. You will be pleased to know that I have nearly finished with my charts; this is slide 13. What we have here, underneath the dinosaur, is the green bars, which are the distribution of alcohol consumption—this is from Scotland, from the Scottish Health Survey. It goes: 0, 10, 20, 30 units per week— that is bottles of wine per week. In a survey population, the majority of people do not drink very much, and there is a tail of very heavy drinkers; there are not many of them. Slide 14 has my patients with liver disease, so this is my survey data of the alcohol consumption of my patients with liver disease. I have already told you the answer to this, which is that they drink on average between four and five bottles of vodka a week. The point I want to make is that they are off the scale of surveys. They are way beyond what most people are drinking. Slide 15 shows the data that I have already alluded to, which is the fact that they are buying the cheapest alcohol. So if you have a policy which chops off the spiky tail of the stegosaurus, you have a policy that exquisitely targeted at where the problem is. You have a policy which is exactly what the drinks industry said it wanted—a policy that is exquisitely targeted at heavy alcohol consumers. When you
do the sums—and this is now slide 16—there is a 400-fold difference in impact in terms of proportion of income, 200-fold in terms of the extra cost per week of a minimum unit price of 50 pence, on my patients with cirrhosis compared to lower-risk drinkers. Minimum unit price is just not a policy that impacts on the lowest risk drinkers. So it is possible to have alcohol policies that are more intelligent than just raising taxation, which are targeted at where the problem lies. I would like to think that this is a solution for Europe in time; I think we will get there eventually.

Q41  Lord Blencathra: This is terribly important. None of you have told us what those policies are. The politics of this are, how can any Government of any complexion target the people who are on four bottles of vodka a week without being accused of just targeting the poor and letting the claret-drinkers get away with it. Or, if the pricing is to be evenly spread, those of us who consider ourselves moderate drinkers, like one glass of malt before going to bed, will pay £200 a bottle for whisky, if we are to increase the price evenly. Do I make sense there? How do you get a policy through that is not accused of being classist, to target those people who, as you pointed out, are poorer and drinking bad, nasty booze?

Professor Nick Sheron: I will quickly answer that then pass it on to Katherine. That is exactly the point I am making. You are absolutely correct: all purchase taxes are regressive. Taxation on cigarettes is regressive. Yet taxation is the most effective and cost-effective way of reducing tobacco-related harm and alcohol-related harm. So that is an issue. However, if you target your taxation, a minimum unit price does not affect the price of all alcohol, only the price of the cheapest alcohol. Specifically, we are talking about 7.5%, three-litre bottles of electric soup cider, which is what my patients with cirrhosis are drinking—and frankly, if you are drinking that stuff, you have a drink problem. Normal people do not drink that stuff. So it is not perfect, but it is very heavily targeted to where the problem is compared to a general increase in taxation. I am sure that Katherine has something to say about that.

Katherine Brown: I agree with both of my colleagues’ statements. Minimum unit pricing is exactly that elegant solution to the very difficult problem that we face with regard to the relationship between price consumption and harm, in that minimum unit pricing impacts upon not only the cheapest drink but the cheapest, strongest drink. So it is not about people who like to go to the supermarket and enjoy one glass of sherry of an evening, but the people who go to the off-licence and buy three litres of cider for probably less than £3 at the moment under the current duty rates. As Nick says, those are the drinks that are being drunk by the heaviest and harmful drinkers, who are causing problems: they are causing burdens on themselves, on the health service and on society as a whole.

Now, some very good modelling has been done that I am sure you have all been made aware of during this inquiry, by the University of Sheffield Alcohol Research Group. They have modelled the impacts that the introduction of minimum unit price would have on drinkers across the social classes. Their modelling predicts that the people who would benefit the most in terms of reduced rates of liver disease, negative health outcomes and social problems would be the heaviest drinkers from the lowest social economic groups. So this is a specifically targeted policy that could help to reduce the gap in inequalities across the UK. That is such an important message that needs to be understood from the research that is coming out. This is exactly the solution that we want to see, because it does not unfairly penalise responsible drinkers across the board, be they from high or low incomes; it just targets drinkers who drink the very strong, cheap drink.
Dr Evelyn Gillan: I want to apologise if we have not made ourselves clear and if you are not clear about what policies would be effective in reducing alcohol harm, because we have such good evidence. Perhaps the focus on minimum pricing, which of course is a policy that has been passed by the Scottish Parliament and is still to be implemented, might have confused things. However, we know exactly what policies are going to be effective in reducing harm. Katherine has explained how minimum pricing would not be seen as classist or only attacking the low incomes; poorer people would be the biggest beneficiaries. However, we really do know the policies that will work. You have to increase the price of alcohol, reduce availability; we have just commissioned some research, which was published a few weeks ago, from Edinburgh University, which showed—and this links to health inequalities—that the number of neighbourhoods in Scotland that had the highest number of alcohol outlets had nearly double the number of alcohol-related deaths, and there was a social gradient to that. So we know what the policies are. We have known for some time that price, availability, marketing—if you do not put that in place, you will not bring about change. It is really down to whether people have the will to put in place the policies that are going to be effective.

Baroness Benjamin: Also, when I ask young people about why they drink, they all say, “Because I can’t stand the world I’m in and it makes me feel good”. That is something that you have to take in as part of the strategy as well. Without recognising why people drink, you will not solve the problems.

Dr Evelyn Gillan: Absolutely.

Q42 Earl of Stair: I will return to the EU strategy. What would be the added value of a new EU strategy as opposed to national strategies and/or the World Health Organization framework? Katherine, I know that you have covered a few points on that already, but I wonder if the others would like to add anything else. However, more importantly, in what ways should an EU strategy differ from the World Health Organization framework?

Katherine Brown: I will attempt to begin, and then my colleagues can help fill in any gaps that I do not manage to cover. As I mentioned before, the added value of an EU alcohol strategy is that the EU can work upon its mandate across the areas of trading and tackling cross-border issues that the World Health Organization does not have the mandate to enact. Indeed, member states’ actions can be undermined if there is not EU buy-in on strategies. I can be specific, which might be helpful if we have not given enough detail on our recommended policies. With regard to pricing, for example, an EU strategy could firstly acknowledge and accept the evidence base for the relationship between price, consumption and harm. We have already seen this being accepted by the World Health Organization, and have seen a report from the World Bank, and there is due to be a very comprehensive report from the OECD that acknowledges the relationship between price, consumption and harm that makes recommendations for pricing controls and minimum pricing as the most cost effective measures to be moving forward. An EU strategy could acknowledge this relationship and perhaps look at revising the EU tax directive to take into consideration efforts being made by member states to raise the prices through fiscal measures and taxation controls in their own countries—at the moment their hands are tied, because as Nick said, the tax-banded system is very complicated and we cannot tax all drinks based on their strength. Specifically, at the moment wine has a minimum tax rate of 0%. All these issues could be addressed to have a more comprehensive EU taxation system that member
states could then go on to implement as they saw fit within their own nations, and in response to their own national needs. We mentioned before that there is not a one-size-fits-all strategy, but that it is about giving Governments the tools so that they can then go away and enact the best policies available to them.

Marketing is another very important area, that is to regulate the promotion of advertising of alcohol, specifically with regard to protecting children and young people. We know that when children and young people are exposed to greater volumes of alcohol marketing, they are led to drink at a younger age and indeed to drink more than they otherwise would have done. Therefore this area needs to have a much greater profile. We recommend that the EU audiovisual media services directive is reviewed to establish greater protections as regards the marketing of alcohol to children and young people and to allow member states to enact marketing restrictions that are not undermined by cross-border issues. With regard to availability, the third best-buy or most cost-effective policy area identified by the evidence base and championed by the World Health Organization, is that an EU directive could establish a minimum purchase age, for example at the age of 18, which could be a very helpful step forward.

We could also look at the EU services directive, which could be reviewed to enable licensing authorities to fully recover the costs associated with enforcing licensing regulations through licence fees. Westminster City Council is currently challenging the EU services directive in this respect.

The labelling issue, which we have also discussed, is again an area where the EU’s powers could effect action across the region, in the sense that an EU requirement could be introduced to establish that all alcoholic beverages list their ingredients and allergy and calorie information in line with the current EU regulations that are in place for the provision of food information to consumers. I personally believe that from a consumer rights perspective, it is simply not fair that we should not know what the ingredients are of something that we are putting in our bodies and our mouths. Certainly, if this thing that is being consumed on a regular basis can give people cancer, it is only fair that EU citizens are made aware of that. That is an issue that should be given greater priority in the coming EU strategy.

Similarly, with drink-driving, a harmonised blood-alcohol content legal limit across the European region would certainly tackle the issue that we have currently in England and Wales where our current legal limit is the highest in Europe aside from Malta. There does not seem to be a sensible justification for that, to be honest, and I am very pleased to see that Scotland is looking at the evidence and changing this law before Christmas. On workplace policies, there could be an encouragement to have a uniform approach to workplace policy with regard to occupational health departments and design of interventions and sharing best practice of delivering brief interventions and screening and advice in a workplace environment. Part of the largest burden that we are experiencing across the European region at the moment due to alcohol is due to lost productivity, both in the workplace but also among working age adults. While we have seen current action directed towards children and young people, the really huge burden we are seeing here is on the working age population, which I am sure Nick will be able to elaborate on. There is currently no strategy to target them, because we do not have one in place.
Alcohol Focus Scotland, Institute of Alcohol Studies and Professor Nick Sheron, University of Southampton—Oral Evidence (QQ 33-51)

Finally—I will hand over to my colleagues after I have explained my shopping list—monitoring and surveillance: data collection is absolutely crucial, not only to inform policy but also to evaluate its effectiveness. The EU could lead with regard to data collection and introducing some kind of sense or harmonisation when it comes to having similar indicators across the European region—whether we look at having similar methodologies of measuring alcohol harms, or maybe even a similar unit system across the EU, so that we could have European drinking guidelines or a labelling scheme across the region, that could be understood by all EU citizens together. I think I have probably done enough talking, so I will hand over.

**Dr Evelyn Gillan:** I do not have anything to add.

**Professor Nick Sheron:** I will add one point. Katherine made a very important point about the economic impact of alcohol consumption. A combined report was issued from the World Health Organization and the OECD recently, which looked at very simple sums. It reckoned that alcohol costs OECD member countries 2% to 3% of GDP. If you take into account third-party harm, you can probably double that to 4% to 5% of GDP. Just the back of a postage stamp calculation is that I reckon that that works out at about £38 per week for every UK taxpayer. So these are very substantial costs of alcohol to society, and as Katherine said, these costs largely in terms of absenteeism—people not turning up for work because they are hung-over or they have an alcohol-related problem—or presenteeism, where they turn up for work on Monday morning but their brains are not there. This has a significant impact. You only have to look at some of the countries in eastern Europe with very high alcohol consumptions to see the impact.

**Earl of Stair:** Two words seem to emerge from this: one is cost and the other is marketing. It seems to be fairly recurrent. Thank you very much.

**Q43 Lord Morris of Handsworth:** We just heard from the Professor about the importance of good data collection—I think that is quite important. Is there sufficient European data on which new EU policies could be based? Is there a need for more standardised data collection to facilitate cross-country comparisons?

**Dr Evelyn Gillan:** There is definitely a need; we have a language problem, for a start, which makes it difficult if things are not translated to know what is happening in different countries. Nick will know more about this, but I understand that we do not have a standard European definition of alcohol-related death. So there is a whole range of data that it would be very useful to know, as regards outlet availability—how many outlets are there in Europe—consumption trends, harm trends, and sometimes it is quite hard to pull all that together. We could definitely do a lot more on that.

**Professor Nick Sheron:** I agree with that. My answer is that yes, there is sufficient data now on which to base alcohol policies. As Evelyn said, we have an absolute mass of data; we know which policies work, but we just have this problem, with which you will be very familiar, of the gap between the evidence and policy. That is something which is in all fields, and particularly the health field. Yes, data collection could definitely be improved. I have three very quick examples. One is that I have already shown you how population survey data does not get where the problem is. What we need are surveys based in hospitals, of consumption of people who drink at the very heavy end, and that simply is not there, or certainly not in a systematic way.
We have a big problem in eastern Europe with unrecorded or illicit alcohol consumption—a lot of home-produced alcohol does not figure in any of the statistics. So when you start to look at the correlations between population-level consumption and, for example, liver mortality, you have a problem in those countries, because you do not have as tight a relationship as you would expect. We need a much better handle on unrecorded or illicit alcohol consumption. The third and by far the most important example is the following. We have talked about marketing, and I am sure we will come back to it, but the UK was the first country in Europe where the advertising spend on below-the-line marketing—in other words, not traditional television and publishing marketing but digital, social media and all that—exceeded the traditional advertising spend. So, at the moment, we have an issue where alcohol marketing to children is being narrow-cast into their bedrooms through the internet and social media, and we have essentially no data on that at all—none. That is an absolute gaping hole. It is really not difficult to solve, but you need very directed approaches.

Katherine Brown: I agree with everything that Evelyn and Nick have said, but some countries do better than others at monitoring and collecting data with regard to alcohol consumption and harm. However, there are definitely gaps with regard to monitoring levels of harm, particularly harms to third parties: rates of alcohol-related domestic abuse, child abuse, rates of foetal alcohol spectrum disorder, and as Nick said, rates of exposure of alcohol marketing and advertising to children. Therefore this is certainly an area there in which more resource would be of great benefit to public policy and measurement of effective public policies, moving forward. I would certainly welcome more resources being channelled into better data collection and monitoring through a new EU strategy.

Lord Wasserman: Although everybody says that we want more data, you are all clear that we do not need more data before we begin. Some people say, “We’re not quite sure, it’s a bit tricky”.

Q44 Viscount Bridgeman: I think we have already covered much of this next question. The gaps in the evidence on levels of consumption and pricing, advertising and availability—I do not know whether you can add anything to that. However, the fourth part of the question is on harm caused to others than the drinker. You referred to third-party damage; would you like to expand on that?

Katherine Brown: Yes, of course. To reiterate what we said earlier, there is robust scientific evidence to establish what the better way forward is regarding alcohol policy. We know that tackling price, availability and promotion as part of a comprehensive alcohol strategy will reduce levels of harm. However, there are gaps with regard to monitoring and data collection to evaluate the effectiveness of strategies. Certainly, with regard to identifying how much of an impact alcohol has, not just to drinkers—in many countries it is still not established how much people are drinking and how many people are experiencing adverse health conditions due to alcohol—but there are gaps with regards to the burden of harm caused to people other than the drinkers: to children, families and society. If we can quantify that burden and that harm, that will produce more evidence and more incentive to Governments to take action and implement effective policies, and that is where better data collection will be able to help.

Dr Evelyn Gillan: I think Katherine is absolutely right: where we have the gap is harm to people other than the drinker. We did a national survey in Scotland that showed that one in
two people reported being harmed in some way as a result of someone else’s drinking, and one in three people had a heavy drinker in their life. People experiencing harm from someone else’s drinking was entirely unrelated to whether the person that was affected drank or did not drink. Sorry if I have not made that clear. So if one in two people had experienced harm as a result of someone else’s drinking, whether or not they themselves were a drinker, a heavy drinker, a moderate drinker or a non-drinker, was immaterial—they still experienced the harm. That takes us into a different territory. You quite often get debates when Governments try to identify the kind of alcohol policies that will be effective and work, and people will say, “It’s about individual choice”—there is a very individual agenda sometimes. However, what is not often talked about is the harm that alcohol causes to people other than the drinker. Our survey was based on a much bigger survey that was carried out in Australia, which found even higher numbers—I think that two-thirds or 70% of the Australians who participated in the study had been negatively affected by someone else’s drinking. That is on a spectrum from low level harassment to violence, so it is a big spectrum. The other important finding from the Australian study was that once you took account of the harm that alcohol causes to people other than the drinker, the cost of alcohol harm doubled. So this is a very important emerging area and it would certainly be useful to shine more of a light on that and help people understand, as Katherine says, that addressing alcohol harm is everyone’s business. We should all be concerned with that.

**Q45 Lord Blencathra:** This has probably been covered, so please feel free to rush through it. Is EU funding being used to its full advantage in this area? Should more or better use be made of existing data collected by the major EU research projects such as AMPHORA or Alice Rap, and what more could be done to improve co-ordination of research across Europe?

**Professor Nick Sheron:** I think we have covered this. However, I would just like to say that there is a perfect role here for the science committee. That committee was set up as an arm of the EU alcohol forum, and is a group of experts who give the definitive verdict on the evidence. They gave the definitive verdict on alcohol marketing and children, and on alcohol in the workplace. However, I understand that their funding has not been continued, which is a tragic shame, because even the official report of the alcohol strategy outlined the very important role that committee have. There is a role here for the Science Committee, perhaps reporting to CNAPA or to the Commission itself, not only giving a verdict on establishing the evidence base and stamping its imprimatur on it, but outlining where the research gaps are. We have illustrated how there are huge areas where we need more focused research and focused data.

**Lord Wasserman:** Our witnesses last week said that there were 37 projects for some €15 million, which, however, was part of an enormous budget of €7.5 billion for health-related research. We were talking about this. If you build a hospital to deal with cancer, it takes time, and that is part of the budget. She mentioned 37 and €15 million. Do you know about these numbers?

**Katherine Brown:** The data that I have available now show that of the spending for the total EU Health Programme between 2008 and 2013, the spending allocated to alcohol amounted to 3%, and less than 1% of the budget for health under the seventh research programme is that FP7—was dedicated to alcohol. So without going into details about what the figures were, we can establish that the amount of research funded does not reflect the volume of harm that is experienced. That is my personal conclusion.
Q46  **Lord Sharkey:** We have heard previous witnesses tell us that indicators should be established right at the beginning of any new strategy, and I think I heard you say that that is a good idea as well. However, are indicators a reliable tool to monitor the success of a new strategy, and if they are, to what extent should those indicators be based on or the same as the benchmarks set by the WHO? Are there any other indicators not present in the WHO set that you think should be added to any indicators that the EU chooses?

*Professor Nick Sheron:* In terms of the indicators, there are various things that you can measure. One of the things you can measure is harms, and I have outlined the reason why I think that liver disease mortality and admission rates are a very good cipher for alcohol-related harm. We have a real problem though, because only around about 25% of the mortality is linked to diseases with “alcohol” in the title of the disease. If somebody is admitted to hospital with alcoholic cirrhosis, it has an ICD-10 code, and that data is recorded. If somebody is admitted to hospital with breast cancer—and between 5% and 10% of breast cancer is alcohol-related—it never has the word “alcohol” linked to it. The same applies to hypertension and so on. So these are the partially attributable diseases. The only way you can measure those diseases is with measures of population level consumption. So a piece of work needs to be done which links those attributable fractions. Therefore there is that, mortality, hospital admissions; and the other thing I would really like to see, as I mentioned before, is alcohol consumption in vulnerable groups, looking at these smaller segments of populations that do not appear in surveys. The final thing—these are just examples that I just noted down—is the exposure to marketing. That is somewhere we really need organised data, Katherine, across the EU. So some of those things are measured by the World Health Organization at the present time—some of it has very good data—while with others there are gaps in our knowledge.

**Lord Sharkey:** Can I press one point, which is that the previous strategy had no hard indicators in it—no systems of measurement. There were three reviews of the strategy, none of which looked at any hard data. Can you say whether you agree that any new strategy should have built into it from the beginning systems which allow hard data to be measured?

*Professor Nick Sheron:* That is fundamentally important, and I would go further than that. I would say that you want a target to aim at. The target we should be aiming at in Europe is for all European countries to have the liver mortality and alcohol-related mortality of the best in Europe. That is clearly a counsel of perfection. However, we should be aiming towards that in time—it might take decades—but we should eventually be able to get there.

**Baroness Benjamin:** Do you have any evidence that there is an increase in Crohn’s disease among young people?

*Professor Nick Sheron:* I am afraid that I do not have the data to answer that question.

**Q47  Lord Wasserman:** Many years ago, when I was in the Home Office as an official, I was responsible for gambling and gaming, and we used to work very closely with the industry—we brought them in, discussed how we would deal with it if there was a real problem, and so on. However, when it comes to this, there seem to be very strong feelings that we should not have the industry anywhere near us when talking about policy formulation or implementation. I wonder whether your view about bringing the industry in to discussions...
about the EU strategy and policy formation in general is very strong—that the industry should not even hear about it until it is published in the Times.

**Dr Evelyn Gillan:** The important thing is that of course you have to talk to the industry—of course they are a stakeholder. No one is suggesting that we ignore them completely. However, we have to be clear about where the industry’s expertise lies. We also have to be clear about potential conflicts of interest. We would certainly abide by the WHO guidelines that say that the industry should not be involved in setting public health goals. It should not be involved in education, because it is neither a health professional nor an educator. I know nothing about bottling whisky, so I would not come here and try to talk to you about packaging of alcohol products, the selling of alcohol products or anything. That is not my area of expertise. However, not only do they not have expertise in health or education, but they have a conflict of interest. We have to be very clear that from the public health community’s point of view, we are here to reduce consumption of a harmful product. My job is to put myself out of a job. The industry’s job is to keep it in a job. So you cannot really avoid that conflict of interest. However, where the industry has a role is, when you have agreed with all the necessary experts and have looked at the evidence about what the public health goals should be of a policy, how you then look to implement that. For example, the industry has a clear role in server training, labelling—there are a number of things that are to do with its role as producers, marketers and sellers of alcohol, and that is what the role should be confined to. It certainly should not stray into territory that it does not have expertise on.

The other concern is that when we allow the alcohol industry to the health policy table, we have quite good evidence that they use that opportunity to try to influence the policy outcomes to those outcomes that favour their business interests. For example, it would want to see the policy forum focus on education, binge drinking, young people, but it would not want to look at reducing overall consumption, availability, marketing or price. So let us work with the industry and talk to it about the things that it knows something about. Where it could really help us would be in making its sales data available. We have asked repeatedly: if the industry really wants to help achieve public health policy goals, make the sales data available. That would be very helpful for us.

**Lord Blencathra:** Did one of you say that the industry is keen on unit pricing?

**Professor Nick Sheron:** No; I said that the industry said that it was keen on policies that were heavily targeted at the most heavy, harmful consumers. However, when presented with a policy which does exactly that, it is fearsomely opposed to it.

**Q48 Lord Sharkey:** The FCTC mandates no contact with tobacco companies at policy level. Would you like the same thing to apply to the alcohol industry?

**Dr Evelyn Gillan:** Yes; it is a good protection. In the climate we are in at the moment, where people are becoming increasingly concerned about democracy, the role of global corporations, their influence on policy—which has been causing a lot of concern—I think it is entirely legitimate to say that the alcohol industry should not be at the health policy table. However, it is also appropriate to talk to the industry when we come to implement policy.

**Lord Wasserman:** Of course the industry should not be at the table, if by “at the table” you mean that it should not be writing the policy. However, surely in implementation of the policy, too often Governments introduce legislation that is unimplementable, or which has
problems. So it is not a bad idea if at some stage, before you introduce a new law, to find out whether it is implementable and what the cost of implementing it is. So I do not think that there is a real problem. People say, “Well, if they’re there, they’ll influence—that means that Ministers will simply listen to them”. Of course Ministers have to listen to it as much as to anyone else, I would have thought, and it is very dangerous to keep it completely out of it for fear that it will be too persuasive. If you have officials who know their stuff, and here is the evidence you put in front of them, no matter what the industry says, that will be the evidence, I am not quite as worried about that.

**Dr Evelyn Gillan:** I appreciate that; that is certainly a view—but we can only go on our experience. For example, if we look at all the alcohol policies in the UK over many years, it was quite clear that the policies that were being proposed were those that would not bring about the kind of change that the evidence suggested was necessary. For example, when we were banning smoking in public places industry representatives said that it would be unimplementable, catastrophic, and so on—but that did not happen. Therefore there was a vested interest in suggesting that a policy was not going to be effective. That does not mean to say that you do not take into account their views, that you do not speak to them or listen to them, but we have to understand that they might be coming at it from a position which is protecting vested interests.

**Q49 Lord Wasserman:** Competition means that people have interests and we have to take them into account. Shame on Ministers who do not give leadership—that is the whole point about the Government: it is about leadership, not just writing down what they have. The other issue is, surely those companies have long-term interests, as well as short-term ones, and surely they see what is coming; working with public health people to ensure that there is not too much damage is in their longer-term interest, otherwise some pretty terrible, draconian policies will put them out of business completely.

**Professor Nick Sheron:** I have to declare an interest here, because I was a member of Andrew Lansley’s Public Health Commission and was a founder trustee of the Drinkaware Trust. I was also the health co-chair of RDAN and a founder-member of the EU Alcohol and Health Forum. All those are arenas in which both health and industry come together. I believe in speaking to representatives of the industry. There may be a value in exposing the discussions to a wider public, because otherwise they take place behind closed doors. It would give you a chance to counter the evidence. I will say that in all those discussions I have met many members of the drinks industry who were quite committed to doing the best they can to reduce alcohol-related harm, but I have not met a single one who would put the health of the population above the health of their company.

**Lord Wasserman:** That is fine, because their business is to maximise shareholder value and not to keep people healthy—we have to do that.

**Professor Nick Sheron:** Evelyn’s point about conflict of interest is absolutely correct, and there is no alignment between the interests. That can sometimes get lost. I will give you an example. There was a big thing in the report of the Alcohol and Health Forum about the value of self-regulation, and the best example they give of that is self-regulation in alcohol marketing. Therefore the big thing that was produced at the Alcohol and Health Forum was the ICAP self-regulatory statutes, which states that at least 70% of the audience for alcohol marketing had to be adults. Slide 25 is the word-for-word pledge of ICAP, which is: “ICAP members commit to take independently verifiable measures to assess the exposure of
children and young people across all print … to ensure our products have a minimum 70% adult audience”. So the total advertising audience is a bit like the cake in slide 26, and if 70% is consumed by adults, 30% is consumed by people who are not adults—and they are not ET or aliens. Those people are children. Therefore children occupy 30% of the share of alcohol advertising. The problem is that in Europe, as slides 27 and 28 show, children are only 20% of the population, so they must be seeing more alcohol marketing than adults. It is worse than that, because when you measure the audience share, you do not count 0 to 4 year-olds, and I cannot believe that huge numbers of four to nine year-olds are watching alcohol advertising as well. So when you add all that up, probably 10% of teenagers are seeing 30% of the audience share of alcohol marketing. In other words, it is perfectly within ICAP regulations for children to see three times as much alcohol marketing as adults, but that is presented as a major development—a major benefit.

That is just one example of the sorts of things that the industry does. The other thing that I am very concerned about in this arena is the unfairness of the situation. I am presenting data to you today, and I have done my very best to show you the raw data. If I tell you something that is untrue, I will lose my job. If somebody from the drinks industry stands up in the Alcohol and Health Forum and says something that is palpably not true, there is no sanction. That is very unfair in this arena. And it is worse than that, as well. There are also organisations that are paid by the tobacco industry and the drinks industry to produce quasi-scientific data—in the same way that the scientists might produce scientific evidence—and policymakers get confused. There is no imprimatur on that evidence; there is nothing to aid MPs and Members of the House of Lords and policymakers as to which data to believe. The media do not help either because they always like to have an argument, so they always have one side and the other side, then present the evidence on both sides as though it was of equal value, when it is not. That is a real concern I have about the involvement of, for example, the drinks industry in discussions. If we are going to have those discussions, let’s have them on an equal basis. Let us have everybody stand up and swear that what they are going to say is the truth and nothing but the truth. If we had discussions on that basis, the world would be a very much healthier place.

Q50 Lord Judd: You referred to the role of public health and those working it the realm of public health in influencing policy in the future. However, there are of course also a large number of non-governmental organisations that do valiant and very effective work, both directly and indirectly on the consequences of alcohol consumption. Do you think that all the experience that has been gained by this work, both by public health officials and the non-governmental organisations, is being deployed to the maximum effect as regards informing and influencing government policy? It seems to me that there is a huge responsibility on those who have the insight to make sure that government faces up to the realities. I also happen to believe—and would be interested to hear what you think—that in particular if these non-governmental organisations get involved in influencing and speaking to government, that will do a great deal to inform the public. They have an appeal and a relationship with the public that an awful lot of other people do not have.

Dr Evelyn Gillan: I will respond briefly and then pass on to my colleague Katherine. I agree completely. NGOs and public health have a critical role to play. We are the Cinderellas—we are very poorly funded. Regarding the example that Nick just gave you about the unfairness of one sector—the commercial sector—being able to make claims for something that would not stand up to any scientific scrutiny, we have to be very careful. We are in receipt of public
Alcohol Focus Scotland, Institute of Alcohol Studies and Professor Nick Sheron, University of Southampton—Oral Evidence (QQ 33-51)

funding—we take that very seriously—but we also take very seriously our role as health advocates. At the end of the day, our role is to ask what are the decisions and policies that are going to advance the public good. That has to inform any position we take. So we look at the evidence, talk to the people we work with, and say, “Is this policy going to be in the public interest? If it is, can we support it?”, because we are public interest bodies. Where it becomes difficult in terms of influencing government is whether you have a Government that wants to hear from NGOs. I read something the current Chancellor recently said, that charities needed to be quiet, basically, because they were threatening the free market ideology, or something. That is quite difficult. If you are working with limited resources and do not have the financial benefits that anyone else who works in the private sector has, you are there for a public interest purpose and you have to really keep your integrity as far as you possibly can. That means that you should not be partisan or party political; you should support any party that advocates policies that have a public interest purpose. However, that also means that if the Government of the day promote policies that are not in the public interest, you have a duty to say, “This is not in the public interest”. The only way you can hang on to your integrity is to have the same message, regardless of who is in power, to seek to get that message to the policymakers—you are absolutely right—and sometimes the politicians want to hear it, and sometimes they do not. Quite often, other more powerful corporate interests are more likely to have the ear of the decision-makers than poorly funded charities. But of course, what you are saying is absolutely right. They have a public-interest purpose. We are not doing this for private gain, but because we genuinely believe that we can do things better and differently, and that that action will result in a better society.

Lord Judd: I have to declare an interest, because I have worked an awful lot of my life in the voluntary sector. Would you agree that there is a sort of maturing in the voluntary sector, and there has been now for a couple of decades, which says that it is to betray your cause if you limit yourself to treating the symptoms, masking what is wrong as distinct from facing up to what is wrong, and using the authority of your engagement and experience to make sure that those of all parties, of course, are taking seriously the issues and formulating policy in an informed way.

Dr Evelyn Gillan: I could not agree more with you. I have just written a piece for the Scotsman newspaper on exactly that subject, saying that we are not here just to deal with the detrimental effects of poverty, health inequality and environmental degradation. That is not our role. It is part of our role, but not our only one. We have to be concerned with the root causes. We have a very important preventive role, which we have to take seriously. Therefore for Government ministers to try to silence charities and NGOs that take that seriously and want to talk about root causes, asking what are the causes that lead to these problems, is very worrying.

Katherine Brown: Evelyn has done an excellent job of capturing the situation regarding NGOs, government officials and policymakers. If we apply this situation explicitly to the European alcohol strategy, at the moment, NGOs and civil society at large across Europe are relatively hamstrung as regards what they can do to fulfil their role to facilitate dialogue between researchers and policymakers and ensuring that evidence to support effective policy interventions is easily accessible and easy to understand for policymakers. That being so, at the moment we do not have a space that is free from commercial or vested interests to discuss scientific evidence regarding alcohol policies, and where the industry operators
are not present. The only space that NGOs have formally to discuss evidence with policymakers is the European Alcohol and Health Forum. I am not saying that the forum does not have its place and that there should not be discussions which involve economic operators, but a separate discussion needs to be had that is free from vested interests so that people can talk about hard science to inform policy decisions in an environment that is not clouded by some of the more dubious claims by industry-sponsored think tanks whose main ambition is generally to cast doubt on the robust scientific evidence—and it seems there is big business in casting doubt.

Q51 Baroness Benjamin: The pressures of modern living are great on all of us, especially on young people. What are your views on the media? We have talked about advertising, but I am referring to television programmes such as soap operas, which are watched by anything between seven and 12 million people. Whenever there is a problem, you go down to the pub—you solve it in the pub. So you are telling all those people that the way to solve the pressures and worries in your life is to have a drink. They might deal with alcoholism—a lot of the soaps have already dealt with that—but every single episode you see, someone is down at the pub. How do we get the producers, the writers, and all those people in the media, to work with you and emphasise the points that you have just made so eloquently this morning?

Dr Evelyn Gillan: Again, I totally agree with you. One of the problems that we have—and I have even seen it over my lifetime—is the normalisation of excessive drinking, even from when I was a child. When I look at the world that my sons are growing up in now, it is very different even from the world that I grew up in. There is a major concern about how normalised and how everyday excessive drinking has become. I was speaking to my own son about this and he said, “It is really hard, Mum. Our generation believes that going out and drinking is how you have fun”. That was not how we had fun. We did a bit of that, but it was not the hallmark of our socialising. That is what has changed. We have moved into this very different space in which excessive alcohol use is very normalised. I was speaking to a young Italian student who had come to Edinburgh, who said that she struggles to come up with reasons to not go out drinking. We have allowed a situation to develop in which nobody seems to question that parent-teacher associations made 8,000 applications for one-off licences in the UK this year. When did parent-teacher evenings have to offer a glass of wine? Even cinemas do nowadays. There is virtually nowhere you can go which does not sell alcohol now. That is also particularly hard for people in recovery. Someone who is a recovering drug addict said to me, “Thank God I’m not a recovering alcohol addict. I do not know what I would do. Every day you walk down the street and the supermarkets are advertising it, you get a bus and there’s an advert, you put your computer on and it’s there, you watch the telly or go to the cinema—it’s everywhere. At least if I want to go to taking drugs I need to seek out my dealer”. Therefore with this normalisation of excessive drinking our environment has changed beyond all recognition. We, the adult society, have to take some responsibility—we have allowed that to happen.

The Chairman: Thank you very much indeed. It is half past 12 and we have taken a lot of your time. This has been very helpful and very comprehensive. As I said at the outset, if there is any supplementary evidence you think will be helpful, please do send it to us, but many thanks indeed.
Evidence Session No. 1

WEDNESDAY 29 OCTOBER 2014

Members present

Baroness Prashar (Chairman)
Baroness Benjamin
Lord Blencathra
Viscount Bridgeman
Lord Faulkner of Worcester
Lord Jay of Ewelme
Lord Morris of Handsworth
Lord Sharkey
Earl of Stair
Lord Wasserman

Examination of Witnesses

Professor Peter Anderson, Professor of Substance Use, Policy & Practice, Newcastle University, Professor Petra Meier, Professor of Public Health and Acting Director of Research, University of Sheffield, and Professor Gerard Hastings OBE, Director of the Institute of Social Marketing at the University of Stirling

Q1 The Chairman: Professor Anderson, Professor Meier and Professor Hastings, a warm welcome to the Committee and thank you for your time. As you are aware, this session is open to the public, and a webcast of the session goes out live on audio transmission and is subsequently accessible via the parliamentary website. A verbatim transcript will be taken of the evidence and will be put on the parliamentary website. A few days after the session you will receive a copy of the transcript to check for accuracy. It would be very helpful if you could advise us of any corrections as quickly as possible. If after this evidence session you wish to clarify or amplify any points made, or have any additional points to make, you are welcome to submit supplementary evidence to us. It would be helpful if you could introduce yourselves and say a little about your areas of research, and then we can get into questions. I will start with you, Professor Anderson.

Professor Peter Anderson: Thank you very much. Good morning, everyone. My name is Peter Anderson. I am a professor of public health and addiction studies at Newcastle University. My main areas of work are setting up and managing large, European-funded projects in the areas of alcohol policy and addiction policy. I used to work with the World
Health Organization, where I set up the first European alcohol action plan, and I worked very closely with the European Commission in setting up and implementing bits of the strategy on alcohol.

Professor Petra Meier: My name is Petra Meier. I am a professor of public health at the University of Sheffield, where I lead a fairly large team of researchers who are mainly in the business of appraising policies on alcohol and other public health concerns, for the British Government but also internationally for European Governments, the Australian Government and others. The main areas that we have looked at so far are taxation, minimum unit pricing, availability policies and screening and brief intervention issues.

Professor Gerard Hastings: I work at the Open University Business School and Stirling University in Scotland. I have an interest in what has come to be termed industrial epidemics. These are problems of public health that are driven by commercial interests—tobacco, alcohol and food are the obvious examples. I have an interest in how those products are marketed and the impact that has, particularly on young people. There is now a good evidence base to show that in each case they have a significant impact on young people. The second part of my work that will interest the Committee is a project that we just completed last year to produce this: *Health First: An Evidence-Based Alcohol Strategy for the UK*. That did not involve government or industry, just the NGO and public health sectors, which came together over a year to thrash out what they think the key issues are that should be dealt with in order to tackle the public health problems of alcohol. I will leave a copy with the Committee. You might find it a useful source material.

The Chairman: When you say independent, is it mainly for the UK?

Professor Gerard Hastings: It is for the UK. It is independent of vested interests on the commercial side. The Government might have their own best interests that they want to take forward. It was deliberately set out to be completely apart from that so that we could think—blank sheet of paper—how we would tackle this problem. There is a massive problem. It needs to be tackled. What are the key levers that could be used to try to deal with it? During today’s session we will talk about some of those.

Q2 The Chairman: Good. Thank you very much for that introduction. I will start off with a general question. What in your view are the achievements of the EU alcohol strategy from 2006 to 2012?

Professor Peter Anderson: I actually wrote the background evidence-based report for that strategy, which was a report called *Alcohol in Europe*, which was funded by the European Commission. Unfortunately, a lot of that evidence did not get through into the strategy itself. The strategy has to be judged on whether or not it has met its broad aims and objectives. Its broad aim was to reduce alcohol-related harm. It had a number of objectives set to reduce alcohol-related harm. On the available evidence, one would have to say that it has not met its broad aims or objectives: that is, there is little evidence that it has had any impact in reducing alcohol-related harm in Europe. In fact, during the time of the strategy one could say that there has been a negative consequence in that alcohol-related health inequalities within the European Union have actually increased: there have been much greater increases in consumption and harm in the eastern part of the European Union than in the western part, leading to a widening of health inequalities. There is no doubt the strategy made a lot of noise and brought a lot of people together, but if you judge it in terms...
of whether or not it has had an impact in reducing harm, which was its main goal, one would have to say that it has not achieved that.

The Chairman: Are there variations in European countries? You are looking at the global European picture, but are there differences between countries?

Professor Peter Anderson: Yes. If you look over the past 10 to 20 years, there are different trends in changes in both alcohol consumption and alcohol-related harm. The group of countries that have had the biggest reduction are the southern European countries. These were the countries that started out historically with very high levels of consumption and harm. Primarily through changes in social structure, moving from a more rural to a more urban-based lifestyle, consumption and harm have come down. In the western European countries, there have been mixed patterns between the countries, but in general some countries have either been stable or have shown a slight reduction, some have shown an increase, and then in the eastern European countries particularly in recent years we have seen this big increase.

Professor Petra Meier: Peter has given you the main conclusion that I would make as well: that in terms of harm reduction it has probably not achieved very much. What the strategy lacked was a clear focus on how to achieve change. It said that it would do all sorts of things, but there was nothing in there that was clear, action-focused messaging. You asked us to reflect on the differences from the WHO strategy, and there you see how changes are going to be achieved in much clearer terms.

Professor Gerard Hastings: To my mind, one of the big gaps in the EU strategy is that it has not dealt with marketing in anything like an effective way. The reality is that with alcohol there is a massive industry that has a vested interest in selling as much of its product as possible. Indeed, wearing another hat—if this were a fiscal committee, for example—we would be saying, “Absolutely. That is what it should do. It should drive growth, it should look after shareholder value, it should look after the interests of its investors. Its job is to market its product as effectively it can”. When we wear a public health hat, however, a different set of issues comes to the fore and a different set of priorities comes out. That has been completely ignored. Indeed, the alcohol industry has been absolutely cheek-by-jowl in the production of this strategy and has been involved all the way through with the policy formulation that has flown from it. It is not surprising that it does not deal with the very thing that is driving this epidemic, which is the marketing.

Within Europe, however, there have been some honourable exceptions to that. For example, France has a very interesting take on marketing, using something called la loi Evin—Evin was a man who shepherded it in in the early 1990s. Essentially that says, “Yes, you can market your products but you stick to your facts and you tell those facts to adult drinkers”. It is very simple. It protects children, it stops any bending of the truth—any suggestion that alcohol is good for you, for example, any suggestion that alcohol is cool or fashionable or all those ways in which celebrity endorsement can make young people think that this is a very attractive lifestyle choice. You stick to the facts. You tell them what the alcohol is, its provenance and strength and so on, but that is it. So you advertise but it is legal, decent, honest and truthful.

The Chairman: When did France adopt that?

Professor Gerard Hastings: In 1990.
The Chairman: Has it worked? Have any studies been done on its effectiveness?

Professor Gerard Hastings: Yes and no. The French would argue very strongly that it has. I think the Anglo-Saxon model would say that they have not evaluated it properly. But there is no question that if you look at what has happened in France over the past generation, they have greatly improved their alcohol situation, whereas ours has deteriorated, and la loi Evin must be part of that.

The Chairman: Is France the only country in Europe that has done that?

Professor Gerard Hastings: Yes.

Professor Peter Anderson: There is some more positive evidence that shows the impact of la loi Evin in reducing alcohol consumption. One of the European projects funded by the European Commission did an analysis of what is called time series data, where one looks at data over a long period of time and then looks at the impact of the introduction of certain policies. When this was done for France, looking at the introduction of la loi Evin, there is strong evidence that it did lead to a drop in the levels of alcohol consumption. So there is an indication of its effectiveness.

There are other countries that have different models of advertising law. Finland, for example, has just introduced very effective laws to completely control advertising through digital media, which is now the media where most advertising, particularly to young people, goes on. It is introducing very tough controls and restrictions—and bans, in fact—on many forms of digital media advertising for alcohol.

Professor Gerard Hastings: I would second that, Madam Chairman. The digital arena is a massive problem as far as marketing is concerned. It has exploded in recent times. It would be perfectly easy to institute systems where children were not exposed to the digital marketing of alcohol. Those systems are not there at the moment. They can be instituted; the gambling industry has instituted them very effectively, particularly in North America. One thing this Committee could do very effectively is find out a great deal more about what is going on. We simply do not know what industry is doing to approach young people through digital media. I was an adviser to the Commons Select Committee when it inquired into alcohol, and one of the great successes of that committee was that it demanded information from the industry about what it was doing. That led to a lot of concerns about the way advertising was taking place. Since then, digital has blown up massively. If this Committee could begin to find out what industry is doing, particularly by talking to the ad agencies as well as the producers themselves, I think it could find out some very useful information as far as public health is concerned.

Viscount Bridgeman: Going back to France, would it be true to say that under the drink-drive laws in France, the limit is lower than in this country and they are very strictly enforced?

Professor Gerard Hastings: Yes, that is true.

Professor Peter Anderson: Yes, that is correct. Again, there is much evidence of an impact on reducing alcohol-related road traffic fatalities. In fact, many European countries have a lower level than the UK—0.5—and this lower level seems to be effective in reducing traffic fatalities.
Q3 Lord Sharkey: The strategy was reviewed in 2009 and 2013, and there is the COWI consortium report of 2012. My cursory reading of some of those is that they seem to lack the kind of hard harm-reduction evidence data that I would look for in any evaluation of a strategy. Is that a fair description of those reviews? Do you think that any future strategy should contain ab initio an evaluation method as we go forward?

Professor Peter Anderson: Yes, I fully agree that the reviews that evaluated the strategy did not look at hard data such as changes in levels of alcohol consumption and alcohol-related harm. I agree that in any future strategy they have to be integral and built in right at the beginning. These strategies are not just talking shops; they are there for a purpose. That purpose is to reduce alcohol-related harm. There are many ways of monitoring that. The World Health Organization, for example, has targets and indicators and ways of monitoring changes in harm. If there is a future strategy, those should be built in right at the beginning.

Professor Petra Meier: There also need to be goals in there so that it is clear what you are working towards. It would also help to frame the strategy with a public health frame of mind, which the current EU alcohol strategy does not actually have. In some ways it is interested in the economics, in some ways in health, and says that it wants to reduce harm, but it is all over the place. A new strategy could do a lot just by being clearer: is this about health harm reduction and, if so, how are you going to demonstrate whether or not it has been successful? So yes, I fully agree.

Q4 Lord Faulkner of Worcester: How does the EU’s alcohol strategy fit in with the efforts of international frameworks such as the World Health Organization in tackling alcohol misuse?

Professor Gerard Hastings: Not very well, I think, is the answer. A very good book was produced under the auspices of the WHO called Alcohol: No Ordinary Commodity. It was updated quite recently. That book goes through the policies that will be effective in reducing alcohol harm. Pricing and marketing are the key ones mentioned. These have not been dealt with. So we have a problem—Petra can speak to this better than I—in that the taxation of alcohol is farcical from a public health point of view. That needs tackling. As I have already mentioned, marketing has simply not been dealt with and that is because industry is far too close to the policymaking process. Peter rightly said that this is not a talking shop, actually, although it has become a talking shop. This is what is happening at a European level. Sadly, it has also happened on a UK level with the responsibility deals. We are trying to get industry to do two things at the same time that are contradictory: to look after shareholder value and give that absolute priority—it has to do that—but at the same time to look after public health. You cannot do both. The fox cannot run the chicken coop—not to the benefit of the chickens at least.

Professor Petra Meier: Just to add to that, 70% of all alcohol is drunk by people who drink over the recommended UK limits. I am sure that is fairly similar in other countries, or where limits are even stricter than ours that might be a larger percentage. How can you expect industry to want people to reduce their drinking to within drinking guidelines if that would take care of 70% of the alcohol market in the UK? It just cannot be done and that is why public health folk are unanimously concerned about industry sitting at the table as part of public health policymaking. Yes, of course, it has something to say about the economics and how things can be achieved, and it has a role to play to reduce the harm of the product it produces, but not in terms of a scientific, evidence-based discussion on harm reduction policy.
Lord Faulkner of Worcester: Would you like them to be treated in the same way as tobacco companies are, and excluded from any discussions about health policy?

Professor Petra Meier: Very much so.

Professor Peter Anderson: Coming back to the original question—matching the EU strategy with, for example, WHO strategies—the World Health Organization has a global strategy to reduce the harmfulness of alcohol. It has 10 points within that. That global strategy is matched by regional strategies throughout the world, including the European alcohol action plan, which follow those 10 points. It would make sense that if the European Union has a new strategy it tries to match that or at least be consistent with it, or identify the points where the European Union has competence that can support those same 10 action points in the WHO strategy, because then you get commonality and added value rather than different bits going off in different directions, everyone is going towards a unified theme.

Professor Gerard Hastings: There is another dimension to this. Tobacco was invoked, and that is an important comparator. If you look at what the WHO has done on tobacco, it has instigated an international treaty on tobacco—the Framework Convention on Tobacco Control (FCTC). One very fruitful way forward that should be considered is a framework convention on alcohol that puts together the policies that we know really work and enables Governments around the world—the Framework Convention on Tobacco Control is one of the most popular international treaties ever—and gives them a lead on what they can do. Incidentally, one of the key provisions of the Framework Convention on Tobacco Control is that industry is excluded from policymaking.

Lord Blencathra: Surely the two are not similar, tobacco and alcohol, in that there is no doctor in the world who says that a little tobacco is good for you, but all the medical reports I read seem to suggest that wine, or sometimes even other alcohol, in moderation—whether it is one glass of red or two glasses of white—is good for the body, the heart, blood or whatever.

Professor Peter Anderson: On this heart disease stuff, it is true that a small amount of alcohol can reduce the risk of what in medical terms are called ischemic events—heart attacks and certain types of stroke. It is alcohol—it is not wine or beer or spirits, it is the alcohol itself; it does not matter what you drink. But the evidence increasingly shows you need only a really very small amount to get this protective effect and that probably the protective effect is not nearly as big as the previous studies have shown. It may well be that it is relevant only for certain people with certain genetic types. In terms of public health, one tends to see it as a complete red herring; it is an irrelevance. It would matter in public health terms only if the country was to really dramatically reduce its alcohol consumption to almost 1/10th of what it is currently. In public health terms, it does not matter. If one looks at how the alcohol industry behaves in comparison to how the tobacco industry behaves, it comes back to the same problems, basically. The alcohol industry uses all the tactics that the tobacco industry used to try to muddy the science and to try to prevent any kind of effective policy being put into place. It is for these reasons that public health says that such industries cannot be sitting round the policy table. They have to be there when you implement and do things, but when you make policy, from a health point of view that policy needs to be made by public health interests.
Q5 Baroness Benjamin: Binge drinking, both here in the UK and across Europe, is not just a problem among young people. It is a much wider problem, involving both men and women—we know that. We have seen many recent cases, such as the increase in Crohn’s disease and liver disease, across the age range. With this in mind, what is your view of the two-year EU action plan, agreed on 16 September, on youth drinking and heavy binge drinking? Do you feel that this is too much of a narrow focus on the problem?

Professor Peter Anderson: The problem is that it is simply youth-focused. When you read the content of it, it is really about addressing young people. This is not the problem that Europe faces. The problem that Europe faces is heavy drinking—you are quite right, including binge drinking among the adult population. If you look back 20 or 30 years, normally what would happen as people aged was that they would start to drink less, but that does not seem to be occurring. As the middle-aged get older, they take forward the heavy drinking pattern and this is going to cause a lot of problems for the European Union; as that group goes on into older age, we will get more and more problems. The European Union is stuck with these big health problems. It is also stuck with the difficulties of being competitive from a productivity point of view in relation to the rest of the world. If it wants to do something about it, alcohol is just ripe for doing something. It is the adult population that we need to deal with. It is the adult population that we need to get to drink less. That results in two things. First, that is the way you get the quickest gain in health, the quickest reductions in premature mortality and in death, the quickest reductions in the costs to healthcare systems, and the best increases in productivity. If you look at the social costs caused by alcohol, almost half of them throughout the European Union are due to lost productivity. If we were able to help that middle-aged group of people reduce their drinking, inevitably that would help improve the productivity of Europe.

Professor Petra Meier: It does not make sense from an intervention perspective to focus narrowly on one group because the same policies would help across the board; whether it is advertising or taxation, the main driver is the availability of alcohol. They will reduce alcohol consumption across population groups. There is no reason to focus on binge drinking particularly.

Professor Gerard Hastings: I agree with what both Peter and Petra have said. It is too narrow in another sense, as well. One thing that is driving drinking in Britain and across Europe is the idea of social norms—what it is normal to do. There is a great danger that if you position this as a problem for a small section of badly behaving people, the rest of us can just breathe a sigh of relief about our own drinking. It is a massive danger: that we let ourselves off the hook. We all have to do something about this.

Baroness Benjamin: Do you feel that if we focus on youth drinking we will nip the problem in the bud because we are focusing on young people and looking at the outcomes that I have mentioned, such as Crohn’s disease and liver disease? Do you feel that prevention is better than cure if we do focus on youth? Are there any benefits to that?

Professor Gerard Hastings: It is not that young people are not important. They absolutely are important and we should be doing things for them. We should in that sense focus on them, but if we are focusing on them at the expense of all the other sectors of society, then no, because that will kick back. You very rapidly get into the hypocrisy of forbidden fruits—“We are going to drink but you should not”, that sort of language—and, again, tobacco has a
Professor Peter Anderson, Newcastle University, Professor Gerard Hastings OBE, University of Stirling, and Professor Petra Meier, University of Sheffield—Oral Evidence (QQ 1-12)

very good evidence base showing how this can not just be ineffective but can actually be counterproductive.

Baroness Benjamin: I think this question is trying to get at the mindset of the people who agreed this policy. We need to drill down to see if there are any benefits of doing so.

Professor Gerard Hastings: If you want to dig down to motives, what is the old saying from the “French Connection”? “Follow the money”. Industry loves this. In the very first internal document I saw from a tobacco company going back to 1950, the opening line was, “Children must not smoke”—love it. Philip Morris will happily jump up and down saying that children should not smoke, even at the same time as its financial future is utterly dependent on exactly that happening.

Professor Petra Meier: It is not just industry; it is also politically fairly uncontroversial that you protect young people from potentially harmful things. It is much easier to get popular agreement on policies that target young people compared to policies that might cost the average drinker a little more or restrict what they can do on a night out. It might be that the lowest common denominator that everybody could possibly agree on is youth-focused and just tackling binge drinking. Clearly you have the pictures in your mind of people on the street and not doing very well. That is probably an easy win to have.

Lord Jay of Ewelme: Why should focusing on the young be at the expense of focusing on others? Can you not do both, or all? Do you not need to do all of them?

Professor Gerard Hastings: That is exactly what we are saying: that is what you should do. The danger is that if you focus on just one—this has happened in the past with both alcohol and tobacco—all you do is demonise one particular section of society. Now, if that really is the problem, and the only problem, that makes sense, but it clearly is not, as Peter has said.

Lord Jay of Ewelme: If there are particular circumstances surrounding youth or young people drinking, is it not right to focus on them but on others as well?

Professor Peter Anderson: Correct. Of course you need to deal with young people, but if you focus just on young people you will not and cannot tackle the problem. This was the lesson of the tobacco experience. For some time in the whole tobacco history there was a focus just on young people, but this did not get anywhere. It was only when the focus started to be on everyone that you got that change. The difficulty with a focus just on young people is that the benefits are very long-term, whereas if you are able to help the middle-aged reduce their drinking, overnight as it were, you can get huge benefits overnight such as reductions in premature deaths and hospital admissions. From a policy and economic perspective, you get a much better return on your investment if you deal with adults. Of course, you cannot neglect the young people, but they have to be part of the whole strategy.

Viscount Bridgeman: I suppose one could say that the older people, the middle-aged people, are rather more set in their drinking ways than the young and are therefore more difficult to tackle.

Professor Peter Anderson: They do change. This is what all the evidence shows: that when you look at the policy approaches, the middle-aged also change. They do take note of the price of their drink, of how easy it is to get and of social networks in making changes. Yes, you can change things. People are not completely fixed in their ways.
Professor Peter Anderson, Newcastle University, Professor Gerard Hastings OBE, University of Stirling, and Professor Petra Meier, University of Sheffield—Oral Evidence (QQ 1-12)

**Professor Gerard Hastings**: Just to follow up on that, Madam Chairman, when the Health Select Committee did its inquiry it recalled a Health Select Committee inquiry from the early 1930s, which included the phrase, “We fear that beer drinking is going out of fashion”. So things do change.

**Lord Blencathra**: Forgive me, I am slightly more confused than normal. I was under the impression from the panel’s opening remarks and from what I had read elsewhere that the problems of drinking in Stirling, Sheffield and Newcastle were quite different from the problems of alcohol abuse in Oslo, Bonn and Budapest. The panel has just said that there is a common problem throughout the whole of Europe of middle-aged drinking, so can an EU alcohol strategy apply to every country, because they are common problems, or should the strategy simply tell each country to produce an independent national plan such as the one you have produced there?

**Professor Peter Anderson**: You need to do both. When you are looking at pricing and taxation structures, you must realise that there are certain things that only countries can do. There are certain things that Europe has to do, because countries cannot act in isolation to do what they would really like to do. Therefore, you need a common agreement across the European Union to do that, otherwise you get political blocks to those changes and the problem of huge changes in cross-border shopping. It is the same with advertising. You cannot as one country manage the whole issue of advertising and digital media on your own, because advertising and digital media too easily cross borders. There are many other examples. In areas where the European Union has competency, in my view it needs to do what it needs to do, and at the same time countries have to do what they have to do. You need both.

**Professor Gerard Hastings**: There is the dreadfully overused word “subsidiarity”: you devolve down to the sensible point at which we make the decision. Coming back to the strategy, we very much focused on the UK and an independent strategy, as I said, but we also see it as a model that other countries can take up and adapt to their own circumstances.

**The Chairman**: Thank you for that.

**Q6 Lord Sharkey**: I think you have answered the first part of my question in answering Lord Blencathra’s question. I was going to ask whether you thought that there should be a new EU alcohol strategy, but I assume that the answer from all of you is yes. In that case, given the EU’s limited competence and the role of the member states, what do you think the focus should be in terms of public health, crime, trade, taxation and the single market?

I would like to add a rider, if I could. I was struck by the evidence given to us by Lord Brooke of Alverthorpe, who said that he was worried about the contribution made by alcohol to the epidemic of obesity in the European Union and elsewhere, and he wondered whether this was something the strategy ought to take into account as well.

**Professor Peter Anderson**: An EU strategy needs to deal with the areas where the EU has competence and where it is not possible for countries to act completely alone: areas such as taxation, the common agricultural policy and warning labels. These are all areas where the European Union has competency, and it should act. If you talk to people at the country level, they feel desperate to have this European Union support, because it enables them to be able to be more flexible in the kind of policies that they can implement at a country level.
The thing about alcohol is that it affects so many diseases and conditions that if you deal with it you get co-benefits across an enormous range of health areas. The obesity one is important, although probably not that important, and it should be added to the list of co-benefits that you would get. There are calories in alcoholic drinks that add to your calorie intake, so if you reduce those calories, yes, you will get a benefit. It is probably not a major outcome—there are many more important and major health considerations—but it is an additional co-benefit.

Professor Petra Meier: What I would like to see in a strategy will not come as a surprise to you: it is about alcohol pricing. You obviously know the problems the Scottish Government face with the EU courts over the minimum unit price. The way taxation is currently legislated in EU directives is such that you cannot tax all alcohol by alcohol strength. Alcohol strength is the driver of harm, so it entirely makes sense to have something that is proportionate to alcohol content. You can do that for beer and spirits but not for wine or cider under current EU legislation. Several countries have tried to find ways around that, but it is not currently possible. I consider it a priority to remove those barriers and to get rid of the zero-rate taxation on wine. All other beverage types have some minimum threshold level that has been agreed, but not wine—for obvious reasons.

Professor Gerard Hastings: I would reinforce what my colleagues have said. The job of the EU is to act where it has competence and to ensure that in so acting it does not also hold countries back from doing what they feel is important. The EU has succeeded in developing those skills in the area of tobacco, for example. From our conversations prior to the meeting today, there are three areas where there are obvious possibilities of action. One is marketing. It is important first and foremost to constrain not the nature of marketing but the amount. La loi Evin in France is a good example of that. Taxation, as Petra has just said, has to reflect harm; it makes no sense any other way. Coming back to the issue of harm, consumers need proper information about this, and the best way of doing that is labelling products, just as we have done with tobacco. We need good, big, clear warnings. In health, first, we talk about a third of the label being given to warnings about the hazards of drinking. We have talked a little about the health-protecting aspect, but the cancer message is really quite grim: any amount of drinking, as far as we can now establish, increases your cancer risk. I do not think many people know that. Indeed, there is research evidence showing that people in Europe do not even realise that is the case. Yet they are buying and consuming this product.

Baroness Benjamin: Do you think they get that through advertising—having that drink, the Martini, the funny side, the humour? Do you think we need to have a big advertising campaign about the dangers of alcohol on the same level?

Professor Gerard Hastings: There is a lot of evidence that good public communication campaigns can have a big impact on public health, so I would say yes for tobacco, alcohol and food—on their own, no, but as part of a comprehensive strategy, absolutely. But the quickest and easiest way of getting information about product harm to the consumer is labelling on the pack. It is perfectly targeted, and as far as the public purse is concerned it is free; we simply require industry to do it—provided that there are careful controls on how it does that, because otherwise it will make it as bland and unreadable as possible, as happened with tobacco. You need to delineate exactly what the warning should look like.
seems very wrong to me that people are not properly informed at the moment about the hazards of drinking, just from a consumer protection perspective.

Q7 Viscount Bridgeman: My question in effect takes up what you have just been saying, particularly about the unit pricing, and your view, which was generally expressed at the beginning, that the marketing issue has largely been dodged in the report. What is your view of the evidence on these three issues: unit pricing, restrictions on advertising and marketing, and availability? To go on, what is the statistical interpretation of the evidence? Does the evidence support the predictions that have been made by the Sheffield alcohol policy model?

Professor Peter Anderson: The evidence is no longer debatable. There have been so many published studies, so many systematic analyses of all of those published studies around pricing, controls on availability and marketing. It is accepted from a science point of view that all these policy areas do work in reducing alcohol-related harm. Many authoritative bodies all over the world that have reviewed this evidence have come up with that conclusion. Petra can talk about her own model but of course the Sheffield model is not unique. There are other organisations that do modelling in similar ways and come up with exactly the same conclusions. The World Health Organization does modelling in a different way and it comes up with exactly the same conclusions. At the time of the United Nations High-Level Summit on Non-communicable Diseases in 2011, it produced a report on what it called the “best buys” for health policy. The best buys for alcohol policy were taxation increases, bans on advertising and restrictions on availability. The OECD will be producing a very comprehensive modelling report in January next year looking at the impact of a range of policies on reductions in consumption and harm and savings to society for all OECD countries, with, again, exactly the same conclusions: minimum unit pricing, bans on advertising, restrictions on availability all work and will all work in reducing harm.

Viscount Bridgeman: I think you have really answered my supplementary question, which is: how sufficient is the evidence on the effect of advertising on alcohol consumption and alcohol-related harm? I think that is what you have just said, is it not? Do you have anything to add?

Professor Petra Meier: When I first got into the alcohol field not that long ago in 2007-08, someone said, “Do we really need more research? This is the best researched area in terms of alcohol policy interventions. If any other area had that much evidence behind it, it would be incredible that no one has acted on it”. While I am happy to work in the area and produce better evidence geared towards particular government questions, the overall principles have been established for a very long time.

Professor Gerard Hastings: Yes, absolutely. At a European level this has been confirmed numerous times. The UK Government have confirmed their agreement that alcohol marketing has an impact. The European Court of Justice has agreed that it has an impact. The only thing that is stopping us doing something about it is political will.

Lord Jay of Ewelme: Is the OECD study you mentioned just on alcohol or on products more generally?

Professor Peter Anderson: This is just on alcohol. It has done similar studies in other health areas but this one is just around alcohol. It is a very comprehensive analysis. The work has
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been completed but it is not yet publicly available. The OECD says it will make it publicly available in January.

Q8 Lord Jay of Ewelme: Do you think there is adequate evidence on the harm caused by alcohol misuse to people other than the drinker? I suppose I am thinking about children, partners, neighbours or indeed society at large, if you think about people hit by cars and so on.

Professor Petra Meier: It has certainly been very much neglected both in research and in terms of the data collection systems that exist. It is fragmented. There is good evidence, for example, on road traffic accidents in many countries and on victims of road traffic accidents. There is stuff on victims of crime in many countries. But where it is around domestic issues such as partner violence or the children, there is much less information there and there are no easy ways of bringing it together, especially at the European level. There are sometimes data collections in individual countries, but even there are large gaps. Any estimates of the collateral damage and the cost to society are usually quite vague, especially the economic cost to society.

Professor Peter Anderson: There was a very good Australian study, which serves as a good model for this. The Australian study looked very carefully at the social costs due to harms to people other than the drinker. It effectively demonstrated that if you factor in all the social costs due to those harms, that effectively doubled the social costs that were occurring from alcohol in Australia. What was surprising, for example, was that the lost productivity costs from someone like a friend or family member having to take care of a friend or partner or to pick up the pieces from their heavy drinking were almost the same as the lost productivity costs of the drinker themselves. It is a really crucial area. There just has not been enough consistent research across Europe, and we need more—better data-gathering and so on.

Lord Jay of Ewelme: I do not know about the Australian study, but would you assume that the conclusions of the Australian study would apply more generally, to all developed societies where drinking is a problem?

Professor Peter Anderson: Yes. If you looked exactly at their methodology, it would apply.

Professor Petra Meier: We have good reasons to believe that, especially in the UK, we would come up with greater harms. We have literally just collected some data on that. Generally the harm to others—how many people know heavy drinkers and how many people have to deal with drinking-related incidents—is far higher than in Australia. If anything, we would consider that to be an underestimate for countries such as the UK, where heavy drinking is possibly more of a problem than there.

Lord Jay of Ewelme: Has there been an attempt, as far as you are aware, in any EU country to do research into the harm to others?

Professor Petra Meier: Numerous EU studies are now being published, especially in the Scandinavian countries, which have tried to quantify harm to others in the same way as the Australian studies. The papers have been published but, as I say, there is no comparative collection system at the moment across the whole of the EU. But surveys are being done in several countries that are comparable, so that is something. That is not just in the EU but in other countries as well.
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Professor Gerard Hastings: I work in food, tobacco and alcohol. At a more anecdotal level, comparing tobacco and alcohol, I feel very comfortable, and always have done, on a public stage talking about the problems of tobacco. When I first started working in alcohol, I thought, “Maybe this is a bit more nuanced”, but it is astonishing how many people’s lives have been marked by alcohol; not necessarily them as individuals but their family and friends. So there is a lot of public concern about this and a lot of harm there, which policymakers should take courage from. It gives them a chance to act on this.

Baroness Benjamin: Also, you find a lot of people are in denial when it comes to alcohol. That is one of the big problems that we have: people protect their loved ones if they are alcoholics, and people who are alcoholics themselves do not want to admit they are alcoholics until it is too late. You have to find a way of getting those people to actually admit that. Then you find how you get the results. My husband was a magistrate and he said that a high percentage of the crime that came in front of the magistrates’ courts was because of alcohol. We have a huge problem. How do we get to it and grasp it?

Professor Gerard Hastings: It comes back to social norms and how we feel about this. Speaking as, now, an increasingly old man, it is difficult for a man to go into a pub and not order an alcoholic drink. If I go out with my friends and just have an orange juice, there is still a little bit of frisson there that it is an odd thing to do.

Baroness Benjamin: I remember when I was young and said that I only wanted an orange juice, everybody thought that I was a freak because I would not have an alcoholic drink. That is still a problem for some young people. I met a young girl of 18 who said her friends thinks she is strange because she only drinks water or a soft drink. There is this kind of social taboo if you are not a drinker.

Professor Gerard Hastings: The Committee should know that the work that Mark Bellis and colleagues did in Liverpool is very interesting in this regard. It is shocking that young women in particular have come to accept inappropriate sexual behaviour as just something that happens on a Saturday night and are completely comfortable with it. Something like a third of young women have had this experience. It is a massive issue.

Q9 Lord Morris of Handsworth: My question is about the structures and mechanisms at a basic level, the toolbox so to speak, for trying to find a solution to the problem. In that context, are the Committee on National Alcohol Policy and Action, and the EU Alcohol and Health Forum, still appropriate mechanisms for facilitating discussion, co-operation and the exchange of good practice between member states, industry, civil society organisations and of course the EU institutions?

Professor Peter Anderson: I will start with CNAPA and then we can come on to the forum. CNAPA is the meetings of the member states’ officials. I have probably attended about one in four or one in three of those meetings as an expert person. There is no doubt that those meetings form a very important networking opportunity, but the problem from my perspective is that you go to those meetings and meet everyone. Next month, you maybe go to a WHO meeting and it is the same people, often saying the same thing. Next month, you go to an OECD meeting and it is often the same people there, saying the same thing again. There needs to be some co-ordination around this. It does not seem to me to be a very good use of government money having the same people going to all these sets of meetings. It is certainly not very good in terms of all the air travel that is involved. Somehow, there needs
to be some sort of rationalisation so that the Europe-based bodies doing work in this area are a bit more co-ordinated and avoid this kind of unnecessary repetition of cost. Member state officials and the desk officers working in government do need to meet each other, but there could be a more rational and efficient way of doing it than the present system, where different organisations are all asking people to come to their own meetings.

**Lord Morris of Handsworth:** In the light of what you have said, Professor Anderson, should the science group on the EAHF play a greater role?

**Professor Peter Anderson:** I am also a member of the science group. The science group has been very well chaired by Sir Ian Gilmore, who is from this country. That science group met several times and ended up doing two pieces of work. The problem with the science group as it was formulated was that it was never given a very clear mandate and it was not sure what it was supposed to be doing. There was no money whatever to support its work, so the two reports that it did were done completely voluntarily. The members were not necessarily the ones you might want to discuss policy issues: there were a mixture of people, who were chosen more to represent different interest groups and to get people there. What the Commission needs is a scientific expert body on which it can call and get scientific advice.

Looking to the future, I would find a way of reformulating the work of the science group; rather than being the science group for the forum, it should be like an expert or an evidence-based group for the Commission itself. Then you can have a much better dialogue with Commission officials about what the science says and what it actually means. You can get into a deep discussion, which I think would be more useful.

**Professor Petra Meier:** One of the key problems with the European Alcohol and Health Forum is that there is a very substantial industry representation, so any reports that the science group sends to the forum get filtered through an industry interpretation process. We have seen that causing problems in the past. Again, I agree with Peter about that direct Commission-to-science link, without the industry as a go-between.

**Professor Gerard Hastings:** The classic example of that, again, is advertising. The science group came out quite clearly and said that the evidence base says that there is a problem here and that marketing is implicated in the levels of drinking that are now going on, but nothing happened.

**Professor Peter Anderson:** You also mentioned the forum. The forum was set up by the head civil servant at DG SANCO at the time, Robert Madelin. If you ever have a chance to talk to him, it would be very interesting to get his perspective on the historical aspect. I think that he is the most senior civil servant from this country in the Commission.

He set it up in good faith as a kind of platform to have a dialogue about what could be done between industry representatives and civil society representatives. The problem is that it did not turn out that way, but turned out to be a highly industry-dominated platform. It almost became just an industry platform. The industry and other members of that platform were required to make commitments to things that they said they would do to reduce alcohol-related harm. The problem was that many commitments were put forward, but they were of such a trivial nature that they were not really open to monitoring or evaluation. Even when they were evaluated, it was found that they were not going to have any impact in terms of reducing harm.
You do need platforms like this but, in my view, a smaller platform, with much higher-level people and where you can have a much more direct exchange, might be a more useful way than this existing structure which, in the end, just became a talking shop for the industry.

Lord Sharkey: To be clear, do you mean it that should not include the industry?

Professor Peter Anderson: I do not deny that at certain stages you need to engage with the industry, but I do not think that this is the right way to do that. You do not need to engage with industry to set policy, but you do need to engage with the industry to push it to do some of the things that it could do to reduce harm.

Lord Sharkey: You were talking about the FCTC earlier, and the restrictions on industry cooperation. Would you not be as strict as that?

Professor Peter Anderson: In World Health Organization circles, in policy-making circles, you need to keep the industry out, because you cannot have an effective discussion about policy. With a body such as the European Union, where you have different Governments, you need to be able to sit down and talk with an industry because you have to get that industry to implement the policies that you are going to put in place. In my view, you also want to have a mechanism where you can force that industry to change and to do things differently. You could put the point to the industry that it is producing so many products that have such high concentrations of alcohol and ask it whether that is really necessary. I do not know the true answer to that. There are areas where the industry can do things such as looking at their own products, and you need a platform or a space to talk about them.

Professor Gerard Hastings: I just want to follow up on this, as it very important. In essential terms, the tobacco and alcohol industries are exactly the same. The firms are corporate operators that have to look after their shareholder value, and if we were a differently constituted committee, we would insist that they did exactly that. A very important way of stopping malfeasance in the sector is to insist that they look after the money that they are spending, which after all is not theirs; it is their investors’ or shareholders’ money. That is perfectly reasonable, but it does not work when it comes to public health. Yes, Peter is right that you have to talk to industry when it comes to the implementation of policy, but not on the formulation of policy. That is for scientists, experts in public health or policymakers to consider before going to industry to say, “This is what we do about it”.

Q10 Lord Jay of Ewelme: It was very much on this area that I wanted to ask questions. In a way, you have answered them. You have been very critical of industry and rather give the impression that you do not accept the concept of responsible capitalism, which I would not agree with. However, I think you are saying that there is a necessary role for engaging industry in how you address this issue, but not in the specific discussions about the policy to be followed. Is that right?

Professor Peter Anderson: That is right.

Lord Jay of Ewelme: Because you think industry is so powerful that it will somehow distort the conclusions that reasonable people would come to?

Professor Gerard Hastings: Correct.

Professor Petra Meier: It has been shown time and again that that is exactly what happens. When there has been agreed policy, draft strategies and so on, and industry has then come
Professor Peter Anderson, Newcastle University, Professor Gerard Hastings OBE, University of Stirling, and Professor Petra Meier, University of Sheffield—Oral Evidence (QQ 1-12)
to the table, things have been watered down and changes made voluntary rather than mandatory, with extended deadlines to achieve changes such as warning labels or content labelling. Industry, especially the alcohol industry, which is the only one I can really talk about, has a very bad track record of sticking to agreements and implementing or helping to implement policies that actually work.

Professor Gerard Hastings: The same is true in food and in tobacco. I share your argument that it is possible to have responsible capitalism, but it is not something that will happen by chance. It will happen if policymakers determine that it should happen and then insist that companies deal with other agendas as well as their bottom line. But at the moment their focus is on the bottom line.

Lord Blencathra: Coming back to the marketing point, I can accept perfectly well that it would be legitimate to restrict marketing that said, “Drink more alcohol, drink more booze overall”, but what about product differentiation? Surely it is legitimate for a company to say, “Drink Laphroaig instead of Macallan”, or when you come to the new English wine industry, which is now superb, surely it is legitimate for a company such as Nyetimber to say, “If you are going to drink champagne, our English champagne is better than Moët”? Surely it is legitimate for the industry to market its product instead of someone else’s, so long as one does not increase overall alcohol consumption?

Professor Gerard Hastings: It is a good question. There are a couple of things in there that I will tease out. First of all, absolutely, la loi Evin says, “Yes, you can promote your champagne and say it is the best champagne; you just have to say why it is the best champagne and give some facts rather than just claim it”, which seems reasonable to me. UK advertising is supposed to be legal, decent, honest and truthful, but I do not know where that fits with having a celebrity endorse alcohol. What is that saying, exactly? This is where you get into terrible trouble when you start to look at the content of advertising and try to regulate that content. So much advertising you cannot pin down—it is about association, it is about image, it is about how people feel about a product. Trying to say, “You can say that but you can’t say that”—particularly “you can’t say that”—is very difficult. What the French have done, I think very cleverly, is not try to do any of that but to just say, “Okay, you can market your champagne, to adults, and tell them the facts. Anything that goes beyond the facts, you cannot establish that that is true, so it is not legitimate”. Personally, I think that is a pretty good motive for all advertising, regardless of product sector.

You also picked up the thing about brand versus category sales. All the evidence is that if marketing is encouraging you to consume a particular brand, it is also going to have an impact on category. That is true for tobacco, food and alcohol. They are not two entirely different constructs. Bacardi Breezer has had a massive impact on increasing the whole sector of flavoured alcoholic beverages, as they have now become called. We have invented a whole new category in the past 20 years; it did not exist before the mid-1990s, and it was branding that did that. So it is a false dichotomy.

Q11 Lord Faulkner of Worcester: My question starts with the premise that I have been involved, for all the time I have been here—15 years—in tobacco control legislation and in attempts to limit the spread of smoking. One of the first successes was the Tobacco Advertising and Promotion Bill, which was passed in 2002. Are you suggesting that a similar piece of legislation should be introduced which covers alcohol sponsorship and advertising?
Professor Peter Anderson, Newcastle University, Professor Gerard Hastings OBE, University of Stirling, and Professor Petra Meier, University of Sheffield—Oral Evidence (QQ 1-12)

**Professor Gerard Hastings**: Yes, absolutely. That would be very straightforward. We have shown that we can do it, and it would resolve what is going to turn into an enormously difficult problem, which is the digital marketing of alcohol.

**Lord Faulkner of Worcester**: You are presumably uncomfortable about alcohol sponsoring sport which appeals to young people particularly?

**Professor Gerard Hastings**: It is not just a matter of discomfort; it is a Lewis Carroll situation. There is a regulation about advertising that says you cannot associate drinking with sporting prowess. It actually says that in the advertising regulations, and yet you can sponsor a Premiership football club. It is nonsense.

**Viscount Bridgeman**: I have a very quick question. I hope we will get a quick answer. The word “drug” has not been mentioned, I think, in this meeting at all. Is there a case for these reports to address any crossover there is with drug abuse?

**Professor Peter Anderson**: It is very interesting. Alcohol itself is a drug, of course. We do not normally like to call it a drug but it is a drug; it has many similar properties to many of the illicit drugs. There have been studies that have tried to look at what happens to drug use if you introduce new policies on alcohol. The studies that have been done do not all say the same thing, but in general the surprising thing is that if, for example, you put up the price of alcohol, you actually get reductions in illicit drug use. You do not get replacement. It may be that people are doing things when they are drinking and they might take illicit drugs, and if they are drinking less there is less opportunity to do it. It is not a big impact but it goes in the opposite direction from what you might think. If the price of alcohol goes up, illicit drug use goes down a little.

**Baroness Benjamin**: Speaking of legislation and campaigns, we had the “don’t drink and drive” campaign, which everybody follows, but do you think that has led to people drinking more because they feel they are safe because they are not going to be driving? In a way, it has kind of backfired on us because someone who would probably have had two glasses of wine thinks, “Well, I’m not driving so I’ll have six glasses”.

**Professor Gerard Hastings**: This is a reflection on what we were talking about with young people, the focus on young people and saying it is their bingeing that is the problem and the rest of the population says, “Fine, my drinking is not a problem”. It is a small problem compared to the great benefit of the reduction in drink-driving, which is one of the great successes of public campaigning of recent generations. None the less, it is sort of implicit that if you are not driving, it is fine—knock it back. You are right, it speaks to that need for a wider, comprehensive, social norms perspective to be applied when you are doing this sort of thing.

**Earl of Stair**: A very quick point about young people. Can you give a bit of clarification on your definition of a young person? It strikes me that the issue here is divided on either side of the age of 18—before 18 youth drinking is governed more by availability rather than advertising, whereas over 18 it could be, “We’re out for a legal evening”, and it links in with the driving point that has just been made. How do you view young and youth drinking?

**Professor Petra Meier**: I do not agree that advertising has a role only where people already drink. Advertising does a lot to shape attitudes and ideas about how society values alcohol. That starts well before children start drinking. On average, the first drink is at around 12 or 13 but even before that children have formed strong attitudes about the context in which it
Professor Peter Anderson, Newcastle University, Professor Gerard Hastings OBE, University of Stirling, and Professor Petra Meier, University of Sheffield—Oral Evidence (QQ 1-12)
is acceptable to drink alcohol, and these are culturally specific. English children will tell you different things from French children, for example, because of what they see around them. Advertising has a role to play when young children are exposed to it. Of course, as children develop into consumers and have spending power and can decide what they drink, then advertising influences between choices between different kinds of beverages, different kinds of lifestyles and so on, and advertising becomes particularly focused on teenage children.

Professor Gerard Hastings: Just to confirm that, the evidence base is quite clear that advertising both recruits children into drinking—we are talking well below the legal age of drinking—and increases the amount they consume. It does both those things.

Professor Peter Anderson: There was also a very interesting study done by the RAND Corporation, funded by the European Union, that looked at whether alcohol advertising was actually targeted towards young people. What this study did across, I think, four European Union countries, where advertising on television was allowed, was to match the TV programmes to their target audience—children’s, adolescent or adult programmes—and then look at the alcohol advertising related to those programmes. It found that there was more advertising per TV viewing for the 13 to 16 year-olds than there was for the adult viewing, demonstrating that the industry was actually targeting those programmes that had higher youth audiences.

Earl of Stair: Recruiting future drinkers.

Professor Peter Anderson: Exactly.

Lord Sharkey: Just very quickly—

The Chairman: Yes, because I have a question as well so you will have to be quick.

Lord Sharkey: In that case I will be extremely quick. The RAND study you were talking about is of course heavily contested by the UK advertising industry, which points to what it claims are methodological flaws in the RAND study for the UK television market. Is there a response to that criticism?

Professor Peter Anderson: I do not know. Perhaps Gerard knows.

Professor Gerard Hastings: It is disputed, as studies often are. They are problematic in that sense. Every study has flaws in it. Peter made reference to this earlier: the way you make progress in policy terms is that you review all the evidence when you get a general pattern emerging. It is something of a storm in a teacup. The fact is that whether there are marginally more children being targeted than adults, children are heavily exposed to it. As I said earlier on, and I really put in a plea to the Committee to do something about this, we really do not know what is happening with digital marketing and you have an opportunity, a Select Committee has the right to demand that sort of information from industry and its agencies about what they are spending on digital marketing and what sort of campaigns they are running. It would be very useful to get that information.

Q12 The Chairman: What I hear from all three of you is that the evidence you have is pointing in one direction and is not debatable. You said that if there was such evidence in other fields, action would follow. But as you all know, it is disputed by the industry. What is your view of the dispute by industry and on what basis is it disputing that evidence?
Professor Peter Anderson, Newcastle University, Professor Gerard Hastings OBE, University of Stirling, and Professor Petra Meier, University of Sheffield—Oral Evidence (QQ 1-12)

Professor Petra Meier: All of us have had recent experience, especially with the minimum unit pricing debate. We have had industry critique after industry critique—basically always saying the same thing and not responding to our rebuttals. We have always responded to these industry critiques, but the same points have just been rehashed without making any reference to anything we have said. Often it is misrepresentation of evidence, of methodologies, or picking up on minor inconsistencies that are already corrected in a final version, but then rehashing that same thing. It is usually about well-considered scientific disagreements; it is just repeating the same misinterpretations time and again. It ties up a lot of researcher time.

Professor Gerard Hastings: There is a famous quote from a senior tobacco executive, I forget the company, going back several decades now: “Our product is doubt”. The tobacco industry for many years disputed the scientific evidence around tobacco, all the time just trying to buy time. The problem with any academic research, whether it is something very economic and statistical that Petra’s team might do or whether it is something much more qualitative, you can pick holes in it. Scientific research, social scientific research in particular, always has problems. So what social scientists do is proceed on the basis of the most hopeful avenues of inquiry and they use multiple methods to try to make progress. There is never any certainty, in fact. All you have is the most likely interpretation of the evidence. In this field we have a very, very likely interpretation, which just happens to coincide with common sense that if you market something very actively and seductively and as powerfully as you possibly can, people tend to consume it.

The Chairman: On that note, thank you very much indeed for your time this morning. It has been very helpful. As I said earlier, have a look at your evidence and if there is anything you want to submit to us as supplementary evidence, please do so. Our very warm thanks.

Professor Gerard Hastings: I will leave these reports here, Madam Chairman.

The Chairman: Thank you very much indeed.
Association of Convenience Stores—Written Evidence

The EU’s Alcohol Strategy

1. ACS (the Association of Convenience Stores) welcomes the opportunity to respond to the House of Lord’s European Select Committee on the EU’s Alcohol Strategy. ACS represents 33,500 local shops across the UK including the Co-operative Group, Spar UK, Costcutter Supermarkets, Nisa Retail and thousands of independent retailers.

2. We support the existing principle in the EU Alcohol Strategy to; bring together stakeholders to tackle alcohol harm, a presumption against a one size fits all approach to alcohol harm policy and the sharing of best practice across member states.

3. Retailers have a considerable interest in the regulatory and voluntary framework surrounding the sale of alcohol. In the UK convenience market alcohol sales, on average, account for 12.8% of total sales\(^{30}\). Retailers take their responsibility for the sale of alcohol very seriously and have proactively worked with the UK Government to create a regulatory framework and voluntary framework to deliver responsible retailing and marketing of alcohol products.

4. Convenience retailers have taken proactive steps in the past decade to address many of the key elements in the EU Alcohol Strategy. Significant progress has been made in protecting children from alcohol harm. This has been driven by the industry creation of age verification schemes such as ‘Challenge 25’ which now forms part of licensing conditions. This has led to significant progress in reducing the number of young people that have access to alcohol.

5. According to the Health and Social Care Information Centre the number of young people that reported drinking alcohol in the past week has fallen from 25% in 2003 and 12% in 2011 to 10% 2012.

6. There are more innovative initiatives that UK retailers are involved with such Community Alcohol Partnerships that work with stakeholders across communities to prevent underage sales. Their success in preventing underage sales in local communities has been huge and the expansion of their work across the country is a priority. ACS has answered the relevant consultation questions below:

Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

7. ACS believes that having an EU Alcohol Strategy that encourages collaboration at national and local level between businesses, government and local agencies to tackle alcohol harm is valuable. The sharing of best practice from across

\(^{30}\) ACS Local Shop Report 2014
the EU could deliver further progress to educate the consumer about alcohol related harm and encourage responsible business practices.

8. Attitudes towards alcohol differ greatly between nation states and the approach to public policy is wide ranging. We do not therefore believe the EU alcohol strategy should serve to build a single public policy framework for tackling alcohol related harm. ACS strongly supports the UK Government’s view that the best way to tackle alcohol related anti-social behaviour and harm is at the local level. Nonetheless convenience retailers would find value in an EU alcohol strategy that focused on established consistency and independence in the way data and research is used in informing policy debate across the EU.

9. There would also be value in the EU alcohol strategy looking at what action it can take on alcohol duty fraud, sharing best practice and intelligence from each member state. Alcohol duty fraud is a significant problem in the UK market, with significant annual losses in spirits (£120 million), beer (£550 million), and wine (£350 million) market. In the UK the Government is introducing a register for wholesale suppliers of alcohol and the expansion of fiscal marks on alcohol products. Joining up the work of members states especially on cross boarder trading would increase the relevance of the EU alcohol strategy.

Are the EU's alcohol policies underpinned by a sound scientific base?

10. One of the most valuable things that the EU Alcohol Strategy can provide is some consistency around the evidence base on consumption levels and other indicators of alcohol related harm across EU. Distinctions should also be made in relation to different cultural attitudes towards alcohol across different member states.

11. Although many organisation claims to take an evidence based approach to the development of alcohol policy it is clear that much of the evidence is developed with particular policy outcomes in mind. Similar claims will also be made of business organisations too.

12. The EU alcohol strategy should have at its heart the ability to deliver objective data from across the EU that can inform policy development. All stakeholders involved in the strategy should have to declare their business interests and relationships to campaign groups.

Are the EU's alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)? Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

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13. We support the findings of the report Commissioned by DG Health and Consumers into the effectiveness of the EAHF and CNAPA, which states:

14. “The EAHF appears to have succeeded in mobilising a broad range of stakeholders to address alcohol related harm and in stepping up actions. Actions under the EAHF have also likely contributed to engaging cooperation among stakeholders at national and local levels. One important strand of work aimed to support further development of industry self-regulatory systems for the marketing of alcoholic beverages. This has been carried out through commitments by EAHF members, through exchange of information in a dedicated Task Force and through reports on the state of play and progress made. Initiatives for further development of self-regulation have built on the effective self-regulation model of the 2006 Advertising Round Table in health and consumer policy areas. The results from the evaluation indicate that the EAHF process has motivated stakeholders to step up action in this area and has thereby contributed to the development and convergence of the alcohol advertising self-regulatory systems across the EU”.

Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?

15. No comment.

Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

16. Yes. We believe that the EU Alcohol Strategy should serve to inform policies at member state levels and the EU should not go beyond its existing remit in seeking pan-EU outcomes in taxation or pricing policy. Member states are free to set taxation levels as they wish to drive outcomes in alcohol consumption.

19 November 2014
The UK Independence Party submits the following evidence. In so doing, we propose only to address questions 1 and 6 set out in the Call for Evidence.

**Q. 1 Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?**

Both as a matter of principle and as a matter of common sense, UKIP answers this question firmly in the negative.

Indeed we believe that there should never have been an ‘EU alcohol strategy’ and that it was wrong of Her Majesty’s Government to have ceded any authority over alcohol policy to the European Union in the first place. We make the point that this is a typical example of how the UK government yields up, effectively for ever, important policy areas to the control and legislative activity of the EU.

As a matter of principle, we in UKIP – and, we are confident, many in our nation – believe that matters of this sort should be exclusively in the hands of The UK Government, aided by the British Civil Service and by and with the consent of Parliament.

No one seeks to deny that this is an important area of policy, but it must be for the UK and its people to decide what is best for us in the context of policy on health, crime, taxation and so on.

This cannot be a matter to be decided for the UK by legislators and civil servants who are not accountable to the UK electorate.

As a practical matter, it must be observed that this is a typical example over an over-weening bureaucracy trying to determine and impose yet another unworkable ‘one-size-fits-all’ policy that ultimately proves not to be relevant or helpful for anybody at all.

This is not least because the culture of alcohol consumption is different in every Member State in the European Union. Indeed the culture of alcohol consumption varies in every constituent part of the UK. We in the UK are best placed to understand the different cultures of alcohol consumption than any remote civil servant in Brussels.

It also means that the Taxpayer will almost certainly end up paying twice for the same thing. The UK will have its views on such matters and the EU will come up with another. Why on earth should the British taxpayer have to fund two lots of policy formulation?

The United Kingdom should withdraw from any future co-operation on alcohol policy and confine its efforts and expenditure to determining if such a policy should exist within the context of the governance of the UK (for the purposes of this paper we take no position...
either way, merely elucidate the principle), if so, what that policy should be and how it should be conducted, whether through education, public awareness campaigns, regulation or taxation or a mix of any of them.

If whatever is decided is approved by Parliament and the elected representatives of the people, all well and good.

Nor is there any evidence that it is in fact appropriate to do this at a European level because that is somehow more efficient or more efficacious. It seems to have been done simply because the EU can, in the exercise of its competences, seize pretty much any area of policy it wants and never has to give it back, leaving those who have to implement the policy not so much ministers of The Crown as glorified postal workers.

So there should certainly not be a fresh EU strategy on Alcohol and the UK should firmly tell the EU that, in future, this and many other policies will revert to be dealt with by Crown Parliament and the British people or will not be ceded to the EU in the first place.

Q 6 Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

The question itself reveals one of the significant dangers of allowing the EU to have control of this matter. It is but a very short step from having a policy on alcohol to the EU taking control not merely of policy on the taxation of alcohol but to forcing the harmonisation of taxation on alcohol or, even worse, using taxation on alcohol as a means of raising ‘own resources’.

It being one of the fundamental attributes of an entirely sovereign nation state, the ability to determine if and at what rate some item or activity should be taxed is fundamental to the conduct of legitimate, democratic self-government at a political moral and legal level.

Whilst UKIP is against the setting of minimum-pricing regimes for alcohol, if the issue were to be whether it is appropriate to have such regimes, then that should be exclusively for the UK government to propose and for the UK parliament to determine.

Furthermore, the danger is that, if we cede such control, then the use of a ‘policy’ on taxation of alcohol will lead inexorably to the deployment of the ‘single market’ as an excuse for, firstly, tax harmonisation on alcohol and thence, in time, to tax on alcohol and tax generally being used for the EU raising ‘own resources’.

That road is wholly inimical to the interests of the UK as a sovereign nation state.

Tax competition is good for the UK and no step should be taken that surrenders any control of our ability to levy and set rates of tax to the EU.
JANICE ATKINSON

UK INDEPENDENCE PARTY MEP
FOR THE SOUTH-EAST OF ENGLAND

17 September 2014
WEDNESDAY 5 NOVEMBER 2014

Members present

Baroness Prashar (Chairman)
Baroness Benjamin
Lord Blencathra
Viscount Bridgeman
Lord Faulkner of Worcester
Lord Jay of Ewelme
Lord Judd
Lord Morris of Handsworth
Lord Sharkey
Lord Tomlinson
Lord Wasserman

Examination of Witnesses

Chris Baker, Consultant, Bacon Strategy & Research, John Duffy, Statistics and Policy Consultant, Professor Theresa Marteau, Director, Behaviour and Health Research Unit, University of Cambridge, and Dr Eleanor Winpenny, Analyst, RAND Europe

Q63 The Chairman: Thank you for your time this morning. As some of you may have heard, this session is open to the public. It will be webcast live and the transmission is accessible via the parliamentary website. A verbatim transcript will also be put on the parliamentary website. A few days after this session, you will receive a copy of the transcript to check for accuracy, and it would be helpful if you could advise us of any corrections as quickly as possible. Also, if you wish to clarify or amplify your evidence in any way, or make any additional comments, you are welcome to submit those to us. Do you wish to make any introductory comments before we start on the questions?

Chris Baker: It might be useful if I introduce myself and say a few words about why I am here. My background is eight years market research and almost 30 years as a strategic planner in advertising agencies. For the past six years I have worked as an independent consultant. I work mainly with advertising agencies, but sometimes with brand owners, and occasionally with the Advertising Association. I have broad experience across many markets,
I have worked with the Advertising Association on a number of issues, one of which was alcohol advertising, and specifically in the context of this session today, I was involved in the response to the RAND report. Much of that is summarised in the response that the Advertising Association made to the inquiry. The analyses, detailed in the Appendices to the Response, are largely my work. My experience lies primarily in the area of advertising communications, which is where I can input to this inquiry, and I suppose what I do could be broadly described as evidence-based strategy. That ranges from the collection and evaluation of evidence, its application in terms of developing strategies and implementing them, and then, importantly, the subsequent ongoing measurement of the effects of implementation and feeding back into the next steps. It is a cycle.

I am probably best known for my work on advertising effectiveness. I have twice been the convenor of judges for the IPA advertising effectiveness awards and I have edited related books of winning case histories. I myself have won a number of these awards. This makes me a bit of a techie in the world of advertising, but I will try to keep things simple today. However, I would like to say that while technical understanding is important, evidence-based strategy is very much about common sense. In particular it is about looking at multiple evidence sources, not just trying to do everything based on one piece of evidence. I was going to conclude by saying a few words about the RAND report, but that will come through later. I was also going to raise the Ofcom analysis, which has already been mentioned, and I will develop on that further.

**John Duffy:** I graduated in maths at Edinburgh in the late 1960s, in statistics at Reading in the 1970s, and I have spent most of my life teaching statistics and their application in medicine, epidemiology and higher education. Basically, I am a statistician. I retired two years ago from the Scottish Further and Higher Education Funding Council where I was head of profession, and since then I have been doing bits and pieces of statistics and policy consulting. I am very grateful to the Committee for asking me to give evidence here today.

**Dr Eleanor Winpenny:** I am Eleanor Winpenny and I work in the health and healthcare team at RAND Europe. RAND Europe is a not-for-profit research organisation. We conduct analyses that are aimed to improve policy and decision-making. We are involved in a number of research projects looking at alcohol policy, for example work on pricing policy and the effect of promotions on purchasing behaviour. My experience is mostly in alcohol advertising. I was an author of a report entitled, *Assessment of Young People’s Exposure to Alcohol Marketing in Audiovisual and Online Media.* I believe that is why I have been asked to give evidence to this Committee.

**Professor Theresa Marteau:** I direct the Behaviour and Health Research Unit at the University of Cambridge. Much of our funding comes from the Policy Research Programme at the Department of Health. We are one of around a dozen policy research units that are funded by government through the Department of Health. We are independent of government, but the idea is that we generate evidence that has the potential to inform policy. The particular focus in the unit I direct is on changing behaviour across populations to prevent disease and reduce inequalities. Our focus is on four sets of behaviours: the consumption of tobacco, alcohol, diet and physical inactivity.
Chris Baker, Consultant; John Duffy, Statistics and Policy Consultant; Professor Theresa Marteau, Director, Behaviour and Health Research Unit, University of Cambridge; and RAND Europe—Oral Evidence (QQ 63-73)

My area of expertise is in behaviour and behaviour change, particularly health-related behaviour change and interventions that influence our behaviour, often without our awareness. Those will include marketing, the availability of products, and to some extent price. I believe that I have been invited here today because I was one of the co-authors of the RAND report. In addition, my group is conducting two systematic literature reviews which are relevant to the evidence today. One of them, which has not yet been submitted for publication although we have the results, is on the immediate impact of the marketing of alcohol on the consumption of alcohol in young people. The second review that we are just starting is on the impact on consumption of labels on alcoholic drinks that indicate low levels of alcohol. In that review we are also looking at similar labels that have been applied to tobacco and food.

Q64 The Chairman: Thank you for that. We shall be asking general questions and not all of you have to answer all the questions. Please respond to those which you think are the most relevant to you. I shall begin by asking whether you think that the alcohol strategy has achieved its aim of developing, supporting and maintaining a common evidence base, and should this continue to be a priority. If so, how could that be achieved?

Chris Baker: My involvement has been quite narrow and largely in the context of the RAND report. But I have seen other work. My impression overall is that the quality of the research is patchy and haphazard, and for the most part is not actually a lot of use in terms of informing any kind of strategy or policy. That is in part down to the quality of the research and in part due to funding issues. They frequently pick off two or three countries at random and then try to draw very broad conclusions from three very different markets. The EU strategy potentially has a role going ahead in terms of research, but the actual execution to date has been poor.

John Duffy: I will pick up on the point about quality issues. Of course it is important to have information to assist in the development of policy, but it is also important to ensure that it is good quality information and to pay rather more attention to some of the defects in the kind of evidence that is routinely collected—the kind of evidence that we read about every day. I am thinking of, for example, sample surveys, which I may come back to later. There are some real problems with the sample surveys in this area. Administrative changes have taken place in aspects such as the recording of deaths. There were huge issues back in the 1970s and 1980s between Scotland and the rest of the United Kingdom with deaths related to alcoholic cirrhosis. People need to pay a little more attention to that.

On future development, I want to say something, but it is really in connection with the next question that relates to Alice Rap. While that is important, it is also necessary to give thought to ways of improving the quality of the information—not just collecting from more countries or persuading some countries that currently do not think it is very important that actually it is. What matters is getting the right information of the right quality.

Dr Eleanor Winpenny: I have a small point to make that is based mainly on our report on alcohol advertising information. It looked at only three countries, and that was mainly because it was quite difficult to get data on the advertising in those countries. One thing that I think could be done at the EU level would be to make more data on advertising available for public policy analysis. That is because a large proportion of the funding for the report actually had to be spent on purchasing data.
The Chairman: Is there a need for standardised data collection in order to facilitate cross-country comparisons?

Dr Eleanor Winpenny: Yes.

Q65 Lord Tomlinson: Is EU funding being used to full advantage in this area? Should more and better use be made of the existing data collected by major EU research projects such as AMPHORA and Alice Rap? What more could be done to improve co-ordination? This arises from the fact that we have been finding it hard to get hard data about some of the research work. The Department of Health referred to EU funding having financed 37 cross-border alcohol related research projects, and yet when we looked at this in a little more detail, it was very much demand-led. It was not the Department of Health setting out the areas where we are deficient in our knowledge and we want some research to be done to plug those gaps. It was, as I say, much more demand-led. As a result, we are still left with the gaps. How do you react to that?

John Duffy: I agree entirely. My view of the AMPHORA and Alice Rap projects is that while they may well be extremely worthy, they always involve the usual suspects. The scientific quality is variable, as has already been pointed out, and they do not take criticism kindly. I found that out to my cost because Alice Rap actually used European Commission money in January this year to pay a journalist to write, and the BMJ to publish, an ad hominem attack on me. Fortunately, the Department for Business, Innovation and Skills complained on my behalf to the Commission. The Commission then told the Alice Rap people that it would not pay for that scurrilous attack.

I worked in the alcohol field and its epidemiology for 25 years, and it is the same-old, same-old. I do not blame the civil servants for this because I have also worked as one. It is not so much that the civil servants do not know what is important, it is that they do not have the time to develop their expertise. To an extent they are occasionally sold, shall we say, a project that might not be optimal in terms of satisfying the requirements. One way to deal with this is to broaden out the whole alcohol research question, but that would be strongly opposed by the people who are currently running projects like Alice Rap and AMPHORA.

Professor Theresa Marteau: It is not my area of expertise, but I appreciate the question. I think you are asking about the scientific strategy that led to the call for research. That is a really important question. There had been analyses and RAND is one organisation that did a well-cited piece of work looking at the payback from different investments in research. I do not think that you are going to get a satisfactory answer from the panel before you today, but I will think a little about where you might be able to find it and perhaps get back to you.

Lord Tomlinson: I appreciate hearing that.

Baroness Benjamin: It would be good to know who is leading who. At the moment the evidence is quite confusing. Who is the research lead? I think you touched on that when you said that the civil servants are too busy. The result is that they go with what they are given, and they do not necessarily have the expertise.

John Duffy: I would not put it quite as bluntly as that, having been a civil servant myself.
We need to know ourselves if we are going to understand where the money is being spent, why it is being spent, and what will be the outcome of all that. We need to know how that process starts and is then followed through.

Q66 Lord Wasserman: I want to get back to Mr Duffy’s point about collecting the right information of the right quality. During this inquiry we have heard an awful lot about evidence-based policy and measuring performance to judge the effectiveness of, for example, the last strategy, the next strategy and so on. Can tell us more about your view of what is the right information of the right quality? Can you put a little flesh on those bones?

John Duffy: What I meant by that is that we should endeavour to improve the quality of the information. For most alcohol-related problems we know roughly what the right information is about: how much do people in the population at large drink and what is the relationship between alcohol and risk? The latter is a very important issue and we do not have information on it, which is why the Sheffield alcohol policy model had to pull out of thin air the relationship between alcohol consumption and risk. That information could be important. The way to find it is not by population studies but by epidemiological studies at the clinical level, such as case control and cohort studies, but they are very expensive. If you do that work, something else will not be done. For example, if you spend £5 million on the Sheffield Alcohol Policy Model, that represents £5 million-worth of cancer research that will not happen. If you spend £5 million on clinical epidemiological research of the type I advocate, that is £5 million which is not going to be spent on Alzheimer’s disease or MS. These judgments about the allocation of scarce resources are precisely what we look to government to inform us about.

Professor Theresa Marteau: I want to come back to the phrase “pull out of thin air” in relation to the model that Sheffield used. That is not my understanding of the basis for the model. The results were published in peer-reviewed journals of the highest standards. The model took detailed baseline data, all of which had been published, on alcohol consumption, price and harms. It used peer-reviewed published evidence on the link between price and consumption, and it used evidence from meta-analyses of hundreds of studies that link the amount of alcohol that people drink and subsequent harms. For me, that does not accord with the definition of pulling something out of thin air.

Lord Wasserman: I want to pursue the question of data and evidence. For example, should the industry be brought into policy decisions? There was always a concern that the industry had one set of indicators while the academics, statisticians and public health people had another set. It seems to me that it would be sensible if we could all agree on a set of objective indicators so that we know whether the policy on reducing the harm from alcohol consumption is working or not. The idea of saying that you do not want to involve the industry because it will produce other sets of figures is not sensible. Can we not agree on what the objective indicators are, or is it simply the case that this field is too vague and amorphous?

Chris Baker: In the case of advertising exposure, which is one of the indicators that is floating around—this speaks to one or two of the other questions as well—the RAND Europe report appeared out of the air, as it were. The industry knew nothing about it until it appeared. There was no involvement or consultation with industry. We did have some dialogue with RAND following that, really just to interrogate them about the thinking behind the approach and what happened in its commissioning. What emerged was that there was very little
transparency, from the Commission as much as anything. RAND had presented various
options (in its initial proposals) for looking at exposure, one of which was quite similar to the
one we applied in our work, but the other route, described as a more novel approach in its
report and indeed by the Commission, was the one that was chosen—on the basis of it being
novel. We asked for the basis of that decision because the other approach (the one followed
in our analyses of the same data) was also referred to by RAND as, “We are not saying that
the alternative is not good, it is just different”. We were then referred to DG SANCO because
they could not tell us what the basis was for the decision. There really is very little sense of
any clear objective, transparency or rational for decision-making at all. It is actually quite
disturbing.

Dr Eleanor Winpenny: I would say, just based on the advertising report, that this is in fact
one instance where we actually used more or less the same data. We purchased data from
the industry in order to do our analysis, and I believe that it was the same data that was
used by the Advertising Association and others for their analyses. If we are looking at
indicators, that is one area where we are using the same basic data, although we had a much
more limited set because we had to purchase it to do the study. It was just the methods of
analysis that differed between the two analyses.

Lord Sharkey: Perhaps I may make the observation that it is not particularly helpful when
two different methods of analysis produce such radically different results.

Chris Baker: It is essentially the same data, and certainly any small differences in the data
does not explain differences. Indeed, Ofcom used the same data, as the AA as mentioned by
Guy Parker (ASA), and came to conclusions that were almost identical to the conclusions of
our analysis and the diametrical opposite of the headline of the RAND report. Yes, it is
essentially the same data, so effectively we are looking at the same indicator and coming out
with radically different answers.

Lord Wasserman: That makes evidence-based policy formation very difficult.

Professor Theresa Marteau: Could I make two points on that? There are different kinds of
evidence. Where the disagreement arises is between evidence that is published in peer-
reviewed journals and evidence that is collected by industries that have an obligation to
shareholders to return profits. That is one observation. The second observation is that I have
not read the Ofcom report, but it was described by the previous witness. He talked about
children as being one group as compared with adults in terms of exposure of advertising.
The RAND report is clear that there were two groups, one of young children aged between
four and nine and one of those aged between 10 and 15. The exposures are very different. If
the data from both groups of children are combined, it could explain why there is a
difference between the two reports.

Chris Baker: I am sorry. I have read the report and, for your information, the data are split
out in exactly the same way: four to nines and 10 to 15s. Obviously the four to nine year-olds
see a lot less alcohol advertising. The RAND report looked at the data in exactly the same
way as we did when we made our analysis. There is no difference.

Q67 Lord Jay of Ewelme: If there had been discussions between industry and the RAND
people before the work was done, would it have made any difference, in your view, to the
way in which the studies were carried out, or possibly the results?
Chris Baker, Consultant; John Duffy, Statistics and Policy Consultant; Professor Theresa Marteau, Director, Behaviour and Health Research Unit, University of Cambridge; and RAND Europe—Oral Evidence (QQ 63-73)

**Chris Baker:** We would question the methodology. We would have suggested the straightforward, tried and trusted approach that has been used by all advertisers, Governments and so on to monitor exposure of campaigns. We would have suggested that that approach should be used. It would have been similar to the one that we and Ofcom applied. That might or might not have made a difference in terms of DG Sanco’s decision to follow the novel methodology RAND pursued, but we certainly would have suggested that what they were proposing was not fit for purpose.

**Dr Eleanor Winpenny:** I am fairly sure that the people who commissioned this work are aware of the standard methodology, and then we proposed our methodology, so I am not sure whether it would have affected the choice. If it is helpful at this stage, I can give a brief description of the differences between the analyses and try to explain why they came to very different conclusions. I was reserving that for a later question.

**The Chairman:** If you can do that briefly, it would be helpful.

**Dr Eleanor Winpenny:** Okay. From what I understand of the industry effort—I am sure that I will be corrected if this is inaccurate; it is not a method that I have applied myself—the idea was to look at the total exposure of a population to alcohol advertising. So if you are looking at a particular age group, you look at the number of adverts that are seen by the people in the age group over a period of time and divide it by the total number of people in that age group in the country. It is a per capita measure. It would say that for each child, this number of adverts would have been seen over that period of time. You do the same for an adult age group and you can compare the two and say, “Young people are exposed to fewer adverts than adults”.

**Chris Baker:** That is absolutely accurate.

**Dr Eleanor Winpenny:** Instead, we were looking in more detail within the data we had for the six months that we were looking at alcohol adverts in this study. We looked at the relationship between the number of people in each age group who were watching television during a given time period and the number of alcohol adverts that were shown. So we were splitting the data down by different times of day, different months and different channels, and looked at this relationship using a regression model, which is the standard methodology that is used in this kind of research. What we showed was that as you increase the proportion watching TV who are in a particular age group, such as the 10 to 15 year-old group, in this case the number of alcohol adverts that are shown goes up. If you increase the proportion in a very young age group (keeping everything else constant and controlling for the other age groups) the number of adverts shown goes down. So the output from this was presented as what is known as an incidence rate ratio, which compares between different age groups the number of adverts seen just by the population that is actually watching television within the dataset, per person per hour of TV watched. You are looking at the rate of adverts seen in one age group compared with another age group. What we found is that in the UK, in the 10 to 15 age group, there was an 11% increase in the number of adverts seen by that group as compared with adults, and in the very young age group there was a decrease in the adverts seen compared with adults, while in the 16 to 24 age group there was basically no difference.

**The Chairman:** Last week, when we saw Professor Nick Sheron, he suggested that children see many more adverts per capita. It is something that we will deal with later.
Q68 Lord Judd: Is there in your view sufficient evidence regarding the relationship between overall levels of consumption and alcohol-related harm? What is your own position on the proposition that a reduction in the overall consumption of alcohol results in a reduction of the harm that is claimed to be related to alcohol consumption?

John Duffy: Perhaps I may make my position on that clear. Of course the consumption of alcohol is related to harm. It would be rather strange if it was not. But where the argument goes wrong is to say that it means that if we can reduce consumption by whatever method, that will also reduce harm. There is a kind of tautology driving this whole thing. If the people who are experiencing high levels of serious harm due to alcohol are drinking large amounts of it, which they are, then populations in which there are more of those people will have higher than average consumption. That is obvious; there is a relationship and I would not for a moment deny it. What I do not agree with is that any reduction in consumption will necessarily be accompanied by a reduction in harm. Some will and some will not. It depends on who in the population reduces their consumption. If you make no difference to the really heavy drinkers, the impact on harm will be slight.

When this all started back in the 1970s, people thought that statistics held the key, but that was because they did not understand what a statistical argument was. The statistical argument is not, as they thought, that you can apply a specific distribution and that distribution will always work and you can fiddle with the parameters of the distribution. Life is not like that. Those are the statistics of the 19th century, of Quetelet, Comte and people like that. They thought that there were always statistical laws, but there are not. What we have is empirical information. If someone says, “We did this experiment and we found that it reduced consumption and harm”, that would be a good thing to do. There are other extant datasets in which consumption has gone up and harm has not and where consumption has gone down and harm has not. We could spend all day cherry picking data to suit either side of the argument. What really upsets me as a statistician is the way my subject has been abused in the form of meta-analysis. It kills the black swans. In other words, if something did not happen somewhere, no one says, “That is interesting. Why did that not happen?”. They say, “Wrap it in with the others and take the average”.

Lord Sharkey: I understand most of what you are saying, but is it not the case that the statistical case and the evidence base are properly used to define the target populations for our campaigns against alcohol consumption?

John Duffy: If you have a clear strategy and you know what you want to do, of course you should try to construct indicators that provide the evidence base for whether your strategy is working. There is no question at all about that and I agree with you entirely.

Professor Theresa Marteau: No one wants cherry picking. A synthesis of global evidence is what all of us want to see. The evidence that is published and forms the basis of recommendations from the WHO as well as other groups involved in policy that seeks to reduce the harms from alcohol are very clear on the evidence. First is the link between consumption and harm and the evidence that reducing consumption reduces harm. For example, in the Lancet series on the burden of global disease, which was published in 2009, one can see without having to understand complicated mathematics that there was a reduction in murder rates in parts of Brazil when the licensing hours were reduced. Dramatic changes could be seen. We have recently had the example in Canada where certain states have applied a policy of minimum unit pricing. As the price goes up by 10%, consumption
Chris Baker, Consultant; John Duffy, Statistics and Policy Consultant; Professor Theresa Marteau, Director, Behaviour and Health Research Unit, University of Cambridge; and RAND Europe—Oral Evidence (QQ 63-73)

goes down by 8%. Similarly, there has been a greater than expected reduction in the number of alcohol-related admissions to A&E—I think to the tune of 9%. That study was published by Tim Stockwell and colleagues. So the evidence is robust that reducing consumption reduces harm. Of course there will be some evidence where it does not happen, but if you look at the evidence in the round, it is not something that is disputed by most academics.

**Lord Judd:** Could the case you are making be further strengthened if more work was done on how far what we are seeing in the increase of rather sinister levels of harm is related to better diagnosis in the health service?

**Professor Theresa Marteau:** The harms I am alluding to are health-related, so we have those which are specifically related to harmful and hazardous levels of alcohol consumption and those that are related to even moderate levels of alcohol, such as an increase in the rate of obesity. But beyond health, there are increases in criminal activity, violence, suicide and death, particularly in young people. It is not just health, it is about the adverse consequences of high rates of consumption of alcohol across the population.

**Lord Judd:** But the argument is often concentrated on liver disease.

**Professor Theresa Marteau:** It might be, but that is not the only harm.

**John Duffy:** I just wanted to say that, with respect, there was a bit of cherry picking going on by Professor Marteau. The Stockwell study was not a study into minimum unit pricing. Minimum unit pricing has never been applied anywhere in the world. That is not an argument against doing it, but to say that it has been applied in Canada is incorrect. It is not a minimum unit price, but a minimum price. The study itself has been quite substantially unpicked by a university in the United States. What is wrong with it is basically the problem that afflicts most alcohol research, and may in fact have had something to do with the differences in opinion about the analysis of advertising data. It is a phenomenon called overfitting. In order to get the results that Professor Marteau has mentioned, the model included large numbers of terms that were not significant but which had to be kept in to achieve the desired ‘result’. That was because if they were taken out, the terms that they wanted to show were significant would no longer have been significant. That is called overfitting and it happens all the time in this field. In fact, the elasticity estimates for the Sheffield Alcohol Policy Model were more or less nonsense because they came from overfitted multiple linear data. I am sorry but I have to be technical because I am technical. If I was not, I would not be doing what I was called here to do.

**Q69 Lord Morris of Handsworth:** It is true that the so-called Sheffield model has its supporters and its detractors, but the fact is that at the end of the day policymakers are looking to academics and others to support their policies as being evidenced based. Setting Sheffield aside, in your opinion, are there general models that offer predictions about drinking patterns that are useful in informing policy decisions that are necessary and can indeed influence the behaviour of those who want to consume and those who are in the business of promoting and distributing alcohol?

**Chris Baker:** I can only answer in respect to the impact of advertising on consumption. A lot of research has been done which universally shows no or only a very small correlation between the two. Being small, it becomes difficult to measure the impact of advertising because there are other bigger effects. In the UK, figures from the Department of Health show that consumption among 10 to 15 year-olds almost halved in a little over 10 years—at
a time when the overall level of alcohol advertising was pretty flat. It bubbled around a bit, but essentially it was plus or minus 5% over the period. There is lots of common-sense evidence as well as modelling evidence that shows inconsistent and small effects. You could argue about them between the different surveys, but none of them shows anything very large. In some research, there is clear evidence of a small effect at best. In other areas (not advertising) there will be bigger effects on consumption, but those are not my area of expertise and I cannot comment on them.

Professor Theresa Marteau: If you are thinking about populations, small effects are good effects because often one is trying to shift the behaviour of a whole population in the direction of better health. Many of our effective policies in tobacco control have small effects. It is the accumulation of small effects that contribute to improved health and other beneficial outcomes. Generally in the context of alcohol there are three sets of policies for which there is clear evidence not just of effectiveness, but also cost-effectiveness. The first is price. Simply, if you increase the price, consumption will go down. I do not think anyone would disagree with that, but the devil is in the detail as regards the exact elasticity: by how much does one need to increase the price for what given reduction in purchasing and consumption? The next is availability. There is good evidence to show that if you reduce the proximity and density of alcohol outlets, you will reduce the amount of alcohol that is consumed and thus the consequent harms. The third component for which there is deemed by many of us to be enough evidence—I think that we are going to come on to it—is direct and indirect marketing. There is evidence to show that the removal of marketing, both direct and indirect, would be a cost-effective way of reducing the consumption of alcohol.

John Duffy: I tend to agree with the remark about pricing. If the price goes up, all other things being equal, consumption will go down. But that is not costless, particularly to the citizen. The citizen spends money on alcohol because he or she derives pleasure from it. If the cost goes up, that citizen is either paying more for the same, so they suffer a financial loss, or they are paying the same and getting less. It is not costless. If you say that it is cost-effective, you have to do the welfare calculation. You cannot just say, “If we put the price up, the Government will get more money and consumption will go down”. Yes, of course that is true, and if the Government want more money, it is a good way to get it. Alcohol is a pretty inelastic commodity, so it is a good one to put excise on.

On the availability issue, what says it all to me is that, yes, if you kill the black swans by meta-analysis—kill the exceptions—you can generalise. But is not the object not to generalise but to be effective? It is only very rarely that we get any predictions being tested by the proponents of these arguments. Even in their own datasets there is a way to test whether the predictions are any good; it is called cross-validation. I have yet to see a single paper in this area which uses the method of cross-validation.

Professor Theresa Marteau: Perhaps I can come back on the point that it is not costless for individuals who buy alcohol. That is a fair point, but we should look at the figures. If a minimum unit price of 45p was adopted as a policy in England, it is estimated that those with the lowest income levels, where the concern has been raised, and who are moderate drinkers, are spending relatively little on alcohol, on average £200 a year. The cost to them would be 4 pence a year. You can contrast that with harmful drinkers in the lowest income group who are spending more than £2,500 a year on alcohol. If you applied a minimum unit price to them, it is understandable that they would spend more on their alcohol, around
£300 a year. It would, to use an economic term, be regressive for them because they would be paying more, but it would be progressive in terms of the impact on their health and consequent harms in their lives. So while alcohol brings pleasure, it also brings harms to families, individuals and society.

**Q70 Lord Faulkner of Worcester:** Do you think minimum pricing would be successful in addressing binge drinking, heavy drinking and, indeed, total population consumption?

**Professor Theresa Marteau:** My understanding is that a minimum unit price would just be one of several policy options to address that. Indeed, it is not expected that a minimum unit price would do much to affect binge drinking. It would be expected to reduce it somewhat, but one would need other policies in place, such as those relating to the availability of outlets and, probably, licensing hours. Particularly among the poorest, it would be those who are drinking heavily who would generally be buying alcohol at below the proposed minimum unit price of 45p. The expectation is that it would do something to reduce their consumption.

**Lord Faulkner of Worcester:** I think you have a rather different view, Mr Duffy.

**John Duffy:** No one knows the answer to that question, to be honest. I do not think that the model itself would even claim to address binge drinking. What would happen of course is that prices would go up. The price of a very cheap drink such as cider, which in my opinion is disgracefully cheap because the Government do not want to offend a particular interest group, would go from £2 for three litres in Lidl to £6 or £7. Who is buying it? It is poor people. It would be regressive from that point of view.

The other thing is proportionality. It is all very well to say that people would only spend 4p a week more of 4p a year more, but the analysis that Sheffield did in support of that completely leaves the welfare aspect out of the account. They will get less for the money they spend—it is not really true to say that it will only cost them an extra 4p, because they are going to forgo utility that they would otherwise have had from drinking the drinks.

**Lord Faulkner of Worcester:** Will they not drink less if the price goes up?

**John Duffy:** Yes, they drink less, so they lose that utility. They wanted to drink, and we have stopped them.

**Professor Theresa Marteau:** Okay, 4p is not nothing, but arguably not factored into that are the potential benefits of a reduction in the levels of violence in the society in which those people reside.

**Lord Faulkner of Worcester:** I find it fascinating that there should be such a difference, but we do not have the time.

**The Chairman:** It may be fascinating but we do not have the time to go into it. Lord Sharkey.

**Q71 Lord Sharkey:** I should declare an interest again, as I spent 30 years in advertising, including 10 years working with Mr Baker—mostly happily. My question was going to be about the RAND study, but I think we have covered that in some detail. I was going to ask whether the different views about the meaning of the RAND study could be reconciled, but I think we have heard enough already to show that that is highly unlikely. We find ourselves in the position that we have competing conclusions based on the same data: on one side we have RAND and on the other we have the ASA and Ofcom. In a more general sense, we have
heard very robust criticism of studies advanced as evidence for policy-making. It seems to me that one of the critical issues that arises is whether you would agree that there is now a strong argument for research studies that have the joint backing of interested parties, including statisticians.

**Professor Theresa Marteau:** It is interesting that you applied the term “robust” to the criticism. I would apply that term to the evidence that supports what we have been talking about and the various important links.

**Lord Sharkey:** Just to interrupt for a moment, I think you are illustrating precisely the problem I am describing.

**Professor Theresa Marteau:** I wanted to draw the attention of the Committee to a report that was published by the House of Commons Health Committee in 2010, called *Alcohol*. It is an extremely learned report in which the Committee reviews the consumption of alcohol in these isles over the last 300 years, looking at policy and how that has influenced the consumption of alcohol. The concluding paragraph in the summary statement says that were the industry fully signed up to responsible drinking—we heard about that from the previous witness—the amount of alcohol that is consumed in England would be reduced by at least 40%. It then poses the question of the extent to which the aims of an industry that is legal but which obviously has a particular set of aims can be reconciled with the aims of those who are interested in the health and well-being of the population. I think that is a genuine question.

**Dr Eleanor Wimpenny:** The irreconcilability of the two different results is because the studies are actually asking two slightly different questions. If you ask two different questions, you do not really expect to get the same answer. The industry analysis is asking for the exposure per capita of the population, which I understand comes from their interest in understanding how much a particular ad campaign is seen by a member of the population. Our analysis was really looking to inform policy-making that would be thinking about the ways to regulate advertising—how advertising could be changed in different ways so that it would not be seen by a particular group, such as young people. One of the three countries that we looked at was the Netherlands, which has a restriction on alcohol advertising between 6 am and 9 pm. We were quite interested to see whether that restriction might mean that young and teenage groups in the Netherlands saw less alcohol advertising than adults. Among the people watching television, you are thinking about who is seeing more advertising and who is seeing less. It turned out in our study that the results in the Netherlands were quite similar to the UK—this particular policy does not seem to be having the effect that the policymakers wanted it to have. It is not the case that because the methods or the results cannot be reconciled, they are not useful; they are just useful for different things and for answering different questions.

**Chris Baker:** It is very interesting that the research was effectively conducted, it seems, to deliver a result—or rather with the objective of seeing how we can reduce exposure—while the way it is presented is that it is a fact that 10 to 15 year-olds are seeing more advertising than adults. That is presented as a neutral piece of information, but what is driving the techniques and the presentation is the question of how we reduce it. It is perfectly valid to look at how we reduce exposure, but it is being presented as a straight factual piece of information. The headline that 10 to 15 year olds in the UK see more advertising than adults is plainly not true.
Q72 Baroness Benjamin: I believe that the RAND research was limited to 10 TV channels. Would the results have been different if it took into account that children and young people are exposed to alcohol advertising imagery online—through YouTube and social media et cetera? Would that have made any difference?

Dr Eleanor Winpenny: I think it might. We have not done that analysis, so it is hard to say what the result would be. We are just looking at television, and the industry method that compares per capita exposure is only looking at television exposure. We are not comparing per capita exposure, we are just looking, within our television dataset, at how exposure goes up and down or how viewership goes up and down compared to adverts shown. In the industry analysis they are looking at per capita exposure but only looking at one channel—TV rather than online television or the internet. We know that young people actually watch less television than adults, which is going to affect the answer that the per capita analysis comes up with. If younger people are watching less television, then they are going to see fewer adverts because of that. If young people are moving on to online television, which is not included in these data, then you would expect them to see a smaller number of adverts per capita in the standard television data. If you are looking at per capita exposure, it is necessary to involve all these different types of exposure.

Lord Wasserman: I do not know why we are spending so much time talking about television. This is not an inquiry about television or about how much television children are watching. The question is how much television watching affects their consumption of alcohol. Children behave differently from adults and from other children of different ages. Have we established yet how much watching an ad on television affects children’s consumption of alcohol? I do not think we have, although I may have missed that bit.

Professor Theresa Marteau: That is one of the questions. I have talked about what the evidence tells us about the impact that alcohol advertising and marketing has on consumption and the association between them. I mentioned in my introductory remarks that my group has just completed a systematic review looking at this. In that review, we looked at the immediate impact on consumption of exposure to adverts and to imagery in films and television programmes of people consuming alcohol. We included 19 studies—all experimental designs, just looking at the immediate impact of exposure either to adverts for alcohol or some other kind of control advertisement. Out of those 19 studies, we found seven that had looked at the impact of advertisements and found a small but significant impact on the amount of alcohol that is observed to be consumed in that context. In the five studies that looked at the impact of watching depictions of people in films or television programmes consuming alcohol, we did not find an impact on subsequent consumption of alcohol. We also found, across the studies, that attitudes towards alcohol became more positive in those who had been exposed to advertisements. So there is some evidence that shows that exposure to adverts is influencing behaviour and attitudes, not drawing people to particular brands—there was no evidence of that. That is one of six systematic reviews that have been published.

Two others, which are the strongest—one involved analysing data on 38,000 young people in cohort studies—looked at consumption of alcohol at a baseline. It was observational work looking at how much exposure the young people had had to marketing. What these two most robust reviews show is that there is an association between exposure to marketing and the age at which young people aged 13 to 16 start drinking. There is also evidence, for those
Chris Baker, Consultant; John Duffy, Statistics and Policy Consultant; Professor Theresa Marteau, Director, Behaviour and Health Research Unit, University of Cambridge; and RAND Europe—Oral Evidence (QQ 63-73)

who have started drinking, that the more marketing they have been exposed to, the higher their drinking. If they have been exposed to less marketing, their drinking comes down. The evidence is imperfect, because it is not possible to control for everything. None the less, the evidence that exists is consistent.

Q73 Viscount Bridgeman: Moving to the objective subject of labelling, what is the evidence that labelling will have an effect on the choice of beverage or on overall consumption? I think that Dr Winpenny has been doing some field work across EU member states to assess the nature and content of the health-related information provided. I have a supplementary question on the concern that there should be a Europe-wide strategy to have a comprehensive programme.

Dr Eleanor Winpenny: I also had a small advisory role in a study that was conducted by another organisation, looking at labelling across the EU. It was a field work study collecting information on the different labels that were available in different places. That study did not collect evidence on the link between labelling and consumption. A number of different studies have looked at the link. The Office for National Statistics in this country has conducted surveys on who has heard of alcohol units, related to unit labelling. The surveys showed that knowledge of alcohol units went up over time, although it is quite difficult to link that back to the labels, because often when you put labels on bottles, it is not just putting labels on bottles but talking about it: it is in the news as well. So it is quite difficult to make a specific link between labelling and understanding.

There is a French study where researchers conducted a survey to understand who knew about the harms related to pregnancy when the French implemented their pregnancy label. The study showed that knowledge of harms associated with alcohol in pregnancy went up. But again, there is the difficulty of attribution. Also, interestingly, there is an Australian study that conducted focus groups with undergraduate students and asked them how much they understood about standard drink labelling and whether they used it when they made decisions about alcohol purchasing. The result was that, yes, they did use it, but they used it to purchase as much alcohol as they could for a given price—which was not really the intended impact.

Professor Theresa Marteau: Could I add a couple of points? As I mentioned at the beginning, we have just started a systematic review looking at labelling for alcohol. It is a very important issue that is being discussed. To complement what Eleanor said, very few studies have considered the impact of alcohol labels on consumption, and the few that have found either no effect on consumption or—in two cases—paradoxical effects where the labelling actually served to increase the amount of alcohol people consumed. So we have to be careful that any interventions are evaluated, because they can have the opposite effect.

There are two possible reasons why the labels are not having the intended effect. First, the information on labels is neither clear nor visible. I invite you all to go to your local supermarket and inspect what labels there are on alcohol products. Secondly, in general, labels on for example food have trivial effects; they are unlikely to change behaviour. But where labelling has been implemented for a long while, such as in the USA, it has raised awareness of harm, and it is thought that this could be important in increasing popular support for effective government intervention to reduce the consumption of alcohol, and therefore harms. So labels might work in that way, rather than reducing consumption.
Lord Blencathra: I have a quick supplementary, probably for Mr Baker rather than anyone else. If alcohol consumption is going down, I assume there is no organisation whose advertising urges people to drink more alcohol generally. Companies, I presume, are trying to encourage brand switching; drink their vodka instead of any other. Do not drink Dubonnet, drink something less vile instead. Are my prejudices right that it is more brand switching than the overall level of alcohol consumption that companies are involved with—and, if that is the case, what is the real problem?

Chris Baker: People talk as if the industry advertises ‘alcohol’ as a category. What actually happens is that there are hundreds of different brands each focusing on selling their brand. So there is no concerted action. The focus is on selling more of their brand at the expense of others. In a declining market such as we are seeing, you are going to grow your brand only by brand switching. The other thing that was referred to in the last session was that companies, to the extent that they have broader strategies, are really focusing on what they call premiumising: in other words, selling less for more. Your business is not about selling more but about making more. So what is driving a lot of advertising strategy is not just brand switching but switching to higher-priced products on which they have better margins. As you say, you are looking at a fairly major decline in the UK over quite a long period, at the same time as advertising is continuing pretty much at the same rate.

Dr Eleanor Winpenny: I have one very small point to make on brand switching. Often, what we are worried about is advertising being seen by young people who are not actually drinking yet, so the problem is not really about brand switching if they have not already developed some kind of brand allegiance.

Chris Baker: But they are drinking increasingly less in the UK despite the exposure that they are getting from the small amount of advertising that they are seeing.

Professor Theresa Marteau: Absolute levels of alcohol consumption are still of great concern.

Chris Baker: Yes, I agree

The Chairman: On that note, I think we will finish. Thank you very much indeed.
Balance, the North East Alcohol Office is a small organisation funded by the 12 local authorities in the North East of England to help reduce alcohol harm in the region. Balance takes a population-level, de-normalisation approach to reducing the harm caused by alcohol and in doing so follows WHO guidance and the evidence base set out in the report ‘Health First: and evidence-based alcohol strategy for the UK’, a report produced by independent experts and signed by 70 organisations and individuals whose collective goal is the reduction of alcohol harm.

The North East suffers some of the worst harms associated with the use and misuse of alcohol. The region has:

- The highest level of alcohol-related hospital admissions in England – though the rate is falling faster than in any other region in England
- The highest rate of 11-15-year-olds consuming alcohol
- The highest rate of children in specialist treatment services

Balance, on behalf of its partners in the North East, welcomes the opportunity to contribute to the House of Lords inquiry into the future of the EU alcohol strategy.

Response to call for evidence

1. Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

Balance strongly supports the introduction of alcohol strategies at local, national and European levels and believes it should be based on the policies outlined in the WHO global strategy to reduce the harmful use of alcohol (WHO) and the WHO European Action Plan to reduce the harmful use of alcohol 2012-2020 (2011). Policies outlined in these documents are clearly based on strong, independent evidence and have been endorsed by all EU Member States. These two documents outline 10 policies:

11. Leadership, awareness and commitment
12. Health services’ response
13. Community action
14. Drink-driving policies and countermeasures
15. Availability of alcohol
16. Marketing of alcoholic beverages
17. Pricing policies
18. Reducing the negative consequences of drinking and alcohol intoxication
19. Reducing the public health impact of illicit alcohol and informally produced alcohol
20. Monitoring and surveillance

In terms of effectiveness and in line with independent evidence, the WHO has identified the three “best buy” policy interventions that are most cost-effective in reducing harmful consumption of alcohol, namely controls on the price, availability and promotion of
alcoholic drinks.

Given that the circumstances surrounding the availability, promotion and consumption of alcohol differ from country to country, Balance recognises that it is not possible to impose common conditions across the EU. For that reason the EU Alcohol Strategy should support and complement comprehensive national alcohol strategies by focusing on policy areas where the EU can add value, for example in relation to trade and cross border issues. It should also provide Member States with the freedom to implement national policies that prioritise the health and wellbeing of their citizens.

A primary aim of an EU Alcohol Strategy must be to ensure that a ‘Health in All Policies’ approach is taken with decisions at the EU level, and that the health and wellbeing of EU citizens is prioritized over trade and economic operator interests. An important objective within this aim must be to address the health inequalities, both within and between Member States, which are exacerbated by harmful alcohol use. This is an issue of particular interest in the North East of England.

2. Are the EU’s alcohol policies underpinned by a sound scientific base?

Significant parts of the old EU Alcohol Strategy were underpinned by a strong evidence base. The framework of policies reflected the breadth of actions needed to reduce alcohol harm across the EU population. Of particular note was the establishment of funding streams to advance the work of alcohol researchers and develop the evidence base for effective policies, through projects such as AMPHORA and ALICE RAP. Critically, funding was also allocated to NGOs to build capacity amongst civil society organisations.

However, the previous strategy could have been more ambitious and the fact that it expired in 2012 presents a real threat to efforts to tackle harm caused by alcohol across Europe. Europe is the heaviest drinking region in the world and a significant proportion of alcohol harm is experienced by adults of working age through chronic health conditions including liver cirrhosis, cancer, stroke, heart disease and also mental illness and dependency (WHO EU Alcohol Action Plan, 2011). The current (draft) EU Alcohol Action Plan ignores those facts by concentrating on young people and binge drinking and does not include recommendations for interventions aimed at reducing health problems caused by regular heavy consumption amongst middle-aged adults, who have the absolute highest rates of disability and premature death due to alcohol.

The Science Group of the EU Alcohol and Health Forum was established in 2008 to provide scientific guidance to the Forum. Balance believes its function and role could be improved to ensure that EU alcohol policies are underpinned by an up to date, independent evidence base free from commercial vested interests.

3. Are the EU’s alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?

The end of the previous EU Alcohol Strategy means that there is no comprehensive policy framework in existence at the EU level that can be compared to the WHO Global Alcohol
Strategy or WHO EU Alcohol Action Plan.

Most notably, EU alcohol policies currently do not include a set of specific, measurable and timely indicators which outline EU ambitions for reducing alcohol harm. This is in contrast to current WHO strategies that include the following goals:

- To achieve a 10% relative reduction in the harmful use of alcohol, as appropriate in the national context, by 2025 (WHO Global Action Plan for Prevention and Control of Non Communicable Diseases 2013-2020 – baseline data from 2010)
- Offer brief advice programmes to 30% of the population at risk of hazardous or harmful alcohol consumption; or offering early identification and brief advice to 60% of the population at risk (WHO European Alcohol Action Plan)
- To achieve a 25% global reduction in premature mortality from non-communicable diseases (NCDs) by 2025 (World Health Assembly Political Declaration, May 2012)

As these goals have been endorsed by EU Member States it seems logical that they should be reflected in and endorsed by a new EU Alcohol Strategy.

4. Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EUAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

Balance believes the mechanisms created in the previous EU Alcohol Strategy still have an important role to play but should be revised to reflect the needs of a new, more ambitious strategy that puts ‘Health in All Policies’ at the heart of it focus.

This requires the role of CNAPA, as the body representing Member States, to be strengthened so that it can lead on the design and implementation of a new EU Alcohol Strategy. When it comes to EUAHF, Balance believes strongly that its role and function should reflect WHO guidance, which states alcohol industry activities should be restricted to their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages and that they should have no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests.

Balance believes the Science Group of the EUAHF should report directly to CNAPA to enable policy discussions on the evidence to be free from commercial conflicts of interest. It is not appropriate that economic operators with financial interests in policy areas such as price and marketing should be involved in the presentation of scientific evidence to policy makers. The Science Group of the EUAHF should therefore be re-established as an independent expert group, free from membership from economic operators. Its members should be able to declare that they do not and have not accepted money or commissions from commercial operators.

5. Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?
Whilst there are funding streams available within EU programmes for alcohol research, there is an urgent need for better data on alcohol in Europe and coordination of alcohol research, both of which should be addressed in a new EU Alcohol Strategy. The European Commission’s evaluation of the Alcohol Strategy to 2012 highlighted that less than 3% of the total budget of the Health Programme for 2008-2013 and less than 1% of the budget for health under the Seventh Research Programme were allocated to alcohol. Given the level of harm caused by alcohol this is simply not enough.

At present several Member States collect relevant data on alcohol harm and consumption; however there are many countries where sufficient data is not routinely available. We recommend that an EU Alcohol Strategy includes funding mechanisms for data collection, so that alcohol harm and policy progress can be monitored and evaluated across the EU.

6. Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

It is clear that tensions exist between the promotion of free trade and the protection of public health through fiscal measures for alcohol within the EU. It seems current EU regulations have the potential to undermine Member States’ efforts to implement pricing policies designed to protect public health. Scotland’s plan to introduce minimum unit pricing for alcohol is the obvious example.

In 2012, the legal challenge launched by the Scotch Whisky Association and Spirits Europe to thwart Scotland’s plans to introduce minimum unit pricing generated an opinion from the European Commission which did not correctly differentiate between the roles of minimum unit pricing and taxation. It recommended that taxation alone could achieve the same objective of reducing consumption of cheap, strong alcohol amongst harmful drinkers when the EU Directive on alcohol taxation actually prohibits the implementation of a taxation system for all beverages based on their alcoholic strength. Indeed, this is one of the many reasons why the Scottish Government turned to minimum unit pricing as a policy solution. Minimum pricing and taxation are complementary policies.

Should the European Court of Justice find against a policy that has been voted on by the Scottish people, passed into law by the Scottish Government and judged as reasonable and proportionate by the Scottish Court of Sessions, there could potentially be adverse consequences for wider public health policies than alcohol.

26 September 2014
Evidence Session No. 8    Heard in Public    Questions 117 - 139

TUESDAY 18 NOVEMBER 2014

Members present
Baroness Prashar (Chairman)
Viscount Bridgeman
Lord Tomlinson

Examination of Witnesses

Paul Skehan, Director General, SpiritsEUROPE, and Simon Spillane, Senior Adviser, Beer & Society and Communications, The Brewers of Europe.

Q117 The Chairman: One advantage of having you in the audience is that I do not have to repeat what I said to the first session. You know who we are and you know what the format is, so we can go straight into the session. Again, can I ask you if you want to make any introductory comments before we get into the questions, tell me a little bit about yourselves and so on? That would be useful by way of background.

Paul Skehan: Thank you very much. My name is Paul Skehan. I am the director-general of SpiritsEUROPE. SpiritsEUROPE is the Brussels-based association representing the distilled spirits sector in Europe. We act as a bridge between our sector and the European institutions. We have, within our range of activities, help and issues linked to alcohol-related harms, but we also do a lot of work on external trade. We do a lot of work on formulating the rules that dictate the production and sale of our products within the internal market. We also do quite a lot on fiscal matters, as you can imagine.

We are a sector that directly or indirectly employs about 1 million European citizens. We are the premier agri-food export from Europe. We export about €10 billion worth of product per year, of which about €9 billion sticks to Europe. We represent 32 associations and eight of the largest companies. It is a pleasure to be here. Thank you very much.

Simon Spillane: It is also a pleasure for me to be here. My name is Simon Spillane. I work for The Brewers of Europe, which is the cousin association of SpiritsEUROPE, and we represent 28 national associations from the UK as the British Beer and Pub Association. In Brussels, we represent the interests of 5,500 breweries across the European Union. In terms of numbers, we create 2 million jobs in the European Union and, in terms of the policy areas we deal with, it is similar to what Paul was mentioning. In addition to issues around alcohol-related harm, we focus also on environmental sustainability, food safety, fiscal dossiers and trade,
and the functioning of the internal market. Like SpiritsEUROPE, we are one of the founding members of the European Alcohol and Health Forum, along with Eurocare as well. We have been involved in this from the start, when the EU strategy was adopted by the Commission in 2006, and we are still part of that and are an active member of the Alcohol and Health Forum.

Q118 The Chairman: Very good. Can I start by asking you whether there should be a new EU alcohol strategy? If so, in what way should it be different from the earlier strategy?

Paul Skehan: We believe that, while our products are enjoyed responsibly by the vast majority of people, they are not by others. If you abuse alcohol, if you misuse it, you will have problems. For as long as there will be alcohol-related harm, there should be strategies in place to ameliorate or reduce that harm. We think that at national level there is a need for strategies to address alcohol-related harm. If that is the case, we believe that there is a value in having a European structure in place that helps share good practice between those countries, the operators and the stakeholders who are involved.

For us, there is a great value in having a European strategy. We support it. We support the existing strategy. We will support whatever happens in the future. We do not think it should be dropped. It should be continued and developed. In terms of how that should happen, we think there are elements of the current strategy that make sense, are valuable and useful, and others that should be amended and changed. We think take the best of what is there, adapt and improve it for the future.

Q119 The Chairman: Any specifics? What do you see as having been the best aspects of the law that you would like to see adopted in the new one?

Paul Skehan: In fact, it comes back to something that Mariann said earlier. It brings very disparate groups together. It brings us into contact with the NGOs, the health community and the Commission. That is not a bad thing because we think the problems associated with alcohol harm are quite complex and are not easily solved by a simple approach. We firmly believe that it is by working together that it is likely that we will find solutions to the problems. In that regard, for the future we would think that the approach as it currently stands is a little bit too fractured.

We have heard already in your session this afternoon of the CNAPA group being separate. It is totally separate and it seems odd to us that we will develop projects and actions that will target harm but we are not joined up to what the member states are doing, what the police forces are doing, what the educationalists are doing, and so on. That to us is a mistake. I guess our big focus would be that there needs to be a joined-up, holistic approach towards harm and a crossing over of the barriers that currently exist within the existing strategy.

The Chairman: What is your view?

Simon Spillane: I would agree that we need a strategy. An interesting question is whether we have a strategy at the moment. This has also been addressed earlier, as to whether the current EU strategy did come to an end or whether that strategy is still valid in the sense that the structures set up by it, the Alcohol and Health Forum and the Committee on National Alcohol Policy and Action, have continued to work at the same rate.

In terms of whether we should have an EU strategy, I think the answer is yes. In terms of whether we need a new EU strategy in order to continue that work, I am not sure to be
honest. I think there is definitely room for improvements and I would agree with some of the points that Paul made but also some of the points that were made earlier in terms of setting better indicators and targets and perhaps building on some of the best practices. I think there is equally room to do that within the current strategy.

While we certainly would not oppose there being any new EU strategy, equally while that debate is going on we should be continuing to work under the current one. These processes can take time and I do not think we should be losing the momentum that we had from 2006. We possibly lost that slightly around 2012 but we still have some at the moment.

**The Chairman:** What you are saying is that we should not lose the momentum, that one should continue and we have to build on it?

**Simon Spillane:** I think the priorities remain the same and the evaluation that took place of the EU strategy stated that. It equally pointed out where there was room for improvement. Some of the links between the CNAPA and the Alcohol and Health Forum have been mentioned already, but I think the priorities are targeting underage drinking, binge drinking, drink driving, alcohol in pregnancy and alcohol in the workplace. These are areas that are still valid priorities and, to be honest, they will not ever go away entirely. They will remain relevant, but I think there is room for improvement.

One of the issues we have had up until now is data on alcohol-related harm. We do not have the data on where things have moved from the beginning of the strategy up until now, but I think there are examples in some countries of areas where improvements have been made. We should look at what has been going on in those countries over the three years. Are there opportunities to implement those approaches in other countries? That could be policy, but it could also be campaigns, initiatives or increased investment in certain areas. I think there is certainly a need to continue the work at EU level, again complementing what is happening at a national level.

**Q120 The Chairman:** Can I move on to something much more specific? You are both involved in the EU Alcohol and Health Forum. From your point of view, how has that cooperation worked? What do you think have been the achievements of the forum in reducing alcohol-related harm? Going forward, what sorts of changes would you like to see in how it might develop and improve its effectiveness, if you think it should be retained at all?

**Paul Skehan:** As I mentioned before, I think one of the main benefits of the forum is having an environment where we can meet face to face with Mariann and her colleagues, the NGOs, the health community and so on. Many of them will have policies preventing them from meeting us outside the forum, so if you do not have a forum we simply will not meet them. We will not listen. We will not hear. We will not challenge and we will not be challenged, except through the megaphone newspaper media orientation. I think that is a very positive thing.

The work going on at the moment in the governance group that was referred to earlier by Eric and Mariann, which we also play a part in, is very useful. In fact, it is looking at ways in which the forum could be improved. It is looking at the types of commitments that are made. It is looking at how that monitoring is carried out, whether there should be a purchase price to get into the forum in the first place. That purchase price in the past has always been that you have to come forward with commitments, and those commitments have to be towards demonstrably reducing harm.
In terms of what it has achieved, I can say that since the start of the Alcohol and Health Forum and the start of the strategy the spirit sector has implemented 326 different actions, mostly at national or local level, some at European level. Would they all not have happened if the forum did not exist? No, we probably would have done some of them, but certainly the forum and the strategy have given an impetus to us to do more and to try to co-ordinate our activities better. In fact, all those 326 activities fall under a single commitment that we have made to the Alcohol and Health Forum, where we made a single five-year, multiannual, multicampaign commitment. I think that is one of the positive things that have come from it, at least with regard to us.

**Simon Spillane:** When referring to the effectiveness of the forum, it is important to think of it as more than just a group of people who get together two times a year for a meeting. There are over 300 commitments to action that have taken place within that forum. The brewers have taken a slightly different approach and 100 of those commitments are supported and owned by the brewing sector. I would say that certainly when it comes to action on the ground at local level there has been a lot of co-operation, working together with NGOs, consumer groups, doctors’ groups, local authorities, on campaigns against drink driving, underage drinking, binge drinking, and on marketing as well, strengthening self-regulation mechanisms.

I would disagree with some of the comments that were made earlier in terms of there not being much progress on marketing. Certainly, as far as the brewing sector is concerned—and I think this applies also to the other producer organisations—this gave us a great impetus for strengthening the self-regulatory systems that govern beer advertising all across Europe. For example, in Bulgaria there was not even any self-regulation system at all until five years ago. In fact, because it was an important point on our agenda, the brewers helped set up that system and then the other drinks producers and all the food and drink industry and other industries came together to set up a system. I think there has been co-operation. At the EU level, it is always going to be a bit limited, I think. For example, as The Brewers of Europe, we have a three-year partnership at the moment with the European Transport Safety Council, an NGO that deals specifically with road safety. We work with it on drink driving. Without the forum, I am not sure we would ever have entered into such a partnership and probably the same would apply for it. It also gives us a lever to share some of the best practices and ensure that we bring up the standards in some countries where maybe the experience of a CSR campaign for self-regulation was less strong than it was in other countries.

**Q121 The Chairman:** I may be wrong, but the sense I get is that there have been a lot of initiatives. Are they all evaluated and are they targeted? Are they focused? You can have the quantity, but what is the qualitative impact of these initiatives? Is this something you have been monitoring?

**Simon Spillane:** I would agree that it is an issue. Certainly, for some initiatives there is a lot less evaluation. Essentially, it comes down to the question: do you spend the last €50,000 or whatever on evaluation or on further implementing the activities? This is a point that has been made by the NGOs in discussions as well, in terms of where the resources are directed. However, by making commitments through the forum you are, in fact, making two commitments. You are committing to do the action, but you are also committing to monitor the implementation of those activities.
When it comes to The Brewers of Europe, we have a European beer pledge and our annual reports go through an assurance process involving KPMG. Does that monitoring process go all the way to the extent of saying, “Is this campaign responsible for reducing underage drinking?” In a number of cases it cannot go that far. For example, there was a campaign that was run by our Italian member in partnership with the Italian association of obstetricians. They worked together to increase awareness of pregnant women around the dangers of alcohol during pregnancy. They evaluated this and they could see that, over the course of the campaign, awareness was increased. Potentially, there were other activities that were contributing to that.

I think that is also one of the reasons why we need to agree centrally at EU level, or at least at national level across the different parties, what the objectives are in order to reach the targets. For example, in order to address this issue you need to increase awareness of the problem; you need to enforce the law; you need to train the servers. If we can agree on the different tasks in order to reach those objectives, then I think we can at least work together towards the same objectives. I think that is the way also at local level, where partnerships are often easier and it is why you have different organisations representing different interests. You may have different motives behind taking part in the action. You may have different skills in the activities, but at least, if everyone can agree what the objective is in area A, B, C or D, I think we can improve actions. That is something that can certainly be strengthened.

**The Chairman:** It has been suggested to us that there be better indicators at the forum in terms of the future.

**Simon Spillane:** Yes. I was interested to hear earlier, especially from Mr Møller, that it was always about consumption and how we reduce consumption. Over the course of the EU strategy, so since 2006, beer consumption in the EU has declined by 8%. For me, that is anecdotal because that does not mean there has been an 8% improvement in alcohol-related harm, but I think we can have indicators on drink driving, for example, where fatalities are shown to be down 50% from 2000 and 2010. We can have indicators on underage drinking, on sales to underage and on awareness among risk groups of the dangers of alcohol misuse. I think there is definitely room for that.

Fixing targets may be difficult because countries are coming from different points and I think it is perhaps unfair to set the same targets for all countries. We have also experienced that when it came to strengthening self-regulation systems. We could say, “Fantastic, what brilliant work from Bulgaria. You started with nothing and now you have 90%”, whereas for countries that were already doing a lot there, obviously there is less of an improvement.

**Q122 The Chairman:** Outside the forum, what action is the alcohol industry taking at a European level to reduce alcohol-related harm? Are there differences between brewers and the spirit sector? Are there differences in quality and quantity of action taken based on member state origin?

**Paul Skehan:** Probably a great deal happens, but does it happen outside the forum? It does. No actions happen within the forum. We report back to the forum. In fact, all the actions that we take, the 326 I mentioned, happen outside of the forum in one form or another.

The five-year roadmap that we have covers three big pillars. One is responsible commercial communications. In that regard, in 2010 we brought out a guide for responsible marketing of
We have disseminated that widely. It helps to change the way in which our products are being advertised. We run training programmes for the advertising industry across Europe, which works and pays off. The second is responsible drinking. We have many programmes and campaigns running on that. One that I liked best was in Romania, where they had a thing called politaxi. They took a car and they painted half of it as a taxi and half of it as a police car. They put the flashers on it and they put the taxi on the other side. They went to festival after festival, and night area after night area, and put this on very prominent display saying, “You have a choice how you are going to go home tonight”. I love that. I think that is just so visual. It is fantastic and it is an example of one of the many things that we do on responsible drinking.

Then in terms of engaging more stakeholders in harm reduction, we try to work across many different stakeholders, and our partners at national level typically do that. There is quite a lot that happens outside of the forum, but almost all of it, one way or the other, gets reported back into the forum. We have a website called drinksinitiatives.eu. Everything we have goes in there and we say what we have done, who we have worked with, what the target was and what the results were.

For the same reasons that Simon mentions, not all of them are thoroughly externally evaluated. How would you evaluate the politaxi? How many people saw it? They make estimates of that. They can measure the amount of publicity and media attention they get, but the overall effect on the areas they go to is very difficult to judge. All the stuff we do is absolutely transparent. Where we have monitored and evaluated, we show it. Where it has not been evaluated externally, we say it.

Simon Spillane: I would say we have a pretty similar approach and the same answer there. As I mentioned, we have a lot of commitments made through the forum process. One of the reasons for that is that it obliges reporting and monitoring, but outside there are also activities that are conducted by our association companies. They are not conducted as forum commitments but they are all still working towards the same objectives.

In terms of how different industry sectors operate, as a producer association we are the producers and the marketers of the product but we are not the ones who are, except in very few cases, selling directly to the consumers. That is why it is not just about having partnerships with NGOs; it is also partnerships across the industry and we are keen to step up further in terms of working with the retailers. Obviously, as the brewing industry, we have a close link with the pubs in a number of cases in certain markets, which perhaps makes it easier for us than some of the other producers, but I think we all have an interest in ensuring that we are working across our value chain to basically ensure that where the expertise is placed is where the activity is taking place.

The same applies for working together in partnerships with doctors’ groups. Our role as brewers is not to be talking to patients. However, we can finance the production of booklets provided that the content is put together by the experts and the doctors, for example.

Q123 Lord Tomlinson: Before we go on to the question that I was going to ask, Paul, I want to raise one thing with you. I read the evidence that SpiritsEUROPE sent in and today you sound to be a perfectly reasonable man, much more reasonable than the evidence as I read it. As I read the evidence, you seem to be saying that co-operation between the industry and the public health sector was “too polarised and inefficient”; next point, that EU funding “is
repeatedly allocated to the same actors, despite the quality of their research outputs”; and, 
thirdly, that, “minimum unit pricing and taxation are both ineffective in addressing alcohol 
misuse”. The thing with each of those points, which came out very strongly in your written 
evidence, is that you do not sound like the same man with the moderate reasonability of 
what you are saying today.

Paul Skehan: Lord Tomlinson, you are sounding like my wife now. Sometimes I am 
reasonable and sometimes I am not, but it is very similar. No, we will come to those points 
and maybe I will sound less reasonable when we do so. I know, within the questions that you 
have asked us today, MUP comes up and the question of research comes up. We feel quite 
strongly about these issues, but overall I have to say that we think we are quite reasonable 
in the sense that we have a sector that produces delightful products. Those same delightful 
products when you abuse them will hurt you, kill you, or hurt your friends. It is a very 
interesting sector to work with and for, but our approach is we believe strongly that the 
product itself is not evil or wrong. It is the consumption patterns and behaviours that will 
dictate whether it is going to be something that is bad. As a result, we try to put forward a 
whole series of very useful suggestions in the forum, in our commitments, in our discussions 
with policymakers and in our discussions with anyone that we can talk to, to say, “Here is 
what we think will help this situation”.

Just coming back to the point you made earlier, we strongly believe that the way forward is 
less polarised than it currently is. Mariann and I have great arguments when we come to the 
forum but, at the end of the day, it is about what works. Let us take the example of drink-
drive over the years—I grew up in Ireland. Drink-drive in Ireland 20 to 30 years ago was 
horrrendous. Now it is much less and the statistics back that up. I do not think that was by 
saying, “We are going to cut down on consumption. If we cut consumption, drink-
drive will stop”. That would not have been the solution.

I think what has happened on the drink-drive issue is that a lot of people have worked 
together, including the member states, the enforcement agency, the licensing agencies, and 
the industry because we have done a lot of server training, a lot more awareness and so on, 
and what has happened there is behaviour has changed. It is no longer socially acceptable to 
do that, and that is where the change has come. Yet, when I listened also to Dr Møller 
earlier, all he concentrates on at the moment is reducing consumption. He says if we reduce 
consumption harms will stop. I do not believe that and I do not think it is a sensible 
approach. I just do not think that the evidence backs that up. Our approach is we think it 
needs to be targeted. If you are going to target these particular problems like binge, 
underage and pregnant women drinking, then we think a holistic, joined-up, multi-
stakeholder approach will work and not much else will work.

Q124 The Chairman: On reducing consumption, it is logical that if people are drinking too 
much and if you are going to target them and they reduce their consumption or stop 
drinking that does lead to less consumption.

Paul Skehan: Yes, of course, if you reduce consumption people consume less, but does that 
automatically transfer into less harm? It does not. It is not a linear progression.

The Chairman: Less harm individually; not in terms of harm to other people but harm to 
individuals. If you reduce your drinking, on the evidence we have had on the impact on the
individual’s health, I do not see why you can say that it does not necessarily lead to less harm.

*Simon Spillane*: I think you were talking about a targeted approach.

*Paul Skehan*: You are.

*Simon Spillane*: Targeted at people who are drinking too much.

**The Chairman**: But that is what you are saying.

*Paul Skehan*: No, that is fine, we agree with you.

*Simon Spillane*: Yes, if the people who drink too much drink less then obviously that is—however, this is different from the population-level approach where you are basically saying everyone drinks less—

*Paul Skehan*: Overall, everyone needs to drink less.

*Simon Spillane*: —and, therefore, the harm is reduced. Consequently, if moderate consumers are drinking less, there is a lot of research that shows that moderate consumption is compatible with a healthy lifestyle. It even has benefits for certain consumers. There are two very different schools of thought. Is the aim: you reduce overall consumption, everyone drinks less, including the moderate consumers, and is that targeted? In fact, is it legitimate to affect the lives of everyone even if they are consuming in a responsible manner? Are the different target groups reducing consumption at the same level? Is your alcoholic drinking less because you have banned marketing? Probably not. The underage drinkers or someone who is drinking informal or illicit alcohol, so moonshine, are they going to drink less if you make the availability of legitimate products harder to access? They are two very different schools of thought.

**Q125 Lord Tomlinson**: But if you followed the view of Dr Møller in relation to the permitted level of blood alcohol content when you are behind the wheel of a car, and if you change that for everybody, because that is the only way you can really do it, to say that 0.8 is too high, we will fall in line with mainstream Europe and have 0.5 and maybe, as he also suggested, reduce it to 0.2 for people who are professionally driving, that is tackling the population as a whole. Are you disputing that it would have beneficial effects?

*Paul Skehan*: No, but that is a different thing from tackling consumption as a whole. Tackling the population and saying, “When you drive you do not drink”, we have no problem with that. We would support that. However, if you are saying, as Dr Møller is saying, “If we take the per capita consumption across Europe and reduce it overall, on average, then the problem is solved”, we do not think that is the case. They are two very different things. Yours again is a more targeted approach, which we would support. It says, “We have a particular problem here. We should harmonise, because that makes sense”. Yes.

**Q126 The Chairman**: Can I be clear? To me, I do not think they are different strategies. If you have a targeted approach to consumption, drinking and driving, health-related harm, pregnancy, calories, if everybody is targeted and the collective impact would be a reduction in overall consumption, to me I do not see that—

*Lord Tomlinson*: Semantic, yes.
**The Chairman:** It is semantic. I do not think there is a difference here.

**Paul Skehan:** Would you mind if I give you a piece of paper? Is that possible during the hearing?

**The Chairman:** Yes, of course it is.

**Paul Skehan:** These are figures from the WHO, the latest report. I am sure if Dr Møller was here now he would probably disavow these.

**The Chairman:** Can you describe it? That would be useful.

**Paul Skehan:** It is a report that was produced in 2012 by the WHO. It is called *Alcohol in the European Union - Consumption, Harm and Policy Approaches*. It was edited by Peter Anderson, Lars Møller and Gauden Galea. In fact, what you have on the top part of the page and the bottom part are the same things, but the bottom part is an infographic trying to describe what the top part is.

What is interesting about this is here is the WHO itself saying, “Have a look at per capita consumption of pure alcohol”, so it is litres of pure alcohol, and that is what the first column shows. It comes back to one of the questions you were asking earlier: if you divide Europe north, south, east, west, what are the differences? Well, here they are. If you take the per capita consumption in litres, what you see, of course, is that Central-Eastern Europe has the greatest consumption per capita. Second, you have Central-Western followed by Southern followed by Nordic. Then you add in the second column, which is unrecorded; so illicit alcohol. Add those figures in.

Across the bottom we have made an infographic so it makes it a little bit easier. What you see in blue are the totals of the adult per capita consumption in litres. What you see there is it goes from left to right. What WHO also did is to develop a hazardous drinking score and right at the bottom in the small type you see what that means. It says, “The hazardous drinking score is a composite score indicating the potential impact of drinking on health and social outcome ranging from one to five. It is comprised of some heavy drinking indicators, including the proportion of drinking with meals and drinking in public places, all of which have been associated with more harmful outcomes for the same volume of overall drinking.”

What is fascinating about this is, despite the fact that the Nordic countries have the least per capita consumption of alcohol, they have the second highest hazardous drinking score in that chart. If you are following the idea that per capita consumption is the key, you would be going after the Nordic model. Yet here the figures from WHO themselves say, “Yes, but this region that has the lowest drinking per capita in Europe still has the second highest hazardous drinking score”. We still come back to this idea that it is not necessarily only the amount that is being drunk. A huge factor is the behaviour of the drinker and the behaviour patterns and the trends of people who are drinking. We make a big line between what is per capita consumption and harm.

**Q127 Lord Tomlinson:** Just so that I can be clear with this: if I draw a line across there, that part comes from the WHO?

**Paul Skehan:** Yes.

**Lord Tomlinson:** The bottom part is yours?
Paul Skehan: Well, the bottom part is simply an infographic showing the top part, but that is right. The top part is taken directly from the WHO figure.

Simon Spillane: The numbers are the same, yes.

Paul Skehan: It is just to try to show it.

The Chairman: Which one? This one here?

Lord Tomlinson: No, the text.

The Chairman: The text is yours?

Paul Skehan: The text on top is all WHO and the text right at the bottom is the WHO as well.

Lord Tomlinson: Everything below the text.

Paul Skehan: It is only the infographic that is ours, the nice coloured bit.

The Chairman: Not this comment?

Paul Skehan: No, that is ours.

The Chairman: That is yours?

Paul Skehan: I beg your pardon, yes.

Simon Spillane: But the footnote is WHO’s.

Paul Skehan: The footnote is WHO as well.

The Chairman: Yes. I need to understand this, but I think it is semantic and it is at cross-purposes anyway. You carry on.

Q128 Lord Tomlinson: I just wanted to raise that. I did not think it would necessarily take so long. If I come to the question then about industry compliance with voluntary commitments, how is it assessed? Does the level of compliance vary between sectors and/or member states? To what extent are commitments, projects and interventions to reduce alcohol-related harms objectively evaluated? Are the results publicly available?

Paul Skehan: I apologise because I have probably half-answered this question before for Baroness Prashar.

Lord Tomlinson: Yes, you have answered some of it.

Paul Skehan: We think there are about three levels of reporting. We have national reporting of the different initiatives that take place throughout our network and, as I mentioned before, on the drinksinitiatives.eu database you get a complete description of the action, the listing of the partners, the objectives, the impact details, and evaluation results when they are available. Secondly, SpiritsEUROPE makes a collective reporting of all initiatives every year to the European Alcohol and Health Forum. We make a very detailed report to it, which is also published. Then the Commission itself may have independent evaluators who then assess those commitments and say whether they think they have been done in a correct way. All those are available for public scrutiny.
Does the level of compliance vary? Yes, it does, I think, because we have different problems in different countries. Indeed, our own network in certain countries is weaker than in others. Our ability to work on the ground is impacted by whether there is a flourishing, vibrant spirits industry. Where there is not, we can do less. SpiritsEUROPE in that case provides some support and financial support to build capacity on the ground.

Are they objectively evaluated? We covered this before. Some are and some are not. For some of the smaller ones it would make no sense to try to do so. Many of those, indeed, come from template-type programmes that have been developed internationally through ICAP/GAPG and we take those template programmes that have been evaluated as templates and we try to push them through the network. Are they available? Yes, through all the websites that I mentioned.

Q129 Lord Tomlinson: If we turn back to the previous strategy, in your opinion was the previous strategy based on sound scientific evidence? Is there any recent evidence to indicate that actions taken within the five priorities have contributed to reducing alcohol-related harm?

Simon Spillane: In terms of the strategy being based on sound scientific evidence, it went through an extensive consultation process involving all the different Commission departments. There was a lot of scientific evidence that went into that impact assessment. Some of it was contested. What came out of it in terms of the priority areas that needed to be addressed in an EU strategy and what could be addressed by an EU strategy—because I think an important point there is what can practically but also what can legally be addressed at an EU level—was all covered through the process that this strategy went through. This was over around an 18-month period, I seem to recall.

Is it based on sound scientific evidence? Yes, I would say it is. We can spend ages discussing the numbers about how bad the problem is or what the cost of alcohol-related harm is, but the fact is there is a cost and it is an issue that needs to be addressed. One thing that certainly survived from the start of the process to the end of the process was, in fact, the priority areas that needed to be addressed by the EU strategy.

When it comes to how individual actions have reduced alcohol-related harm, this has also been discussed earlier by the other people being interviewed: how do you isolate the impact of an EU strategy compared to a national strategy and compared to what was just happening because of lifestyles changing and because of the economic crisis? As I mentioned, beer consumption and the beer market declined by 8% from 2006 to 2013. There was a significant decline from 2008. I think there is a lot going on that is contributing to both overall consumption but also, more importantly, to consumption patterns. As I mentioned on drink driving and we perhaps keep on coming back to it because it is the one example where we do have data, because the EU has been collecting data on this for a long time, there is a 50% reduction in drink-drive fatalities. Whatever is being done must be going in the right direction.

On other areas, I think the Commission needs to do a lot more work in terms of looking at the data from the ESPAD survey and from the Eurobarometer surveys because there are certainly areas within there where we can see very clearly that there have been improvements over the course of the strategy. Whether to attribute those to one specific action or, indeed, to the EU strategy, I think often it just depends who you are talking to.
Q130 Lord Tomlinson: The last question that I would like to ask is: what is your opinion of EU-funded research on alcohol-related harm? We have had all sorts of partly conflicting evidence in relation to the value of EU-funded research. From your written evidence you are obviously not that taken with it, although we have had some very positive evidence as well. Can we get a little bit more discursive about it now?

Paul Skehan: Sure, with pleasure. In general, though, let me say that we would support the concept of EU-funded research on alcohol-related harm. We think there is a huge need for it. I come back to some of the points that Simon made before. For me, it is a little bit astonishing that we are eight and a half years after the start of the strategy. We still do not have absolutely comprehensive data, pan-European data, saying here is the incidence of binge, here is the incidence of underage, here is the incidence of drink-drive, here is the incidence of all the different ones that you would imagine should be in there, given that they were the priority areas that were identified eight years ago. That is the one area of the strategy that has not worked. WHO, the Commission and member states have not built comparable data, aggregate datasets, which can be produced into reports very easily.

Is there a need for more research? Absolutely. Is there a need for the Commission to help fund some of that? Why not? At a national level, it is clear that there is research going on. At European level, the benefit of European research would be in showing: here is the state of play across all these different member states, here are the differences within those member states, and then identifying where there are differences and where certain member states make real progress in a certain harm indicator. Then you could focus in and say, “How did that happen? What have you done?”

Q131 Lord Tomlinson: I do not want to appear to be leading you, but I am, so I confess it in advance. It has been suggested to us that one of the problems with the EU research is that the actual areas of research, instead of being determined by the Commission as, “Here we have a gap in our knowledge; we ought to plug this gap and this is what we are going to call for bids on”, is being demand led by the research institutions. How do you react to that?

Paul Skehan: I would say there would be some truth in that. You would need to ask the Commission how it determines what areas to fund, but I suspect it is also open to the same lobbies that we would be under from the NGOs, from the health community and others who will be saying, “You have to focus on advertising. You have to focus on marketing”. Then the Commission will produce a tender; people will bid on that.

In fact, we did a small piece of research on this and looked back over about the last five or six years of funding coming from DG-SANCO or the Chafea, which is the agency linked to SANCO. We looked at the funding that came out of there since about 2009. It is about €15 million, so not huge but not insignificant either. In that, certainly you see pretty much the same characters appearing as beneficiaries and drawing down those monies. We have identified three different groups who would be well known to our industry as not being terribly supportive, but they are listed as the organisers of these particular pieces of research.

We do have problems with the way in which that research is then carried out. We have gone back to the Commission afterwards saying, “Look, we support the idea of this. We think this could have been a useful piece of research, but the way it has been done is simply not robust
Q132 Lord Tomlinson: Do you raise these things within the forum?

Paul Skehan: We do. In fact, I raised one last week in the same meeting that was referred to earlier by Eric. If I give you that as an example perhaps you would understand. This was a relatively small amount of money by European standards. It was about a €99,000 grant. It was to look at the incidence of health warning labels or pregnancy labels or, “Do not drink if you are under 18”; those types of labels. It was meant to look at 15 different countries.

I can give you the evidence that we gave back to them, but in summary the researchers looked at four shops in 15 countries. They took the bottles that were on display in those shops. They allocated a weird weighting system. To explain that, if you had 100 bottles facing you in the shop and 99 of those were Heineken and one was a local brewer and the local brewer did not have a health warning label on his bottle but all of the Heineken bottles had a health warning label on them, they counted that as a 50% hit rate, that the Heineken bottle had compared to the other bottle that had not. That was a 50% hit rate. They then extrapolated that up to a national average and then they drew huge policy conclusions on the basis of that.

What was fascinating for us was, at the same time that they came to the conclusion through their extrapolation that about 7% of the bottles in the UK had these labels, the Department of Health/Campden BRI report came out the same day saying that about 80% to 90% of bottles had these labels on them. On the one hand we had this Commission-sponsored report saying 7% in the UK, and we had the Department of Health and the Minister for Health in the UK saying it is somewhere between 80% and 90%.

On the basis of the 7%, these consultants were making policy recommendations. They were saying, “Self-regulation does not work. You, the Commission, should go forward and regulate”. For me, that would be a good example of the type of research leaps that we have seen and then very general, generic proposals coming forward on the basis of what we would consider to be very limited research.

Q133 Viscount Bridgeman: Taking up Lord Tomlinson’s point and your reply just now, it may be rather platitudinous to say this, but is not one of the solutions to have a sophisticated terms of reference to the researchers with big input from, incidentally, professional statisticians, too?

Paul Skehan: I think it would be fantastic. What you are getting instead is a whole number of people who have an interest in alcohol rather than statisticians, behavioural scientists and others who cover multiple different areas. In fact, I think what you tend to get is a whole lot of people who specialise in alcohol doing the research. There is a vested interest. If you imagine that business have a vested interest in seeing research come one way, I could agree with you. However, I can tell you that the advocates on the other side of the table also have an interest, but some of them wear the white coats.

Simon Spillane: Just on that point, for us the main issue with the piece of research to which Paul referred was the fact that there were then policy conclusions. If this had been, “This is the start of the research. We need to build on this”—because it was a piece of research that looked at a lot of countries—it would have been less problematic. It looked at a lot of
brands. This is not to say that we should chuck this all away, but I think the point is, and this is an issue with a lot of the research, it looks a bit like the policy conclusions had been written upfront. That is also what we have seen in some of the pieces of research that have been published, especially if it is by the same contractor three times in a row self-quoting. Of course, you end up with the same policy conclusions.

The issue for us is not about NGO-funded research or industry-funded research. To us, it is just a matter of good research is good research and bad research is bad research. Equally, there may be budget limitations to certain pieces of research, but when there are caveats in there these should also be taken into account when you get to the conclusions. The point that we made at this same meeting was, yes, let us build on this and it should be an area where you can have facts. There is no room for interpretation in whether labels have information on or not. There should not be room for interpretation here, but if we end up with a situation where two pieces of research potentially look like they are looking at the same thing and one is 80% and one is 8% results, then I think there are problems.

Q134 Viscount Bridgeman: My supplementary on this last one is: what is the medical—that is, clinical or public health—representation on the forum specifically in relation to alcohol-related harm?

Paul Skehan: I think most of them are there. I would need to double check but most of the British medical establishment is there in one form or another.

One final, very small example comes back to this long list of research grants that have been given over the last number of years. One of the other agencies that appear three times in that list was involved in the AMMIE report back in 2010-11. It made a mistake. At the end of it, it produced its report. It came and presented to the forum; it presented to CNAPA as well. About halfway along, the forum asked it to come and make an interim report and it made a written submission to the forum, which we took and we looked at and we sent off because, in fact, while the report itself was in English, some of the annexes were in Dutch. It was a Dutch research agency that was carrying this out. It had kept in its annex some of the internal emails between the researchers. When they were translated, one of the email’s direct translations said, “It is not the purpose of this report to promote self-regulation but to enhance legislation”. That was at the start of the research.

We have great difficulty with some of these people appearing time after time. We know what the conclusions will be in terms of policy. I think there is a big difference between a piece of research like this being given to an external, very neutral, independent, unbiased set of researchers to come back just with the research and then leave it to the policymakers to make their conclusions from that. Once you get researchers who are either by inclination or invited to do the research and then make a policy recommendation, for those researchers I think it is extraordinarily difficult a year later or two years later to do other research and not come to that same policy conclusion.

What we see time and again is that we have a whole group of people who are not quite making a living from this but certainly it is a part of their life and they are drawing down funds to produce material that we do not have trust in. We are not against research. I come back to this. We firmly believe it is the way it should be, but we would love to see it be more neutral, less biased, with oversight by some neutral body.
Viscount Bridgeman: That is your mission and the example you gave first is almost schoolboy-type research. You must try to update the research skill game, must you not?

Paul Skehan: We will but, to be honest, a lot of that comes back through the Commission because it provides the funding and is ultimately responsible for it.

Viscount Bridgeman: Yes, I can see that.

Q135 Lord Tomlinson: Does it not ever ask for peer-group review of research papers?

Paul Skehan: On these ones I do not think it does but, Lord Tomlinson, I have to say that after three years here my appreciation for peer review is less than it was. I thought coming into this job when I saw something had been peer reviewed that it meant a certain standard had been achieved and, honestly, the stuff that I have seen coming through the British Medical Journal and others over the last year I find to be appalling and it is all peer reviewed. I think it depends who your friends are.

The Chairman: That is interesting.

Q136 Viscount Bridgeman: Thank you. Can I go on to the next question about the scientific evidence? I think that the last two witnesses in particular were very strong on the need for scientific evidence. What we are asking is: how should this membership be structured? Should it be as part of the forum or as a separate body?

The Chairman: This is the scientific committee we are talking about here.

Simon Spillane: The issue we had with the previous science group was they gathered 20 pretty eminent scientists who were experts on a whole field of different areas, liver specialists and cardiovascular specialists, and then over two years they asked them to produce a report on alcohol marketing. Funnily enough, 18 of the members of the science group said, “This is not my area of expertise and I am certainly not going to pay for my own travel to come across and sit in a meeting to produce a report that is not my area of expertise”.

After four years of the science group, every meeting struggled to have a quorum and, in the end, it was driven largely by scientists linked to organisations that were able to fund their science. Consequently, you ended up with probably the most polarised people sitting in these groups. It was interesting to hear earlier the scientists who were there described as NGO scientists and industry scientists. As far as I am concerned, maybe there were one or two but there were not industry scientists in there. Everyone in the forum was asked to put forward names and then I think the Commission chose scientists on the basis of their CVs in order to have a wide range of expertise. Getting together a network of scientists that can then advise on certain issues has an added value.

In terms of whether industry should be in this science group, to be honest, if the question is how you produce non-alcoholic beer, which is potentially of interest when there are proposals that brewers should be reducing the alcohol content or making non-alcoholic beer more available, the answer may be yes—I would see that as an area where you would bring in a brewing scientist. However, I certainly would not expect a brewing scientist to be taking an opinion on a report on the impact of alcohol on the liver.

We need good science. It is interesting that in the governance group—of which NGOs and we are members; there are around 12 of us in that group—we all came to the agreement
that having a science group that has no money and consequently does not ever meet is pointless. Let us look at the existing structures, especially where there are funds, and essentially you tap into the research and the researchers in the areas where the researchers have expertise. That is a way forward. Again, when it comes to actual research, the final product, I come back to good research is good research and bad research is bad research.

The Chairman: You have made that point, so can we move on? Time is running out.

Q137 Viscount Bridgeman: We can almost take the last two questions together. What is the effectiveness of pricing policy such as minimum unit pricing on the below-cost sale of alcohol? Of course, this has been the subject of discussion in previous meetings as well, as you know. What is the relationship between such measures and alcohol taxation? Should a new alcohol strategy incorporate any such measures? We have been given to believe that this is a subsidiarity issue and that the initiatives for the taxation must be fed up from the members. I hope that is stating it more or less correctly.

Going on from that, do current EU policies strike the right balance between considerations relating to the single market and allowing member states to introduce measures intended to protect and promote public health, which is the same question asked in a different way? It is the minimum price of alcohol. Do you have any short comments on that?

Paul Skehan: We are against. We are against it for different reasons. We do not think it would be effective. We do not think it would achieve what it is being touted as achieving. We think it is based on relatively flimsy evidence. It astonishes me how much people talk about the robust evidence that is behind it. It is a model and a model depends on the data you put in and the assumptions you apply to those data. If you put in the right assumptions you might get good evidence coming out. If you do not, you will not. We have seen the Sheffield model change two or three times now. We do not have a lot of faith in it. In its original iteration, it said that if you applied this minimum price consumption would drop by the following and if consumption dropped by the following all of the following harms would decrease. That was the very original one and on the basis of that the Scottish Government went ahead and applied it. Of course, minimum pricing was not implemented at the time but consumption dropped more in any case, through natural reasons, than had been targeted by the minimum price. Did those harms change? No.

Lord Tomlinson: It is not just the Scottish Government, is it?

Paul Skehan: Currently, it is. That is the one that is before the ECJ.

Viscount Bridgeman: It has the support of the UK Government.

Lord Tomlinson: It has the full support of the UK Government, does it not?

Paul Skehan: No, they withdrew. Well, at least that is in abeyance, I think.

Lord Tomlinson: Not that I understand.

Paul Skehan: Sorry, through the ECJ, in fact, it has to be prosecuted by the UK Government because, of course, the Scottish Government are not a party. I think the Scottish Government were proposing to bring it in. Mr Cameron at one stage was proposing it but then seemed to withdraw for England. What is happening now, of course, is that it goes to the European Court of Justice and it will be the British Government, on behalf of Scotland,
who will be arguing the case. We just do not think it will be effective and we do think it is illegal.

Q138 The Chairman: Can I clarify one thing?

Paul Skehan: Of course.

The Chairman: You are opposed to minimum pricing because you think the evidence does not show that it does—

Paul Skehan: Also because we think it is illegal. We do think it is in breach of the community treaty. There are about 30 years of jurisprudence in the ECJ, mostly through tobacco in the past where different countries have looked to apply minimum pricing on tobacco. Every time it has gone to the ECJ, it has said, “No, this is, in fact, breaking the internal market. It is not warranted. It is not proportionate. It could have been achieved in a different way; i.e. principally through taxation”. Now it is all subject to that court, but we think when the case gets there in 18 months’ time we would be pretty sure it would say, “This is illegal”.

Q139 Viscount Bridgeman: Can I have one more supplementary?

The Chairman: Yes, of course.

Viscount Bridgeman: What about increasing alcohol taxation as a means of control?

Paul Skehan: You could. It has been a fairly horrendous six years for us since 2008. If you look at the way in which alcohol taxation has increased, it has been huge. Has that solved the problem? No. It pushes up price. By the way, I think Dr Møller underestimates the scale of the illicit market at this stage. I think you would have a far bigger percentage of alcohol. In most of the central European countries it would be far higher than 10%. Even in the UK, there are some huge figures now coming through in terms of illicit alcohol, which pays no tax and fits into that gap where people have less money in their pockets. Our products are taxed more and more, and it is a red carpet to criminals to step into that, and that is happening. Yes, tax is an option but, honestly, I think you reach a point where the returns will be diminishing rather than increasing because it is just moving away.

Viscount Bridgeman: Is this illicit producing or correctly branded stuff but finding its way—

Paul Skehan: It is both, in fact, but a lot of it is production. In the example that Dr Møller or someone gave earlier of the Czech Republic, over 50 people are dead and there is still product in the marketplace that they have not found. It is not just in the Czech Republic; it is an international business. It is across the borders in neighbouring countries that this same methanol-laced product has now been sold and is still being sold.

Viscount Bridgeman: Thank you. That was very interesting.

The Chairman: Good. Thank you very much indeed for your time. If there is anything else you want to send us by way of supplementary evidence that will be helpful. You have the questions. Thank you.

Paul Skehan: Thank you very much.
The British Beer & Pub Association (BBPA) is the leading body representing Britain’s brewers and pub companies. Our members account for some 90% of beer brewed in Britain today, and own around half of the nation’s 49,500 pubs. In the UK overall pubs and brewing support over 900,000 jobs and contribute around £22 billion to the UK economy annually.

The beer and pub sector is committed to reducing the harmful use of alcohol and we welcome the opportunity to contribute to this consultation. Brewers and pub operators continue to work in collaboration with the UK Government through the Public Health Responsibility Deal and with a range of other stakeholders on developing initiatives to reduce the harmful use of alcohol, which do not unduly penalise responsible drinkers or place unnecessary burdens on business.

Summary of key requirements for a new EU Alcohol Strategy

The BBPA is of the view that any new strategy should seek to build on the current strategy and strengthen its existing mechanisms, rather than seeking an entirely new approach.

The evaluation of the current strategy carried out towards the end of 2012 clearly showed that the strategy remained relevant in tackling alcohol related harm in Europe.

The evaluation highlighted a number of areas where the mechanisms, actions and structures coming out of the strategy could be strengthened; therefore a new strategy could address these in order to promote further action.

This includes greater coordination between the CNAPA and the Forum, more profile and prominence for the structure of the strategy and better monitoring and evaluation of the impact of commitments and policies.

It is also crucial that any new strategy is in line with the current strategy in seeking to target alcohol related harm rather than aiming to reduce overall consumption.

Any new strategy must also be properly focused and achieve the right balance of tackling alcohol related harms whilst recognising the contribution that the alcohol industry makes to the EU economy with the beer industry alone worth €50 billion annually and supporting over 2 million jobs and without disproportionately penalising responsible consumers.

The importance of a multi-stakeholder, partnership approach also should be stressed. The value of this can be seen at both at both the national and European level through outcomes from the Public Health Responsibility Deal and the range of commitments and engagement under the European Alcohol and Health Forum.

Responses to questions

Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?
The decision on whether to have a new strategy remains one for member states, however if there is one then it should build on the previous strategy rather than seeking to create something entirely different. The last strategy was fully evaluated and found to have been useful in bringing together stakeholders to work towards alcohol related harms and supporting member states in their action:

"The results of this assessment show that the EU strategy’s five priority themes have been addressed, and remain relevant for Member States and stakeholders. The work carried out so far has had clear results in terms of supporting Member State action."

The EU strategy and its implementation have provided an EU-wide approach to address common issues, including a shared evidence base, and an EU-wide baseline and benchmarks for further action.32

The priority themes identified under the previous strategy for action were -

Protect young people, children and the unborn child;
Reduce injuries and death from alcohol-related road accidents;
Prevent alcohol-related harm among adults and reduce the negative impact on the workplace;
Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;
Develop and maintain a common evidence base at EU level.

These were also found to remain relevant for member states and therefore it would be valuable to retain this structure and focus going forward.

It is important that any new strategy recognises that the majority of adults drink responsibly and therefore maintains the focus, as the previous one did on alcohol harms. According to data from the 2010 Eurobarometer, a quarter of adults (15+) in Europe are classified as abstainers whilst 69% report having 2 drinks or less on a day when they drink. Whilst not very recent, these figures are still indicative of the scale of the issue and demonstrate that any approach much be proportionate and not seek to penalise moderate consumers or the economic contribution of the industry.

The evaluation of the previous strategy also recognised the value of the multi-stakeholder approach and the involvement of a range of different bodies from industry and civil society. This is very important to retain going forward and allow industry to continue to be involved in and contribute to actions to tackle alcohol harms. It also clearly highlighted the value of the voluntary and partnership approach alongside regulation where appropriate.

Action by the European Alcohol and Health Forum has included commitments in a number of areas with particular progress on developing self regulation of digital and online advertising. In the UK, the Public Health Responsibility Deal has provided a clear framework for industry to make commitments to help address tackle alcohol misuse and harms where they occur. This has led to some good progress including:

32 Assessment of the added value of the EU strategy to support Member States in reducing alcohol-related harm, final report by COWI submitted to DG Health and Consumer (DG Sanco)
252 million units of alcohol removed from circulation through product innovation by the end of 2012 and industry on target to remove 1 billion by the end of 2015. 80% of products on shelf now having health information included information on alcohol units rolled out in the on and off-trade. £5 million annual industry support for Drinkaware the independent charity promoting responsible drinking.

Support for Challenge 21, Challenge 25 and the Proof of Age Standards scheme to tackle underage drinking and selling which has fallen sharply in recent years. A strict system of self-regulation through the Portman Group and the Advertising Standards Authority to prevent irresponsible marketing and advertising of alcohol. Industry support for the range of partnership schemes including Pubwatch, Best Bar None and Community Alcohol Partnerships which have made a significant contribution in tackling alcohol related crime and anti-social behaviour in local areas.

This demonstrates that UK should be championing the voluntary, partnership approach as far as possible in the European context.

**Are the EU’s alcohol policies underpinned by a sound scientific base?**

We would agree that the current strategy and the priority themes identified are relevant and there is a scientific basis and evidence to demonstrate the importance for member states to focus on these areas to tackle alcohol related harm.

A sound evidence and scientific base is crucial to ensuring that policies and initiatives are effective and appropriately targeted, however the first consideration should also be the cultural variations in drinking habits and local circumstances as these will inform what the priorities should be for member states.

The primary intention of the previous strategy was to facilitate and enable activity by member states and promote coordination on joint activity where appropriate. Any new strategy should ensure that there is a solid evidence base for any new focus area or policy proposals and not recommend measures that compromise the value and operation of the single market.

**Are the EU’s alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?**

The current EU strategy and priority themes are consistent with and reflect aspects of the WHO framework where relevant. It is right that EU policy and the Alcohol strategy sits within the broader WHO framework, however we would suggest that there is no need to duplicate this entirely and the EU should focus on areas of particular relevance and consider all available information if developing a new strategy.

As the central role of the EU is to fulfil an economic function all EU alcohol policies should seek to balance tackling alcohol related harm with the economic and social contribution of industry. There is therefore an onus on the Commission to examine all evidence with sufficient rigour particularly where the evidence base is not as conclusive as is sometimes
suggested, for example on price and ensure that they consider and reference the balance of research available rather than selected pieces.

Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

The evaluation of the EU Alcohol Strategy was positive about the mechanisms of the strategy including the EAHF and the CNAPA. According to the COWI evaluation:

‘The EAHF has succeeded in mobilising a broad range of stakeholders to address alcohol related harm and in stepping up actions.’

On the CNAPA the evaluation states:

‘The results from the enquiries indicate that the Committee has contributed to building consensus among the members on alcohol policy related issues.’

This demonstrates that this approach is still valid and these mechanisms should be retained in a new strategy. The evaluation recommended a range of reforms to facilitate better interaction and cooperation between the different bodies particular between the Commission, CNAPA and EAHF as well as greater profile and visibility of the CNAPA and action being undertaken.

In addition they suggested that there should be a clearer process for measurement and evaluation of Forum commitments and a greater focus on specific areas as well as broadening involvement in the EAHF to ensure better representation including more alcohol retailers. The success of the Public. Health Responsibility Deal at a UK level mirrors the work of the EAHF at a European level in bringing together the relevant stakeholders. This clearly demonstrates the value of the this approach.

Furthermore, they highlighted the importance of strong evidence base on the effectiveness of any new policies/recommendations proposed by the member states or Commission and a consistent structured approach. All of these recommendations should help to focus and improve the outcomes from any new strategy whilst retaining the aspects that have already shown to be of value.

Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?

It is important that the Commission considers a wide spread of funding to different institutions rather than only a select group. There are a range of bodies carrying out useful research into tackling alcohol-related harms and it is important to ensure that they are given the same opportunities to access funds as others.
In addition although positive comments were made in the evaluation about the Forum, monitoring and evaluation of commitments was highlighted as an area that could be strengthened, therefore it may well be useful for consideration to be to additional funding allocation to this purpose.

Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

There is a need to maintain the benefits of the single market which are of value both to our sector as well as member states and citizens in terms of the ability to trade easily and on equal terms. It is important that this is central to all policy making at an EU level. Any undermining of the single market in terms of large differentials in pricing or taxation could lead to smuggling and illicit trade which could be damaging and disruptive to member states. The very high excise duty rates in the UK, relative to our closest continental neighbours, is already leading to fraud. Minimum Unit Pricing, the policy which currently remains a focus by some member states remains to be decided in the European Courts. In addition, although there are mixed views amongst our membership on this as a policy the balance of evidence does not suggest that it would be effective in targeting harmful alcohol consumption and may have a negative impact on moderate consumers.

There are some potential changes to tax directives which could perhaps run less risk of affecting of coming into conflict with the single market which could also be useful for member states in tackling alcohol related harms, for example changes to allow allowing greater differentiation of tax rates within categories to allow more flexibility to promote lower strength products.

In general, as previously highlighted, we would suggest that there are other ways of tackling alcohol related harm which could be promoted by the EU as best practice. For example the Responsibility Deal which has been extremely effective in stimulating a range of actions and could be a model for other countries to follow.

19 September 2014
WEDNESDAY 26 NOVEMBER 2014

Members present

Baroness Prashar (Chairman)
Baroness Benjamin
Lord Blencathra
Viscount Bridgeman
Lord Faulkner of Worcester
Lord Judd
Lord Morris of Handsworth
Lord Sharkey
Lord Tomlinson
Lord Wasserman

Examination of Witnesses

Miles Beale, Chief Executive, Wine and Spirits Trade Association, David Frost, Chief Executive, Scotch Whisky Association, Brigid Simmonds, Chief Executive, British Beer & Pub Association, and Paul Waterson, Chief Executive, The Scottish Licensed Trade Association

Q186 The Chairman: Good morning and thank you for your time this morning. As you know, this session is open to the public, a webcast of the session goes out live as a video transmission and is subsequently accessible via the parliamentary website. A verbatim transcript will be taken of the evidence and will be put on the parliamentary website. A few days after the session, you will receive a copy of the transcript to check it for accuracy, and it would be helpful if you could advise us of any corrections as quickly as possible. If, after the evidence session, you wish to clarify or amplify any points that you have made or you want to submit any supplementary evidence, please feel free to do so.

If you can begin by introducing yourselves and declaring any conflicts of interest that you may have, that would be very helpful, and then please make any introductory comments that you wish to make. We will start with you, Mr Beale.

Miles Beale: Thank you, Chairman. My name is Miles Beale. I am Chief Executive of the Wine and Spirit Trade Association. I have no conflicts to declare, although I can say that I am a former civil servant. I do not think that is a conflict, but it is worth mentioning.

The Wine and Spirit Trade Association represents 340 wine and spirit producers, distributors and retailers across the UK. This includes everything from individual vineyards and distilleries to global producers as well as large multinational retailers, right down to very small independent wine and spirit merchants.

You will have noticed from our submission that our view on the EU alcohol strategy is that we do not need to reinvent the wheel. We think the existing strategy should perhaps be renewed. While it is by no means perfect, it does respect national competency over a range of issues and allows member states flexibility to focus on particular problems in their member state or, indeed, at regional or local level. We do, however, agree there is some benefit in highlighting a couple of areas to look at. Underage drinking and drink-driving would be the two that are clear in the strategy currently.

The WSTA’s view, in a nutshell, is that we think a renewed EU alcohol strategy should maintain three essential elements. The first is it should be complementary to national alcohol policy, in accordance with the treaties. Secondly, it should enshrine a multi-stakeholder approach that includes at least government, the drinks industry and the public health community. Finally, it should support and facilitate the sharing of good practice across member states without being prescriptive.

I have one final set of comments on the UK experience. It is our view that it is only really through partnership that success is achieved in tackling alcohol misuse. We believe the UK has done great things in recent years in this respect, particularly under the Public Health Responsibility Deal, with things like 80% of all labels on alcoholic products now containing health and unit information, all of which is voluntary. We have also introduced schemes like community alcohol partnerships, which have seen underage drinking driven down by up to 30% in some neighbourhoods. There are now 85 CAPs across the UK. You have already heard about some of the self-regulatory measures, particularly the retailer-led Challenge 25 approaches.

The final comment before I hand over to colleagues would be that the WSTA certainly believes that more can be achieved and faster, including at less cost, with government, industry and the public health community working together, so that is what we would hope the EU alcohol strategy enables.

David Frost: My name is David Frost and I am Chief Executive of the Scotch Whisky Association, which represents the global interests of the Scotch whisky industry. I took up this role at the start of this year, and before that I was an ambassador and diplomat in the UK Foreign and Commonwealth Office where, among other things, I specialised in European Union affairs.

I would like to make three brief comments, perhaps, as we kick off. First, this Association thinks that the EU strategy has been useful, and it has been so because it has kept a clear focus on reducing alcohol-related harm, on supporting member states’ own efforts and not pushing one-size-fits-all solutions, and we would like any renewed strategy to continue in that direction.

Secondly, we do not agree with the emphasis that some in the public health community put on reducing overall per capita alcohol consumption as opposed to reducing alcohol misuse, i.e. hazardous and harmful consumption. We do not think the evidence supports a clear relationship between overall consumption and harm levels, and that is why we in this

Association do not support minimum unit pricing of alcohol—and I can explain a bit more about why.

Thirdly, and finally, the Scotch whisky industry is a responsible industry that committed to reducing alcohol-related harm. We think we have an important role to play in the debate about policy and implementation, and we also believe that tackling alcohol-related harm is not all about or maybe even primarily about regulation, but that partnership working, voluntary, self-regulatory approaches are an important part of that mix.

**Brigid Simmonds**: My name is Brigid Simmonds and I am the Chief Executive of the British Beer and Pub Association. We represent 90% of brewing companies in the UK and about 50% of pubs. We have worked very closely within the European Alcohol and Health Forum. We particularly had our own commitments, which have been around Challenge 21 and about unit awareness, which I am very happy to talk about. Like my colleagues, we believe that the European alcohol strategy should evolve and that it should be very much about partnership working, but it would be good to see the CNAPA and the European Alcohol and Health Forum working more closely together.

**Paul Waterson**: Good morning. My name is Paul Waterson. I am chief executive of the Scottish Licensed Trade Association and am also an hotelier. The Scottish Licensed Trade Association was formed in 1880 and looks after the interests of licence holders in Scotland. These are predominantly individual operators who run not only public houses, hotels and restaurants but nightclubs and other late-opening premises. It would be accurate to say that we find it difficult to become involved in European Union alcohol strategies. Other trade organisations find that very comfortable. We do not have the resources to be involved. We would like to be, but there are reasons, financial and otherwise, why we are not involved. We support minimum unit pricing and have done since the late 1960s. We are very pleased that the Scottish Government decided to implement it. We are not so happy that it has been challenged, of course, but no doubt we will talk about that later.

**Q187 The Chairman**: Thank you for those introductions. I have heard what you would like to happen, but can you just give me some idea of what you think have been the main achievements of the EU alcohol strategy?

**Miles Beale**: I am happy to go first, Chairman. The key advantage and benefit of the EU alcohol strategy 2006 to 2012 was that it established something called the EU Alcohol and Health Forum, which has very much proved an effective way of exchanging good practice and putting in place some sort of European framework that allows member states to learn from each other and make progress. We have calculated that there were some 317 initiatives begun under that strategy. We think 140 are still in progress. The community alcohol partnerships initiative, which is ours in particular that we have seen come into fruition in the UK, is one example of those and of course is exclusively UK based.

The last thing to say is that it has particularly allowed a flexible approach, and that is really what we think is required. Population-based one-size-fits-all policies clearly do not work. All the evidence relating to alcohol harm suggests that there are a number of quite separate, very complex issues. They are different member state by member state, and as a result all you can really do at EU level is compare them and learn from each other.

**Brigid Simmonds**: If you look at what it has achieved, particularly in the United Kingdom, it has been translated very much into the responsibility deal, and as an active member of
Brewers of Europe, which has very wide membership, I see some of the best practice that we have created here now being translated into rest of the EU. If you look at the billion-unit reduction pledge, the first year showed that 250 million units of alcohol were taken out of the industry, and much of that was beer. Eighty per cent of alcoholic products on shelves now have the three elements of labelling. If you look at the unit information that we have put out in both the on-trade and the off-trade, an Ipsos MORI survey, which the Department of Health has not yet published, shows that 41% of people asked had seen specific information on units and 42% had seen that information in pubs. The £5 million that we put into Drinkaware and a lot of the work that we are doing on supporting Challenge 21 and Challenge 25; the proof of age standard scheme, have been good achievements under the EU alcohol strategy.

The Chairman: The impetus for those came from the EU alcohol strategy, is that right?

Brigid Simmonds: The partnership working translated its way into member states. I do not believe that the EU alcohol strategy should be prescriptive. It should be enabling a framework that allows the United Kingdom Government to act and to implement and to work with us in partnership.

The Chairman: Do you wish to add anything, Mr Frost?

David Frost: We would agree with what has been said and with the verdict of the consultants on the strategy. It may be worth just saying a word about why we think it has been successful, and there are two or three reasons. One is that it very much went with the grain of treaty Article 168: support for member states’ efforts, no pushing at the competence boundary and the deliberate decision at the start that there would be no legislation gave comfort and assurance to the very pragmatic partnership way of working. The fact that it focused on a small number of priority areas that were relevant to every member state really helped again in encouraging partnership, collaboration, focus. The creation of the CNAPA and the health forum, in their different ways, were helpful to this. They could probably work better and interact better between each other, but they did not exist before and have been very helpful.

All that has been useful in giving coherence to the strategy and setting a framework for what member states are doing and in helping us move forward. There are a couple of areas that work less well, but certainly overall we think it was a good achievement.

The Chairman: Mr Waterson, do you wish to add anything?

Paul Waterson: No.

Q188 Lord Wasserman: I was very taken by Mr Beale beginning by saying that the strategy should perhaps be renewed. Now, can I move on? Can you give me a yes or a no answer? Should we have an EU alcohol strategy and, if so, why? I do not want answers that say it is very good for Poland or Bulgaria. I want to know if it will be useful here. Should we have an EU strategy as opposed to a national strategy?

Miles Beale: Yes, we should. I focused on not reinventing the wheel. It is more useful to countries other than the UK, because without wishing to sound in any way arrogant or taking it for granted, the UK has made great progress and those ideas have been picked up disproportionately elsewhere. However, there are also some areas where we think, if it were renewed—so you keep the main elements that I have already talked about—you should add
evidence to the strategy. Some of the evidence that we would be particularly interested in looking at is on illicit alcohol, which we have talked about, and the Home Office has expanded on some of the details on that. It should definitely look at that. The other thing that it should do is stop looking at problems with the research programme. Of all 11 projects of the research programme, with lots of very similar deliverers of those projects, none looked at what works. Consumption has fallen by almost 20% in the UK in the last nine years, which is huge. It also demonstrates that it is not as though we have solved all the problems. It is not just about driving down consumption. It is about driving down harm, but what we really should understand is what works. That is why we think that looking at road-traffic accidents and drink-driving is important, and comparing ways of approaching that across the EU is quite interesting. We had some comment earlier about the lowest blood alcohol levels not being associated with the best performance across the EU. Surely we should understand that better. Equally, underage drinking has fallen fastest in the UK, faster than any other section of the population. Why? That, I think, is Baroness Benjamin’s point.

Lord Wasserman: Does anyone else want to comment?

Brigid Simmonds: Yes, we should have a strategy. I would entirely agree with what Miles has said.

David Frost: We think so too, and one area that we have not touched on where it would be useful in future is better data. The consultants identified this as an issue. Better comparability of data across the EU can really only be done at EU level, by the Commission, by Eurostat, and others. One area where this is a problem, for example, is that WHO, Eurostat and member states all have slightly different definitions of alcohol-related harm, and that gives you obvious comparability problems in looking at the figures across the Union.

Lord Wasserman: Therefore, there are real advantages for us in having a European strategy.

David Frost: I would say so, yes.

Q189 Viscount Bridgeman: The World Health Organization names measures for restricting availability as one of the most cost-effective policies for reducing alcohol-related harm. Do you agree with this assessment, and in particular what role does licensing play?

Brigid Simmonds: Can I pick up on licensing? The introduction of the Licensing Act 2003 has made a difference and local authorities have huge powers to tackle licensing and misbehaviour at a local level. We have worked very closely with a lot of local authorities. Durham was one of the examples that was given by the Home Office earlier. Theresa May, when speaking about the Best Bar None scheme in Durham, said it had reduced alcoholic crime there by 60%, with a 40% to 60% day and night variation. Pubwatch, community alcohol schemes, Best Bar None, and Business Improvement Districts have all made a difference, and local authorities and the police have plenty of powers to tackle licensing at a local level and to deal with premises where they do not behave appropriately. You would have the total support of all of us to deal with premises where they do not behave appropriately.

However, we also have to recognise that 70% of alcohol is now sold in the off-trade. That is not true necessarily for beer. For beer, it is still 50:50, and that is because draft ale is still important to pubs. Pubs are very important to people’s local communities and they provide social interaction. In a pub, seven out of 10 alcoholic drinks sold are beer.
Getting the relationship right at a local level is very important, but I do think that some of the partnership schemes that we have in place have worked well.

**Paul Waterson:** Just for clarification, Scotland does have its own Licensing Act, which came in in 2005. Three of the things that we find very important are: the cost, the availability and the training of servers. The 2005 Act does have regulations regarding the training of servers, so every personal licence holder in Scotland must be trained to a certain standard. Every member of staff must also have mandatory training, so we have taken care of training through the Act.

In terms of availability, there is always controversy around the hours when we are open. If you get 10 publicans together you will find 10 different answers to when they should be open. However, there has been some liberalisation, which we believe has not really worked very well. There is blurring of the lines, for instance, between late-opening premises and pubs, which does not always help. We believe there is overprovision of licences in Scotland. Certainly in the off-trade there is overprovision. Overprovision is included in the our licensing act, but local licensing boards in Scotland find it almost impossible to enforce it, so we need to do something about that. The third factor that we think impacts on abuse is the cost of the alcohol itself, which no doubt we will talk about later.

We have the training in place. In principle, we have the agreement on overprovision. We cannot really do much about too many licences. The third thing that we have tackled is the price and, as I said before, the Scottish Government have agreed with Minimum Pricing.

**Viscount Bridgeman:** Is the trade satisfied with the enforcement of underage drinking?

**Brigid Simmonds:** I think the trade has taken the initiative. One of the first commitments we made to the European Alcohol and Health Forum was Challenge 21. You now see Challenge 21 everywhere. It is almost impossible to get served in an on-trade premise without identification. I even camp in a campsite in Dorset where they have Challenge 21 posters. We make it available to everyone. It is well understood and it is well used.

**Paul Waterson:** In Scotland, we have Challenge 25. If you believe somebody is under 25, you should ask them. If they do not have identification then you do not serve them. It is quite simple. Remember, the law is still 18, so it is very strict.

**Brigid Simmonds:** As it happens, I am Chief Executive of the Scottish Beer and Pub Association as well and we work very closely. In Scotland, we were responsible for the posters and, indeed, for funding and getting them out to everyone in Scotland, and to help in that way with the Scottish Government as part of the Scottish Government Alcohol Industry Partnership.

**Q190 Lord Sharkey:** Could you say what the advantages and disadvantages are of pricing policies, such as the minimum unit pricing or bans on the below-cost sale of alcohol? Do you believe that any such policy is likely to reduce harmful alcohol consumption? I am particularly interested in how you explain the differences in opinion on this issue within the alcohol industry.

**David Frost:** Perhaps I should go first on this. As I am sure you know, it is the Scotch Whisky Association that is taking the Scottish Government to court over this very issue, and the substantive issue is in the European Court at the moment, so we wait for that.
Let me try to be as brief as I can. First of all, to distinguish the different pricing policies, very briefly we would say that minimum unit pricing is illegal under the EU treaties. We would say that a ban on sales below duty and VAT, as in England and Wales, is not illegal because it does not distort competition, although in our view you could improve it by some reform of the duty system. A ban on sales below cost is also legal for the same reason, although in my knowledge of where this is done elsewhere in Europe it can be difficult to identify what cost is over and above tax and VAT. Of course, excise duty changes are legal. Those four things do have to be distinguished as different ways of approaching this.

There are two difficulties with minimum unit pricing from our point of view. The first is effectiveness. The second is legality. On effectiveness, first, we think that minimum unit pricing is quite a heavy-handed way of getting people who already drink responsibly to drink slightly more responsibly by making their drink that bit more expensive, while having no effect on those who drink harmfully or hazardously. Why do we think that? Of course, if you put up the price of something, other things being equal, demand for it falls. The problem is that other things are not equal in the case of those who misuse alcohol, and all the international studies that we are aware of suggest that harmful and hazardous drinkers, in those circumstances, simply cut other things in order to maintain alcohol consumption or they go to illicit alcohol instead. In other words, the price responsiveness of heavy drinkers is close to zero. So, as I said, we do not agree with those who say that if you bring down overall consumption you bring down misuse of alcohol. The figures simply do not support that, in our view, even if the models claim to support it.

I am just going to give you a couple of examples. In the UK, as we heard, alcohol consumption has fallen by nearly 20% since 2004. In Scotland, part of the UK, harm has fallen by nearly 40%. In England, harm has not much changed. So what is the causality here? If you look more widely at European examples—in Scandinavia—in Denmark consumption is down but harm is up. In Sweden, consumption is basically stable, harm is down. In Finland, consumption is up but harm is down. You have three totally different patterns in rather similar societies, strongly suggestive of the fact that the causality between consumption and harm either does not exist or is so tenuous as to be a poor guide for policy. We guess that is partly why the UK Government said, in 2013, that they were not proceeding with minimum unit pricing, because they had not found evidence that demonstrated that it would do what it said it would do.

Just briefly on the legality, which is the other side of this, the EU single market system subjects member state action in almost every area to treaty principles; obviously, that is how the system works. The BIS report on the balance of competences in the single market that was produced a couple of years ago says, “Anything member states do in almost any area of public policy is, in principle, subject to the general principles of the treaty and specific single market jurisprudence and almost any action can be struck down by the court if a member state infringes them”. Now, that is true in this area as in any other. What we have is a framework. Article 34 forbids quantitative restrictions unless they can be justified under Article 36, and that is the core issue in this case: can you justify this under EU legislation? Consistently the court has said that you cannot have minimum pricing schemes, and we believe that argument is as strong as it has ever been.

I am sorry that is quite a long answer, but there are some important points in there.

**Lord Sharkey:** Perhaps we can hear the contrary point of view.
Paul Waterson: As I said before, SLTA has supported some form of price control since the late 1960s, and having run pubs in the city centre of Glasgow in the 1970s and seen all the problems that we had there, something had to be done to put some quality back into the business. All-day opening came in with the 1976 Act and that allowed us to do that to a certain extent. We started to upgrade premises and change pubs from being places where people went to get drunk, which they were, into places offering various different types of entertainment and so on.

We were very concerned in the late 1970s about price cutting in pubs, because there was so much competition with more and more people opening pubs with the new liberalisation of the law. We had a lot of problems then in pubs. This is not a pub versus anybody else argument. We originally started lobbying for minimum pricing to bring quality back into pubs. If pubs were not creating enough profit, if it was a race to the bottom on price, there would be no reinvestment in the business, in training, and other improvements. Little did we see on the horizon that off-sales would take price cutting to a whole new level, supermarkets especially. Alcohol is a very dangerous product when it is abused. If people think it is right that it should be sold cheaper than water and more or less given away as a loss leader to get people into stores to make money off other products, we cannot agree with that.

When the market overheats and loses its equilibrium, it needs something to come in to guide it through this battle between volume sales and price. We need to realign prices, and minimum unit pricing does that. It targets strong drinks. It is not like a tax; it is far more targeted. A I do not need any studies to show me that if you cut the price of something volume sales will go up, which is exactly the opposite of what, i we are trying to achieve. We want a profit-based, quality-based industry. We are getting better; I think that is true. We are working hard at getting it better, but all the good work that has been done by many is thwarted by the constant race to the bottom on price in supermarkets. We see many young people now pre-loading before they come out, so they come into the pubs and nightclubs and they have already had parties at home, where they are drinking significant amounts of alcohol. One thing that always worries me about price and this argument that some people will drink no matter what is that people, especially younger inexperienced drinkers, are seduced into drinking more than they would normally by price. Within the 2005 Act, there is a package of measures in Scotland to stop irresponsible promotions, but it cannot be totally prescriptive. Minimum pricing would be a far more efficient way of stopping irresponsible promotions.

People making money by exploiting Scotland’s uneasy relationship with alcohol should be stopped. As has been said before, the vast majority of alcohol in our country is sold through the off-trade and the vast majority of that by supermarkets, we have to realign pricing. We have to get some equilibrium back into it.

Miles Beale: The Wine and Spirit Trade Association is the only trade association represented here that has retailers in its membership. We have a particular consumer angle on this as well. Where I would agree with Mr Waterson is that price is relevant. It would be silly to ignore the basic economics, but alcohol is already absolutely and comparatively very expensive in the UK. UK consumers pay almost 40% of all the duty paid across the EU. That is more than consumers in Germany, France, Italy, Spain and Poland combined, so it is pretty unfair. I will give you another example. What the public health community would like to see
as a level for a minimum unit price would affect over half of the products on a supermarket shelf.

Where I would certainly disagree with Mr Waterson is that it is targeted. I know that some of the evidence you have taken has suggested that it is. Any economist will tell you that this is a population-based measure. It is in no way targeted; it cannot be. As a result, it hits the poorest drinkers hardest. There is no evidence to suggest that they are the most irresponsible drinkers—quite the reverse. In addition, in some of the areas where we do agree there are problems—someone mentioned earlier overconsumption among middle-aged females, for example—minimum unit pricing will have absolutely no effect. Equally, the heaviest drinkers we know very well are the least responsive to price. The only thing I am sure about with minimum unit pricing is disappointment will ensue. It is just not sensible.

I will leave the legal issues aside, because David has gone into those in great detail. Just one thing on so-called pre-loading or home drinking. What often gets in the way of a good story are the facts. Consumption has fallen by almost 20% in the last nine years. Underage drinking is falling fastest of all cohorts of the population. All this is very welcome and good news, even to my members who sell this product, because ultimately they wish to have a consumer. They do not wish to drive a consumer into being not a consumer because they are no longer around.

On drinking at home, we also know that statistically it was at its peak in 2004. It has declined by 12% since then. That is probably not enough, but it is certainly in the right direction. Finally, from studies that have looked at people going out and whether they have drunk at home beforehand, the answer is normally 21%, or about one in five, have.

The final thing that I would say in this area is that there is modelling and there is reality. The University of Sheffield has done a lot on minimum unit pricing. They have redone and redone the evidence and it consistently falls. Expected falls from a minimum unit price being introduced are now one-third less impressive than they were when the model was first run, but they are also three times less effective than what has happened in reality. The reality is that we are making progress without minimum unit pricing, which you can only judge by a model. It has never been tried anywhere else in the world. Why would we start when we are going in the right direction? We are fundamentally opposed, because it would not work.

Brigid Simmonds: Can I just add one final concern? I would agree that this is a blunt tool and the majority of people are drinking responsibly and we should look at it that way. The concern, certainly for beer, has been about taxation. As you probably know, we had a 42% increase in tax over four years. We have succeeded and we have been very grateful to the Government for reducing beer taxation in last two Budgets, and there is a concern that if you had minimum unit pricing the Treasury would certainly have a black hole at the end of the day and would want to increase duty. That is something that, frankly, will close pubs and it will close brewing, which is a great British manufacturing industry.

Q191 Lord Wasserman: I am a little confused, because Mr Beale talked about going in the right direction and you are measuring that by total consumption going down. However, is that what we are really concerned about? Are we here to discuss how to drive down consumption? If we are doing that, we might as well drive it down to nothing and that would be a great success. That is surely not what we are really here for. That is another objective.
Why is the fact that consumption is down taken as a measure of success? Is it not something else? Is it the harm that you have talked about or the Home Office talked about? We are always confusing it in terms of, on the one hand, consumption is down and that is great; we are going in the right direction. On the other hand, why do we care what the consumption levels are?

Miles Beale: I would agree that it is not as simple as being about consumption. What you will find—in evidence you will have already received from some members of the public health community—is that it is all about consumption, but we do not think it is. It is fair to suggest that there is some correlation, a bit like price. As a UK population, we drink no more now than we did in 1979. However, we do have some pockets of problematic behaviour; I have mentioned a couple already. All we are saying is that if you look at it comparatively, the cost of alcohol in the UK is very high. Consumption is 17th out of 27 member states—we do not know about the 28th yet—so it is just below average. Harms, depending on how you measure them, are medium to high, but it does very much depend on how you measure it. I am a former civil servant; I am trained to look at evidence for evidence-based policymaking. There is lots of anecdotal evidence. There is much less that is hard and fast. Consumption is one that you can measure reasonably well but, no, it is about harm. If you were to ask what we think the answer is, it is education, enforcement and building on things that work. The responsibility deal and community alcohol partnerships, for example, are really good case studies where there is no regulation involved. The drinks industry, working with government, and when they are happy to be around the table the public health community, have set up targets, agreed them and delivered them. There is no regulation, therefore there is no cost. We should be focused on the outcome, so what is the outcome we want and how do we get there? It is absolutely not as simple as being about consumption only, so I would agree.

Paul Waterson: The consumption figures referred to only shows how much people are drinking, but not when they are drinking. We know we have consumption that is all taking place on one or two night of the week, thanks to things like drink-driving legislation and other social changes. The consumption figures might be down. There is a depression going on, so you could argue that it was going to come down a bit anyway in the last few years. If you are looking for evidence, I am not going to sit here and discuss evidence about the health problems we have with alcohol. Everybody knows them. The way I am listening to this is that there is no problem with alcohol; we do not really have any. Well, I think we have considerable health problems and minimum unit pricing would help.

The Chairman: We need to move on, because time is pressing.

Q192 Lord Morris of Handsworth: What is the relationship between taxation and pricing policies, and should a new EU strategy favour one over the other and, if so, why?

David Frost: Maybe I should kick off on that again. To take your second question first, we think an EU strategy is best if it effectively gives a menu and allows countries to share best practice. We think it is not the role of an EU strategy to promote one policy over another and, in fact, the previous one has not and the WHO global alcohol strategy does not. That is a slightly bureaucratic point, if you like; it should not promote one thing over another but should encourage and share best practice about what works in particular circumstances.
Turning to the relationship between taxation and pricing policies, I have touched a bit on this in the previous answer, obviously, and I have tried to explain why I do not see this connection between price and harm in the way that some people would put it. However, if you must pursue a pricing strategy and if the Government decide they want to do that—as I say, we do not think they should, as we think that alcohol is already pretty expensive in this country and spirits extremely expensive—the advantage of taxation is that it does not distort the competitive advantage between producers. It allows the market to work. Low-cost producers remain so. And it ensures that whatever money is raised goes to government rather than the retailers and the producers. That is why it is slightly galling sometimes to be accused of putting profits before health. In fact, the money from minimum pricing would go to the retailers or the companies who make the alcohol. With taxation it goes to government, and if we are about the public good, it should go to government. Those are some of the differences.

**Brigid Simmonds**: On the whole, we believe that it should be enabling at an EU level and that it is up to member states to decide what to do. However, I know that the Department of Health, in its own evidence, mentioned that there are certain parts of the excise duty across the EU that might be looked at. One in particular is under the Structures Directive, where low-strength beer can be taxed at a lower rate only if it is less than 2.8%. We would like to have the ability to innovate and to make the taste better by raising that to 3.5%, and that would be better under the EU directive. There is a piece of research that the Department of Health is undertaking at the moment, because currently you cannot promote via strength, and one of our commitments under the responsibility deal is that all members of the BBPA will encourage lower strength, but you cannot say, “Drink that beer there because it is lower strength than that beer there”, and that is an Advertising Standards Authority regulation. It is going to take a year to undertake this research, but I hope at the end of it we can have some changes to the food labelling regulations that will make advertising lower strength possible, but there is also a restriction at an EU level that we would also like to change to increase the lower rate of tax for beer from 2.8% to 3.5%.

**Miles Beale**: It is worth saying that that status quo is quite interesting as an example in itself, because originally you were not able to promote a product on the basis of strength, because the assumption was that it would be promoted as high strength and therefore having a particular effect. That is why it was ruled out. In fact, the self-regulatory mechanism through things like the Portman Group that the industry voluntarily signs up for means that none of our member companies can do anything about advertising in that way at all. Therefore, we are having to go back to the drawing board and re-look at why we ruled this out for ourselves in the first instance and work with the Department of Health to get there.

The only thing that I would add to what colleagues have said is duty plus VAT as a full price was offered by the drinks industry. That was the suggestion to government. The Government then talked about minimum pricing and then found they did not have enough evidence and we went back to that, and then you look at taxation. If you look at all of those mechanisms, unless they are given voluntarily, only one of those is definitely legal and it is for national Governments to decide what taxation looks like. Relatively and absolutely the UK’s taxation on alcohol is very high.

**Q193 Lord Judd**: This is a rather different subject, but how do you see the role of non-governmental organisations and other parts of civil society in formulating and
implementing alcohol policy? In your view, did the EU alcohol strategy between 2006 and 2012 lead to a productive partnership between the alcohol industry and the public health sector? Can you provide examples of good practice in this regard?

Brigid Simmonds: There are some very good examples of where that has worked well. At a European level, Brewers of Europe had a commitment on drink-driving and they have worked with the European Transport Safety Council. Here in the UK, we have members who have specifically worked with public sector bodies like Addaction. Heineken have some really good examples of schemes; there is one in Glasgow where they worked with over-50s to understand their relationship with alcohol, and the results were that 70% had improved physical health and 83% reduced their dependency. In Manchester, they have worked with ex-offenders. In Sheffield, they have been working with the British Legion on resettlement of ex-service personnel. SABMiller, whose headquarters are in the United Kingdom, has trained 10,000 under its scholarship scheme to undertake particular training in licensing, which has been right across all types of licensed premises. You can look at the work Diageo has done in training midwives to help would-be mothers to understand the problems of foetal alcohol syndrome. There have been some really good examples and we would like to build on that.

Miles Beale: I would certainly echo that. In the UK, we do have some really good examples of working closely with NGOs and, under the responsibility deal, with the public health community up until a certain point. Some of the initiatives and targets under the responsibility deal—80% of bottles labelled with additional consumer information, health information, taking 1 billion units out of the market—are completely innovative, and I find myself in an utterly different conversation in Brussels from the one I have in London. In Brussels, I have lots of other trade associations representing the drinks industry saying, “How did you get to a point where you were sitting around a table with government and the health community agreeing voluntarily to do these things?”.

I have talked about community alcohol partnerships a few times. I just wanted to spend maybe a minute on that so I can explain how that works, because it is remarkably simple but highly effective. We look to build and fund partnerships that have a minimum number of partners in areas where underage drinking is a problem, so it is very much neighbourhood-level. We draw a shape on a map. Inside that boundary we ask for a business plan put together by a minimum number of partners, which has to include local authorities, police, Trading Standards and, very importantly, every single retailer in that area. There is then a lead retailer, which is always one of the large multiple retailers, who takes the lead in training all of the other retailers, whether they are small convenience stores or slightly bigger ones, in what they are and are not legally allowed to do. The Challenge 25 scheme again is a retail-led scheme. They take every convenience store owner through exactly the same training as their own staff have, and you can see it almost immediately. In Barnsley, we saw a reduction in underage drinking and antisocial behaviour related to it of 30% very quickly. In Durham, the Home Secretary, alongside another scheme called Best Bar None, saw a similar level of reduction. It is to do with the fact that proper training is out there, people understand the law and enforcement, and you then have a partnership on the ground that works very quickly and effectively in practice. If you have someone coming in trying to buy alcohol either as a proxy purchaser for someone underage or underage themselves, you know what you are allowed to do. You then also ring whoever is in the community alcohol partnership on the police side and it also helps with other problems as well. In fact, our biggest issue with the 85 community alcohol partnerships that exist in the

UK now is how to replace the activity. In other words, for example, in Barnsley we have football training sessions with Barnsley Football Club put on for former underage drinkers who are now not drinking and want something else to do. It really is a virtuous circle in many senses, and we are very proud of it.

Q194 Lord Judd: You did rather emphasise the minimum number of people. Some people might be a bit surprised at that and ask why the minimum number. Surely it is the level of concern and interest and engagement in the issue or in the consequences that is important. That is one question. The second is: could you just give us some specific examples of the NGOs with which you are co-operating?

Miles Beale: Yes. On the first question, the reason we have a minimum level of partnership is very interesting. In some local areas the police and crime commissioner will be the most interested. In other areas, with public health delegated to local authorities, it is they who are most interested. However, our experience to date is that you have to have representatives of the police, Trading Standards, local authorities and the retailers around a table to agree the business plan for which we provide delivery funding. Otherwise you have a very important piece of the jigsaw missing and you simply cannot enforce it. We have examples where it has not worked. That is why it has to be minimum, but it is minimum because it may well include local charities and other schemes that operate, often funded by the industry, such as taxi marshals, street pastors. They may also be part of the partnership as well.

Brigid Simmonds: There are a few Business Improvement Districts where that has functioned.

Miles Beale: It is highly focused.

Paul Waterson: I agree with all of that. There is some really good work going on. We sit with others on the Scottish Government Alcohol Industry Partnership, which has a number of initiatives going on—CAPs, Best Bar None schemes to name a couple. They are working very well, but one thing to remember is that when you switch to big home-drinking populations you have to work harder to stop abuse, because drinking is not controlled. All this good work going on, as I said before, it is being thwarted. Also relationships between industry and health professionals is deteriorating because of the minimum pricing debate that seems to underpin everything at the moment. In big home-drinking populations we all have to work harder to try to stop the abuse of alcohol. Why do we have big home drinking populations? It is because of price. I know we have spoken about that already. There is a lot of good work going on in Scotland to try to offset alcohol abuse problems.

Brigid Simmonds: Can I suggest that the Committee might have a look at the work that DCLG has been doing on the Future High Streets Forum, of which I am member? It is part of DCLG and has been building on the Portas Pilots. We have just had a competition and I was one of the judges, and there are some really good examples of local authorities working in partnership between public sector and public sector and public and private to improve their night-time economies. In fact, the town that won, the overall winner, which is Belper, had a reputation for having hen nights and stag nights. It closed seven pubs, but it opened five more with a very different focus. I went and looked at the London Road area in Brighton, which is very socially deprived, and there was definitely a problem there, but it has
recognised that to have a successful town centre it has to have a successful daytime and night-time economy. There is lots of really good practice that we could build on there.

**Brigid Simmonds:** Can I suggest that the Committee might have a look at the work that DCLG has been doing on the Future High Streets Forum, of which I am member? It is part of DCLG and has been building on the Portas Pilots. We have just had a high streets competition and I was one of the judges, and there are some really good examples of local authorities working in partnership between public sector and public sector and public and private to improve their night-time economies. In fact, the town that won, the overall winner, which is Belper, had a reputation for having hen nights and stag nights. It closed seven pubs, but it opened five more with a very different focus. I went and looked at the London Road area in Brighton, which is very socially deprived, and there was definitely a problem there, but it has recognised that to have a successful town centre it has to have a successful daytime and night-time economy. There is lots of really good practice that we could build on there.

**The Chairman:** Thank you for that. We need to move on.

**Q195 Baroness Benjamin:** It would be fair to say that we live in a commercially led world where we have constant emphasis on growth, growth, growth. We have taken evidence from a wide range of witnesses in earlier sessions who have stated that the alcohol industry’s primary responsibility is towards its shareholders and that this disproportionately influences the companies’ involvement in the formulation of alcohol policies. Is this a fair criticism? How do you see your involvement being beneficial to the public’s overall health and crime issues? How can you convince your critics otherwise?

**David Frost:** I do not think it is a fair criticism. It will not surprise you to hear that, I am sure. Honestly, I do not think there is any company in this country that nowadays only thinks of its shareholders. Obviously, it does think of it—they are important, but we all have to think about a range of stakeholders—the employees, consumers—as well as our reputation. We have seen companies very badly affected, not in this sector but others, by not thinking about their reputation, not thinking about how they behave, and not thinking about how they interact with society. We have no interest in seeing our products irresponsibly or dangerously consumed. That is why we do all the work that has been set out.

**Brigid Simmonds:** We also represent a range of family companies—family brewers up and down the length and breadth of the United Kingdom. They are very much engaged in their communities. They do much more than brew and own pubs, and I would say categorically that all our members are interested in their products being consumed responsibly.

**Baroness Benjamin:** Why do you think they have this criticism then?

**Brigid Simmonds:** It is an easy criticism to make, and if you look at somebody like Heineken and the work they have done on moderation, why would you take alcohol out of your products if you were not interested in how it was being drunk and whether it was being drunk responsibly? There has been a lot of criticism. There was a lot of criticism of Diageo and the work they have done with midwives. We also have a blind trust that the industry has set up. It has put £250,000 into an education fund, which we are totally independent of. All we have done is provide the money. That money is going to fund alcohol education in schools. BBPA has put £50,000 into it over two years from a trust that we have. That is the
sort of attitude and, I think, a very good example of how the industry is interested. It is not in our interest that people behave badly and that our product is used irresponsibly.

Miles Beale: There is one thing you can add. This is partly a discussion about the EU alcohol strategy. The comparison between the UK and elsewhere is worth looking at. If you look at the UK environment, you see how much regulation there is and how much self-regulation there is through things like the Portman Group. There is the investment in work through organisations like Drinkaware and the suite of industry-funded initiatives, which are specifically designed to help tackle the problems of alcohol misuse. It is utterly impossible to say that the drinks industry in the UK does not take its responsibilities very seriously. They do have an interest in it, because that is what their shareholders and stakeholders want, so it is too simple to say that it is all about profit. I do not think that is fair and it is pretty well borne out by the comparisons.

Paul Waterson: Remember we represent independent owner-operators. Some in the industry have got themselves into a mess. You are asking why there is this criticism. If you look at the figures, the vast majority of alcohol sold in this country is sold by four or five big operators—supermarkets. Somewhere along the line the industry decided to chase volume instead of profit. It was very much a profit-based industry and now it is a volume-based industry. Producers of alcohol dance to the tune of these four or five big operators and it is all about creating volume all the time. That can be very difficult when the producers are being blackmailed by the big players to get prices down and down and down, so it can be pushed out at lower and lower prices. That is where some of the problems lie—they cannot lose those relationships with their biggest customers.

The work to combat alcohol abuse is there for to see, and there is some really good work being done, but that is where the criticism comes from. It is the constant growth, the constant push for volumes all the time.

The work that is being done is there for everybody to see, and there is some really good work being done, but that is where the criticism comes from. It is the constant growth, the constant push for volumes all the time and being at the behest of others.

Miles Beale: Again, as the only organisation able to represent the retailers, you are certainly right they are interested in driving down the cost for consumers, but that is what they do for all products and the consumer benefits. Affordability of alcohol is quite interesting. Alcohol is no more affordable today than it was in 2004, and in real terms alcohol is 24% more expensive now than it was in 1980 when we were drinking the same amount. It is not quite as simple.

Paul Waterson: Not in the off-trade.

Lord Wasserman: It comes back to the objectives. If you believe the objective is reduce overall consumption, then it is not in your interest. You want consumption because consumption is sales and so on. If you want harm reduced, then it is in your interest to co-operate with policy. Some people we have seen simply want consumption down as much as possible. That is not in your interest.

Brigid Simmonds: We are interested in co-operation.

Miles Beale: On a slightly lighter note, I have been used to lots of jargon in government. A new one on arriving in the drinks industry was “premiumisation”. It took me a while to
understand, but that really is all about selling less but at a higher price because it is higher quality, and that is about experience.

**Paul Waterson**: I must say this. You talk about prices. The price in the off sales continues to go down and the price in the pubs continues to go up. I have the graphs here. It is widening all the time. The price in pubs is going up and up and up. We create the profit; the off-trade, through the supermarkets, creates the volume, and that is the difference.

**Brigid Simmonds**: That is another reason why we need another beer duty cut, because it is pubs and small businesses that struggle.

Q196 The Chairman: Could I ask a broader question on the balance between regulation and voluntary commitment? Do you think the new alcohol strategy should retain the same balance?

**Miles Beale**: Yes is my answer, very definitely yes, because it allows to happen what we have been doing in the UK through the responsibility deal and other things. Your former witness, Daniel Greaves, from the Home Office, and I and Henry Ashworth from the Portman Group have met at least monthly for 18 months precisely to drive forward what we said we would achieve under the responsibility deal. I come back to the point I made at the beginning, which is we genuinely think that you get more done towards the objectives you are looking at of driving down alcohol harm more quickly at less cost if you do it through a voluntary approach. At the moment, the EU strategy allows that to happen, and therefore we would want exactly the same balance.

**David Frost**: It has to, because under the Treaty the EU simply does not have the power to legislate extensively in this area. It has very limited power, which it does not use much. It has to be based on voluntary collaboration, voluntary commitments, encouraging best practice and so on. That is the right thing, because if you think about what we have heard in the last hour, if you try to imagine setting EU legislation to do that, you have the Commission phase, you have the Parliament, and you have the whole legislative process. We would still be arguing about that now and trying to pin down the detail. And when you had done it, it would be very difficult to change or to reverse. You would find it very difficult to write it down in way that allowed the right sort of local flexibility. I just think it is a total blind alley to go down the legislative route when it is local initiative and the ability to change and adapt that is so important.

The Chairman: When you develop voluntary commitments, how far are people outside the alcohol industry involved in developing those voluntary commitments?

**Miles Beale**: In developing the original commitments, David and I were not there for some of the original ones, but the public health community were very much involved. They co-chaired the responsibility deal alcohol network. In community alcohol partnerships, we have the chief executive of Addaction on our board. We really are trying extremely hard to be inclusive and to include them. We are conscious that there are problems of alcohol misuse in this country. If you had taken the problems that there are now and said to someone 15 years ago, “Would you like to be here?” they would have bitten your arm off.

**Lord Sharkey**: I just want to follow up on the new strategy. All your written submissions say, more or less, that the new strategy should achieve the right balance between tackling alcohol-related harm and recognising the contribution of the alcohol industry to the EU economy. I am sure you all agree with that. I just wondered how this new strategy should, in
fact, recognise the contribution of the alcohol industry to the EU economy. What should it include to do that?

David Frost: It is a very good point. We talk about it as an EU alcohol strategy; it is actually an EU alcohol strategy about dealing with the misuse of alcohol, which of course is one part of the issues raised by the alcohol industry more generally in Europe. We engage with the Commission, Parliament and the institutions all the time for support for our exports and our companies as businesses. The UK Government give us lots of support on that as well. We export 85% of our products, so only 15% stay in the UK. I definitely think there is room for that wider discussion, but it probably ought not to be in this strategy, which, if it is going to be useful, needs to focus on dealing with harm.

Brigid Simmonds: That is the balance between the economic part of the EU and the Department of Health in this way, and we have worked certainly with Brewers of Europe very much on looking at the economic part of the industry and its contribution. If you look in the UK, we support almost a million jobs in the UK and that would be replicated across the whole of the United Kingdom.

Q197 Lord Judd: You spoke earlier about the need to concentrate on outcomes. How do you monitor the implementation of voluntary commitments? Can you give us any examples of measurable benefits that have resulted from such commitments?

Brigid Simmonds: We have had the billion units of alcohol, which has been externally looked at. The figures came from the CGA and, indeed, the labelling audit was undertaken by Campden BRI. They are all external to the industry. I mentioned Ipsos MORI, which has looked at the unit awareness, and the Beer Pledge at European level was looked at by KPMG. So, overall, I would have said external verification is really important, but we have seen more external verification here in UK of the commitments that we have made to the responsibility deal than would be normal in any other area.

Lord Judd: Is there not a tension there between the objectivity of external examination and the need to develop a culture within the industry of commitment within the industry?

Miles Beale: No, quite the reverse. It was very interesting listening to the Home Office colleagues before. Any statistics I have used today are government statistics, because we recognise that if the alcohol industry comes forward with statistics, somebody, perhaps our public health colleagues, will say, “We do not think those are objective third party statistics”. It is very important that the monitoring is done by third parties, so that everyone has faith in them. The responsibility deal specifically has third parties to bring statistics to bear and look at the monitoring, so you cannot claim that either the public health community or the drinks industry have influenced or suggested anything.

Lord Judd: Do you have examples of outcomes?

Miles Beale: At a European level, it is far more difficult. There are some statistics on things like mortality from road-traffic accidents where alcohol is predominantly to blame. Otherwise it is very difficult. In the UK, again, I will always come back to community alcohol partnerships, which we know best, but there we have a number of indicators that we can compare every single community alcohol partnership against, which allows us to say what is happening. We also have a mean or a test. Barnsley is a good example of where we have police data that suggest alcohol-related antisocial behaviour was driven down by 30% in the
area where we had a CAP as compared with a decline of 7.5% for areas in Barnsley where the CAP did not exist.

**Q198 Lord Blencathra:** First of all, Mr Frost, I was appalled to read last week, absolutely appalled, that some Japanese spirit has won the best whisky in the world award, so you are slipping. Please do not let that happen again next year. It is selling at a premiumisation rate of £110 a bottle.

Seriously, though, Mr Beale, written evidence submitted by the Wine and Spirit Trade Association states that the quality of the research on a number of projects funded by the European Commission has been poor and that, “the same researchers seem to get funded time and time again for the same old stuff”. I want to know your view on this, and I think I heard you say earlier there are 11 projects they have been researching, but no one is researching the things they should be about what has been working—why young people are drinking less and so on. You can either answer now or send us a paper, but what should they be researching?

**Miles Beale:** Can I do both? I have here something that I would be very happy to send to the Committee via the officers. Eleven projects have been conducted, to tune of €15 million, and some organisations—and I shall not name them—appear four or five times, so that is almost 50%. These are all aimed at things that are predominantly to do with consumption or how to solve a problem. There are two examples that we would certainly look at. Take the UK as an example. Do we know why consumption is falling and do we know what the impact between that and harm is? That goes back to Lord Wasserman’s point. Do we know in particular why young people are drinking far less than other cohorts? That seems rather important, particularly if we are going to make a difference quickly. That is the cohort that we have always wanted to target. Something seems to be going well, but we find it difficult to substantiate what, and if the drinks industry did it, I suspect there would be some query about whether they were good data.

The second is one that you raised earlier, which is illicit alcohol. HMRC believes that about £1.2 billion is going missing from the Exchequer thanks to illicit alcohol, but they also reckon it is a range, so it could be twice that much. Just to give you one example, the amount of tax on an average bottle of wine in the UK—that is duty plus VAT—is about 57%. For spirits it is just under 80%. The comparison in France for wine is 21%. It does not take a huge economic mind—indeed, otherwise I would not be able to do it—to work out that it is not very hard to go over the border and come back with more, and it is very difficult then to work out what is happening in the grey market. I should add there are some significant health issues there, because illicit alcohol is not just alcohol bought abroad; it is also what it is in the bottle, and that is far more serious.

**Brigid Simmonds:** On that particular note, we would have concerns about HMRC’s figures for the size of duty fraud for beer. They reckon that the midpoint on the beer side is somewhere between 9% and 10%. That would be the size of the entire convenience store sector, so you would have to say that all alcohol being sold in convenience stores was illicit, which simply cannot be true. We would think it was probably between 3% and 4%. That is not to say we do not take it very seriously. We have a task force that we are sitting on with HMRC. We are working very closely with them. They are going to institute registration of wholesalers, which will also affect pubs. We do a lot of work on ‘Know Your Customers’, and we are in no way complacent about it.
Brigid Simmonds: Also, if you look at it at an EU level, you have to be very careful with their sample size. For example, the GfK report that was commissioned by the Commission found that only 7% of alcohol labels in the UK contained health information. We found it was 80%, but it is undoubtedly to do with the size of the sample.

Lord Sharkey: Still, it is within the margin of error, no doubt.

The Chairman: Fine. We have taken a lot of your time and thank you very much indeed for your responses. If there is any supplementary evidence you want to give us, particularly on research, if you want to send us some stuff, it would be very useful. Thank you.
Summary

1. Evidence available especially from Health and Justice sources indicate that alcohol abuse continues to be a major problem.

2. Question 1. Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

3. Response. An EU strategy is required because alcohol is traded across borders and indeed worldwide so unilateral action though helpful is impeded and not fully effective unless there is consistency in approach.

4. Given its impact on obesity and diabetes the failure to include calorific content and sugar content on alcohol labels is a serious omission and should be addressed in the next EU Alcohol Strategy. In order to inform, educate and raise awareness on the impact of alcohol consumption, and on appropriate consumption patterns consumers must be informed of the calorific content and the sugar content of alcohol. A major UK supermarket has voluntarily included calorific content on certain alcohol products and its CEO has confirmed this has an effect on consumers’ behaviour.

17 September 2014
WEDNESDAY 3 DECEMBER 2014

Members present

Baroness Prashar (Chairman)
Baroness Benjamin
Lord Blencathra
Viscount Bridgeman
Lord Faulkner of Worcester
Lord Jay of Ewelme
Lord Morris of Handsworth
Lord Sharkey
Earl of Stair
Lord Wasserman

Examination of Witnesses

Adrian Brown, Alcohol Liaison Nurse, Northwick Park and Central Middlesex Hospitals, CNWL NHS Foundation Trust and Vivienne Evans OBE, Chief Executive, Adfam

Q217 The Chairman: Mrs Evans and Mr Brown, thank you very much indeed for your time this morning. We are very grateful to you for making the time to be with us. As you are aware, this session is open to the public, and a webcast of the session goes out live as a video transmission and is subsequently accessible on our website. A verbatim transcript will be taken of the evidence and will be on the website. A few days after the session you will receive a copy of the transcript. It would be very helpful if you could check it and give us your comments as soon as possible. If, after the session, you want to amplify any points or give us some supplementary evidence, that would be welcome too. Perhaps you can start by introducing yourselves and giving us any introductory comments that you wish to make.

Vivienne Evans: Good morning, everybody, and thank you, first of all, for the opportunity to come here this morning. I am Vivienne Evans; I am the Chief Executive of Adfam, the national charity that researches and supports, conducts research and policy work, and provides services for families affected by substance misuse. That would include illegal drugs as well as alcohol. I have a particular interest, therefore, in families, and that includes children, grandparents and kin carers.

I am very pleased that the Committee has decided to have a look at the issue of families and children affected by alcohol, because in my view it often gets overlooked, and I think it is
high time that we began to look at the harms that are caused and associated with alcohol misuse for people other than the person who is using alcohol.

**Adrian Brown:** Thank you for the invitation to speak. I am a registered mental health nurse specialising in the treatment of alcohol misuse for 20-odd years. I mostly do that within acute hospital trusts, with patients admitted with no clear, defined alcohol problem necessarily as their reason for coming to hospital. It is often the first port of call where somebody would be given to believe that they were drinking too much. Because of that, I work within accident and emergency, where we have done a lot of work researching why people are arriving—how they are ending up there drunk. I have been involved in projects to see if we can do an intervention there and then, and provide support and advice to people before they develop problems. In my current role, I work on medical admission wards mostly people who have been admitted via accident and emergency usually, and I see maybe 10 or 20 referrals a week of people who have some level of alcohol dependence. I have also worked within community alcohol services and drugs services previously, so I now link people from the hospital setting to those treatment settings.

**Q218 The Chairman:** Good. Thank you very much indeed. The Committee are obviously very interested in hearing from you about the effect of alcohol consumption on families, because it would be very helpful to have some indication of some case studies that you may have to share with us, and how it impacts on domestic violence, child abuse and neglect and sexual exploitation of young people.

**Vivienne Evans:** The first thing to say is that the data on this are quite difficult to collect; if I say they are unreliable, that sounds a bit pejorative. Our view is that a lot of drinking is taking place in the home at possibly levels that might not necessarily mean that they come to the attention of someone like Adrian, but parents, for example, may be drinking at levels that can affect relationships and parental responsibility and competence. We know from people who have a severe alcohol problem or dependency that their children tend to suffer from a whole range of difficulties, ranging from what I would call neglect: certain kinds of abuse, emotional neglect, financial neglect. The adult family members that are affected often tend to want to hide the problem, because it is deeply stigmatising to admit that you have someone in your family who has a problem. We know from the figures from ChildLine that there are on average 100 calls a week to ChildLine regarding substance misuse from children and young people about their parents, and the majority of those are around alcohol. Between 1999 and 2003, I was a member of the Advisory Council on the Misuse of Drugs Committee that produced a report called “Hidden Harm”, and that was about the effects of parental illegal drug use on children. We heard stories then and we hear stories now at Adfam about children often taking an inappropriate caring role. They end up caring for their parents. They live very often in financially reduced circumstances. Alcohol misuse at the really dependent end and the effects on children and families do not come as a single spy, if you like. They are in battalions.

You mentioned domestic violence. While all the evidence would suggest that alcohol does not cause domestic violence—someone who is violent is going to be violent and abusive anyway—there are certainly very strong parallels, and we cannot ignore that. We cannot ignore the links with mental health and families and children who are living in circumstances that are fragile, and often these children end up having a problem themselves as they get older.
Adrian Brown, Alcohol Liaison Nurse, Northwick Park and Central Middlesex Hospitals, CNWL NHS Foundation Trust and Vivienne Evans OBE, Chief Executive, Adfam—Oral Evidence (QQ 217-227)

Adrian Brown: With regard to the question about case examples, I had thought of a couple of people that I have seen in the hospital, and also understood domestic violence to include verbal abuse and other kinds of abuse that are taking place. One particular person who was using alcohol as a way of dealing with abuse. They were not an abusive person but went from a series of abusive relationships, all the time developing alcohol dependence and all the time frequently being admitted to hospital in severe crises, either intoxicated or stressed because she was not able to get something to drink to deal with what was going on at home. The family members often would be involved, would come to the hospital and be very caring, and apparently very supportive. It is very difficult to engage people at the best of times, but in the hospital setting we were able to see a bit more of what was going on.

I also thought of families with older members, because we have focused on children and young families, but people are starting to drink more as they are getting older, because they are extending their free time. They have always enjoyed a drink and are not picking up that they are drinking more and more at home. Leading to physical dependence at a much lower level then the partner is left to deal with somebody who is intoxicated when they see them. Again, the physical effects in that age group are likely to be damaging, so we do see a lot of older people admitted to hospital with a lifelong relationship with alcohol, which has only recently become problematic.

Q219 Lord Sharkey: I wondered whether you could tell us about the impact of alcohol use on the volumes and the nature of admissions to A&E departments and wards. Are patients disproportionately of one gender, age group or socioeconomic background?

Vivienne Evans: I think that is for Adrian.

Adrian Brown: Thank you. I would say there are two main groups of people that are attending with alcohol-related problems, and that is the first thing to point out. There are people who are intoxicated because they have been drinking and they get involved in accidents and fights. That age group is predominantly equalising over recent years. The change in the culture of people who are drinking has gone from mostly male one to more of a 50-50 men to women in younger people. Among this group, the people we see in A&E are just as likely to be female as they are to be male. Having worked in alcohol treatment services where that ratio is often 3:1 even, in terms of males are more likely to attend services, and a much older group (attend services compared with A&E). There is a fairly even population there, but it is skewed for the people with dependent problems.

The other group of people attending A&E are those people who have chronic problems related to alcohol, the obvious being liver damage, but cognitive impairment, heart problems, and so on, that have developed over time. Those people come in with a physical emergency and their reason for attending is often designated as that physical emergency and the alcohol levels are found out later on. It is often harder to pick out that group. Bits of research have said that at certain times 70% of people attending accident and emergency have been attending because of alcohol-related problems, and other times, in the middle of the night, for example, when a lot fewer people attend accident and emergency, almost all of them are having alcohol-related attendances.

Vivienne Evans: To add to that: I think there is a hidden population of families and children of people who have got a drinking problem; we do not know enough about it. Also just picking up on a point that Adrian made, if you look at serious case reviews of child deaths,
Adrian Brown, Alcohol Liaison Nurse, Northwick Park and Central Middlesex Hospitals, CNWL NHS Foundation Trust and Vivienne Evans OBE, Chief Executive, Adfam—Oral Evidence (QQ 217-227)

for example, you will see that in a lot of cases—I do not know how many; I have not got the figures—even though the presentation, the child’s death, may have happened through neglect or whatever, there is often a history of alcohol misuse there in the family that has contributed to that, but it is not necessarily the presenting feature of the child death.

Q220 Earl of Stair: You have mentioned just then, and previously I think, that you did not know enough about this kind of area. Is there a general shortage of data about the damage that alcohol actually does or might do in society?

Vivienne Evans: Yes, broadly. I think also there is an absence of data, or clear data, specific data, about family relationships. When somebody attends a drug or alcohol specialist unit they will be asked questions about their parenting responsibility, but that does not necessarily tell us a great deal about the effect on the child or the family. Often people—Adrian mentioned the majority are men—pitch up at services, and they may have parental responsibilities, but they may not actually be living with the child; they may be fathers, but not living with their children. I think it is very, very difficult to quantify, and therefore it is difficult to tackle.

I mentioned stigma earlier on. I think that is another compounding feature—people with a drug or alcohol problem, but also their families. We did some work a couple of years ago when we talked to families about, “How do you feel about being a family member?” One woman talked about going down to her local post office—she lived in quite a rural community—and she said that because it was known that her daughter was an alcoholic the people in the post office turned away and did not talk to her. That is an extreme case, but it is one I use to illustrate what people who are living with these problems experience, and it makes it more difficult for us to tackle the problem. Many people, not so much with illicit drugs, but certainly with an alcohol problem, keep it within the family, they try to cope with it within the family, and often that can be successful, but it is not always, and it puts enormous stress on relationships for adults and children.

Earl of Stair: Are these problems spread evenly across the whole country, or do you think that there are certain areas that are far worse than others? You have highlighted a mindset in slightly more isolated areas than perhaps in the more urban areas, but I do not know whether the alcohol issue as such is evenly spread across?

Vivienne Evans: I would say it probably is. Secondly, I do not think we know exactly, but Adrian possibly would be better on answering that than me.

Adrian Brown: The range of the problems probably is pretty much the same, but there is also the scope: the number of people it affects. The two sets of data I looked at are health and social data from the Health and Social Care Information Centre, which looks at how much people say they drink, and the admissions to hospital data, local area profiles from Public Health England. They match each other; the north of England shows a much larger area of heavy drinking; urban areas show much closer concentration and a higher number of people with problems. The danger there is to say that it does not happen in those other areas. Those people in those other areas probably find it harder to access treatment and support networks.

Earl of Stair: It is more focused in different parts of the area you think than the others.

Adrian Brown: Yes.
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**Vivienne Evans:** That is certainly the case with support for families, which is often provided on a voluntary basis by people who have had experience themselves. It is the way Adfam was set up; it was set up by the mother of a child with a problem. There is a lot of voluntary support for families with an alcohol problem, but, again, they are not by any means universal across the country; there are some areas that have got stronger community support mechanisms than others.

**Q221 Baroness Benjamin:** Can I just ask a supplementary to the first question that was asked: do you have any research done as to why people start drinking in the first place and whether children are affected by their parents drinking and then start drinking themselves?

**Vivienne Evans:** I am not sure I am answering the question, but what I can say is there has been some work done certainly on the influence of parents on their children drinking. Am I answering your question?

**Baroness Benjamin:** I want to know the reasons why people start, because that is the question we have asked over and over again; it is trying to get to the route of the cause of the problem. For the people that you come across, why do they start drinking in the first place? Will their children be influenced by seeing them drinking? The pattern keeps coming up.

**Vivienne Evans:** Yes, I would say so. There is certainly some evidence that children growing up in a household with problems—drugs or alcohol—will tend to be far more at risk of developing those problems themselves. There is also some research on parents’ influence on children’s drinking and that can be positive as well as negative. There is some work that has been done on parenting styles, and the evidence is that if you have a fairly laissez-faire attitude towards your parenting then your children are more likely to drink—not surprising, I suppose. There is an absence of longitudinal studies; there is an increasing interest into what I call intergenerational transmission of alcohol problems, and you will find families where the grandparents have been drinkers, the parents have been drinkers, and then no surprise that then the children end up with the same problems. For those families, their problems will be compounded by domestic violence, and other issues as well.

Why do people start drinking? Yes, it is a very good question. I would say that the evidence suggests that if you grow up in a family of drinkers then you are far more likely to become one yourself at some level.

**Adrian Brown:** We see a lot of people in treatment who have started drinking as teenagers, very often because their family introduced them to drinking, either as a way of managing them as a child or because everybody was socially drinking in that way. I am talking about people in their 40s and 50s who have drunk their whole life, and drunk excessively their whole life.

**Baroness Benjamin:** My question is: to your knowledge, do other EU countries face problems of a similar scale and nature to the ones that we are facing here in the UK?

**Adrian Brown:** I have a very short answer to this, as most of my knowledge is focused in London. I think there are cultural variations across Europe, so it is recognised northern states are drinking in a certain way, central Europe in a different way. What I see is that there are benefits of each of those different patterns of drinking and the way that they are managed in healthcare. I was thinking about whether I would mention the idea that we would become
Adrian Brown, Alcohol Liaison Nurse, Northwick Park and Central Middlesex Hospitals, CNWL NHS Foundation Trust and Vivienne Evans OBE, Chief Executive, Adfam—Oral Evidence (QQ 217-227)

a Mediterranean drinking culture, and I feel that has overlooked the fact that there are these different cultures in Europe, and it did not happen.

Vivienne Evans: I can let the Committee have the links to this piece of work that was done at Brunel University, and that was a survey about children of problem drinkers across Europe, and I think there were about 18 countries that took part in a survey. I suppose the easy answer is yes, these problems are not confined to the UK. The second answer really picks up on Adrian’s point about cultural differences, and also across Europe there are different definitions of levels of drinking. I think it is something that we find quite difficult here actually, particularly in terms of public education: what is the difference between hazardous and dependent and harmful? Certainly this was picked up in the study, and there are some countries where there is very little awareness of this as an issue, and certainly very little support for and interventions for children and families where they have a problem. We are pretty good on that scale.

Q222 Lord Faulkner of Worcester: I wonder if I can ask for your views on some of these solutions that are being proposed to us during this inquiry for dealing with the problems that you are both facing. What is your view on increasing the price of alcohol, first? Do you think it would be better to restrict where alcohol is sold, or do you think there should be restrictions on the advertising and sponsorship of alcohol? Which of those are likely to work with the sort of people that you are dealing with?

Adrian Brown: I feel that I am convinced by evidence in favour of a minimum unit price for two reasons: one, where it has been applied there seems to have been a benefit in overall consumption. I do not know if that would necessarily affect the people at the more severe end of dependence, but it certainly is meant to target the general population and I feel it has done so. I also feel that in my lifetime as a drinker and working with people who have drink problems the relative cost of alcohol went down quite significantly, and the number of problems went up very significantly.

Lord Faulkner of Worcester: What about advertising and sponsorship? Do you think that makes people drink more or not?

Adrian Brown: A personal example of being totally unaware that something was branded as a drink until I spoke to my friends from Glasgow was that T in the Park was actually “T” for “Tennent’s”. They were all aware; I was not. I think it should be downplayed and examples in football grounds of clubs taking responsible action by advertising Drinkaware is a much better way of dealing with it.

Vivienne Evans: I would agree. We do not know what the effect of minimum unit pricing would be on families, because as far as I know we have not asked the question. My suspicion is that families would say, “Yes”, because what they are doing is they often find that they pay for the alcohol on behalf of their loved one. Certainly all the evidence that I have seen suggests that a ban on sponsorship and alcohol advertising, particularly if it is aimed at young people as increasingly it seems to be, would be beneficial.

The Chairman: Lord Bridgeman. It has been answered. Did you want to ask anything further?

Viscount Bridgeman: No, I do not think so. The Scottish experience is going to be a very interesting one.
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Vivienne Evans: Indeed.

Q223 Lord Morris of Handsworth: Are you aware of any other policies in addressing alcohol-related A&E attendances and harm to families? Are they effective in reducing either type of harm?

Vivienne Evans: No, I am not.

Adrian Brown: I took that wider to mean policies such as local policies, local actions; is that what the question meant?

The Chairman: I think it is local policies at A&E departments.

Adrian Brown: That is how I took it, and it might help to open up the question to Vivienne. We have had projects that have helped family members because their loved one had been admitted to hospital, found to have an alcohol problem, but completely rejected that diagnosis or that idea, so the families are left needing support. Local groups, carer-support groups in Wandsworth where I used to work, would provide support to that individual’s family to help them build support around people with drink problems. There have also been projects that take on supporting the individual around other social factors. Rather than just focusing on an alcohol dependence or an alcohol-related problem, they help with things like accommodation and employment, and that benefits families. It recognises that the person does not exist in a vacuum with an alcohol problem; there are people around them that also need support.

One other type of project, which again has benefits for the people around, is that when somebody comes to hospital several times with a problem, does not accept help, does not accept referral, and the family then present at the hospital saying, “You have not been able to help them with this, with this, and with this”, there are now assertive outreach groups that take that person as a referral from the hospital and, again, support people around them to help them get into treatment.

Viscount Bridgeman: How do you measure progress in respect of people who need this sort of help and treatment attending accident and emergency more than once; how do you measure that?

Adrian Brown: We would see two factors: a reduction in the number of attendances, and a reduction in the duration of those attendances. If somebody is physically ill they will be admitted for a longer period of time. If we can help to reduce their time in hospital by supporting them not to relapse, or giving them other support, then those are beneficial.

Viscount Bridgeman: What do these statistics tell us: is the problem increasing or diminishing?

Adrian Brown: Where those services exist, we are able to reduce attendances for some individuals, and those projects have shown that.

Q224 Lord Faulkner of Worcester: Just a quick supplementary to Mr Brown: the press from time to time suggests that where you are dealing with A&E cases at a hospital and you have people coming in who have effectively harmed themselves by excessive drinking, they should be given a lower priority in terms of treatment, compared with other people who have maybe suffered a road accident or accident at home. Has there ever been any consideration about grading patients in that sort of way?
Adrian Brown, Alcohol Liaison Nurse, Northwick Park and Central Middlesex Hospitals, CNWL NHS Foundation Trust and Vivienne Evans OBE, Chief Executive, Adfam—Oral Evidence (QQ 217-227)

Adrian Brown: There has been consideration. I made a note for an earlier question, which is that people who are intoxicated are harder to manage in an acute phase. I have heard debates among nursing staff who work in acute settings in accident and emergency. I have spoken to many of them directly, and occasionally the view arises that maybe the alcohol should be considered as a factor. Most people think that you have to treat the need that is there first and foremost, and there are risks of ignoring a drunk who has a head injury or a gastric problem, and I think in general my colleagues would not take that chance and would not want to take that chance.

Vivienne Evans: If I can just pick up on that and broaden out again in answer to the question: I do not believe there is enough support for families in their own right. Often the attention of the services is drawn to the alcoholic and there are not enough services for families; I mentioned services in the community—often voluntary-led services that are doing an excellent job. Families tell us often that if they go to a GP often the GP is not perhaps recognising that they also have needs that need to be met.

This picks up on a point that Adrian made: they often do not think that they are deserving of support. Particularly if it is a child, they think it is their fault, and maybe in a relationship, “It is something I have done that has caused all this”. They often think, because alcohol is legal, it is not as bad as drugs, and also, because of the availability of alcohol, again, they think, “Oh, alcohol is everywhere”, and it is hard to tell often when a problem has arisen.

They often do not feel that they are themselves deserving of support, and yet some of the stories that we hear are of families really suffering a lot of particularly psychological and emotional damage, because of the strain and the stress of living with someone with a problem like this. I would argue for more services and more services for the children as well; there are very few that address the particular needs of young people who are living with someone with substance misuse.

To go back to your question, Baroness Benjamin, about why people drink in the first place, if we could provide perhaps more support for children where they are living with parents, or one parent, who have a problem, then that may develop their resilience and help them not to have this problem themselves.

Baroness Benjamin: I must admit, I fear Christmas for some children; I know what is going to happen to them, but that is another point.

Vivienne Evans: Yes, indeed.

Q225 Baroness Benjamin: Are you aware of policy approaches to these issues in other EU countries? Do you ever do any exchange visits to find out what is happening there and how they are dealing with it?

Vivienne Evans: I have never had the opportunity I am afraid, so no, I am not, but I have some colleagues who have, and I can provide some information about that. There are one or two, but, again, I think attitudes towards alcohol are very different across the EU, are they not, but I can certainly refer to the work that my colleague has done.

The Chairman: Do you have anything to add?

Adrian Brown: No, people have visited, but not from EU countries, to find out what we do.
Adrian Brown, Alcohol Liaison Nurse, Northwick Park and Central Middlesex Hospitals, CNWL NHS Foundation Trust and Vivienne Evans OBE, Chief Executive, Adfam—Oral Evidence (QQ 217-227)

**Q226 Lord Jay of Ewelme:** I am interested in your views on the role of education and raising awareness in reducing alcohol-related harm, and whether you think we should try to target the drinkers, the consumers, families, third parties or professionals, or all of the above, and if there are any particular examples you could give of ways in which this has been done well in your experience?

**Vivienne Evans:** If we are talking about education for young people that has been under a lot of threat over the years, and I think sometimes that is done quite badly. Sometimes people who have got lived experience will go into schools and talk about it, and for me that is not an adequate educational response. There are some schools that will include alcohol awareness, for example, in the curriculum, but it is by no means universal or standard.

I think we should target alcohol awareness and information at everybody; it goes back to the point that was made about advertising: the advertising industry is very powerful, and often the awareness that groups like ours or Public Health England, for example, can promote—there is not enough money to promote an awareness-raising of some of the problems associated with alcohol as there is of the “benefits” of it, if you like.

In answer to your question, possibly there is a case for targeting family members—parents actually, not necessarily family members; I would say parents to be more specific. I think there is work to be done with parents to raise their awareness of their own influence on young people’s drinking and the awareness of drinking at home. Although we hear a lot about drinking in pubs and clubs, there is evidence that drinking at home is increasing, and that is something of course it is very difficult to find out about, but that kind of information should be out there for parents to help them to help their children to drink responsibly rather than irresponsibly. There is not enough awareness of the health dangers associated with drinking, particularly if you begin to drink at an early age, and there is increasing evidence about the risks of cancer, for example; it is not just liver disease, I think I am right in saying. My understanding is it is not just your liver that is just going to suffer; it could be other health risks as well.

I would very much go for more public awareness campaigns, more work in schools, more work with young people, and more work with parents, raising their awareness of what their own drinking can do. I was quite struck when I looked at the Mumsnet website to see recipes to make vodka at home, and you can make it—I have not tried it—in the dishwasher apparently; it is called dishwasher vodka. I could rant on for ages about this, but I think we need to begin to tackle that culture. I think our relationship in this country with alcohol is extremely complex, and it is very difficult to change our culture—I am not necessarily arguing for that—but I think we have forgotten that all of us as adults and parents do play a very key role in what is going to happen to their own alcohol use and also the effect that their drinking can have.

We were talking recently in our office about a colleague who had just had a baby, and she did not drink during pregnancy, but once she has the baby, she now thinks, “Oh, great, I can now start to drink again, so we will have that bottle of wine, not just to celebrate”, and that is possibly going to affect—I do not know; it is possibly going to affect her relationship with that child as the child grows, and also, in terms of parenting ability. For example, if you have had a few glasses of wine in the evening and then you have got to get up in the night and feed the baby, you might not be as aware as you should be.
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Q227 Lord Jay of Ewelme: Just on the Mumsnet example, which is rather striking, would your organisation, do you think an organisation, if it spots something like that, should write to Mumsnet and say, “Look, do you think it is responsible to have this sort of thing?” or make them aware?

Vivienne Evans: Yes, indeed. I think we should, and I think you have probably taken evidence from Alcohol Concern; we work in partnership with them a lot and have developed an alliance—we call it the Alcohol and Families Alliance. We have got a wide group of people from across the charity sector who are working in family charities, to try to raise their awareness of the role that they can play as charities that support families and children—the awareness that they can rise with their colleagues and their supporters about the effects of alcohol on parenting and families. We have been trying to do that, and the issue that keeps coming up is this one about what I call low-level drinking, and the people that Adrian sees are the ones who have got a real problem; I am right in saying that, am I not? There are so many people who never, ever get to a service; they would not see that they have a problem. They do not recognise that they have a problem at all, and therefore they do not recognise that they would need a service or that they would need an intervention, which is why I am in favour of intervention and brief advice that GPs might be giving them.

The Chairman: Is there anything you wanted to add, Mr Brown?

Adrian Brown: In the two other areas, there is a lot of information for consumers: the “your drinking and you” leaflets, the examples that were given by earlier witnesses about the drinks industry making people aware in part of the risks. I see a lot of people in the hospital, who say that they do not understand it, and I think something that is simpler and a clearer message needs to be out there. I think there have been changes that may be down to education in younger drinkers. A lot of that is perhaps cultural and family education that is taking place among non-drinkers. I was going to mention alcohol brief interventions in accident and emergency, in GP settings—pretty much anywhere where people who might have alcohol-related problems come into contact—but actually they should also be targeted at people who have not yet got to that stage. I think the GP surgery, as part of general health checks, is perhaps where that is heading at the moment.

The other was about education of professionals in the field, and I have two groups here: for health and social care professionals, the education that we get is really poor about alcohol problems. It often takes place across different parts of the education, but bringing it together in terms of how to intervene.

Lord Jay of Ewelme: Who do you get it from?

Adrian Brown: As part of nursing training, as part of medical training, as part of social work training. It does not happen well enough. For specialist training thereafter, there are good examples: the Royal College of GPs has a substance misuse GP group, which provides excellent training on alcohol and drugs, and is open to people more than just the medical profession. I have done it, and I would recommend it.

The other group of professionals is people who sell the stuff; they do not always know enough about who they are selling to: to intoxicated people. There are examples of the bar trade doing training for their staff. I know examples of people who work in bars told to serve drink to drunk people and refusing their manager; I know this thing happens. The education
Adrian Brown, Alcohol Liaison Nurse, Northwick Park and Central Middlesex Hospitals, CNWL NHS Foundation Trust and Vivienne Evans OBE, Chief Executive, Adfam—Oral Evidence (QQ 217-227)

and the recognition of good practice among people who sell alcohol is something that should be done.

Baroness Benjamin: My husband is a JP, and once when a barmaid told a customer that he had had too much to drink, he smashed a glass and shoved it in her face, so we have got to be aware that that kind of violence could happen if somebody takes it upon themselves to tell somebody in a bar, “You have had too much to drink”.

Vivienne Evans: Just to pick up on the question about professionals, there certainly is not enough training for social workers, and that is something we have been trying to campaign about for a long time. Their awareness of drugs and alcohol and the effect on the family and children is quite limited. We believe that that should be part of their overall initial training.

Adrian Brown: One final point on the selling, before I lose my voice. I have seen a research paper where somebody interviewed people working in off-sales trade, and found that the people in the larger firms had really good policies and training, but the people working in the local shops knew the customers, so they were more concerned about people who had got problems, so there are two levels of prevention that needs to be done. The latter group do not necessarily get the support and training that happens in the larger companies.

The Chairman: Thank you very, very much indeed for your time this morning. Mrs Evans, it would be very helpful if you can send us a link to that Brunel University survey that you mentioned, and the other one that you mentioned. If there are any other points that you wish to raise with us or send us some supplementary evidence that would be very helpful. Thank you very much indeed.
WEDNESDAY 22 OCTOBER 2014

Members present

Baroness Prashar (Chairman)
Baroness Benjamin
Viscount Bridgeman
Lord Faulkner of Worcester
Lord Jay of Ewelme
Lord Judd
Lord Morris of Handsworth
Lord Sharkey
Lord Tomlinson
Lord Wasserman

Examination of Witnesses

Crispin Acton, Programme Manager, Alcohol Misuse, Department of Health, Lindsay Wilkinson, Deputy Director, Department of Health, Sarah Godman, NHS European Office, and Susannah Simon, Director, European Reform Directorate, the Department for Business, Innovation and Skills

Q13 The Chairman: Good morning, and a warm welcome. Thank you for your time this morning. As you know, this session is open to the public, and a webcast goes out live with an audio transmission, which is accessible via the parliamentary website. A verbatim transcript will be taken of the evidence and put on the parliamentary website. A few days after the session, you will be sent a copy of the transcript to check it for accuracy. It would be helpful if you could advise us of any corrections as quickly as possible. If, after the evidence session, you wish to clarify any points that you have made or with to make any additional points, you are very welcome to submit supplementary evidence. Perhaps we could begin by each of you introducing yourself and saying a little about your area of work, starting with you, Mr Acton.

Crispin Acton: My name is Crispin Acton. I work in the Department of Health’s alcohol policy team as programme manager. I also represent the UK on the EU Committee on National Alcohol Policy and Action.

Lindsay Wilkinson: My name is Lindsay Wilkinson. I am the deputy director in the Department of Health for drug and alcohol policy, so my area covers more than alcohol.
Sarah Godman: My name is Sarah Godman. I work for the NHS European office in Brussels and am here in my role as the national focal point for the EU’s public health programme.

Susannah Simon: I am Susannah Simon, and I am the director for European reform in BIS. My area covers the promotion and defence of BIS-linked UK interests in the EU, including the single market.

Q14 The Chairman: I will start with the first question. It is addressed to all of you, so I would expect all of you to respond to it. What do you see as the key achievements of the EU alcohol strategy for 2006 and 2012 from the public health perspective?

Crispin Acton: Perhaps I could start. Out of the current five themes, we would say that there has been significant success with two, and we would go along with the official evaluation report published by the Commission, which we think is a very good report. It shows essentially that on the two themes, young people and drink-driving, there has been an influence from the current strategy, particularly in member states that had weaker policies in the past. There has been some harmonisation of approaches towards blood-alcohol levels and better enforcement in respect of drink-driving. There have also been quite a lot of moves towards greater commonality on underage purchasing, so there is much more similarity in the age levels for underage purchasing and improved enforcement.

On other areas, such as information for consumers and education, it is quite hard to measure success. There are still quite a lot of challenges with data development, as the evaluation report notes. Finally, it is not clear that there has been a lot of progress on reducing alcohol harm in the workplace.

The Chairman: So are you saying that it did not necessarily achieve the overall objective of reducing alcohol-related harm?

Crispin Acton: I do not think it is possible to say one way or another. I should also note that I do not think the current strategy has the explicit objective of reducing overall alcohol-related harm—it is implicit.

Lindsay Wilkinson: I agree with Crispin. I think it has made some inroads into some specific areas, but we would argue that it could go further. We would also say that it has been a useful tool for starting to introduce the Health in All Policies approach, but it has further to go on that too.

Sarah Godman: I think it would be fair to say that the alcohol strategy has influenced the funding channelled through the EU’s health programme over the years, and provided encouragement for more proposals and more projects relating to alcohol-related harm.

The Chairman: Did it succeed in any of its five priority areas more than others?

Sarah Godman: The five areas of the strategy were covered by different projects, and there were a number of successful projects in each area. The health programme is designed to support and promote activities and learning across member states. In all areas, there is evidence of projects that supported good practice, shared methodology and standardisation of data. That in itself is an explicit, or implicit, example of how EU member states are working together to share practice and experience. Hopefully, that then gets taken up on the ground in the national implementation programmes and strategies.
**The Chairman:** How about a reduction in alcohol-related harm? Did it have any impact on that from your point of view?

**Sarah Godman:** Again, there are a number of projects that focus on that. For example, for alcohol-related road traffic incidents, there was a very good project that worked on peer education for young drivers. Another project looked at the monitoring of marketing and commercials for alcohol, and young people’s online exposure and interaction. There were a number of projects looking at best practice in work-based strategies and prevention of the harmful use of alcohol in older age. These all built towards a supportive policy environment for alcohol-related harm.

**Susannah Simon:** BIS has not made an assessment of the alcohol strategy, because we see it largely as being about public health, which we see as something for the Department of Health.

**Q15 Lord Morris of Handsworth:** Do the Government believe that there should be a new EU alcohol strategy? If so, should it build on the priorities of the previous strategy and should more emphasis be placed on a Health in All Policies mainstreaming approach?

**Crispin Acton:** Perhaps I could start. The Government have argued, and are arguing, for a new European Union alcohol strategy, although we think there is still validity in the principles and priorities of the current strategy. The current priorities are not wrong, but they could probably go a bit further. We would like a new strategy that focuses more on a Health in All Policies approach as far as the EU’s own policies are concerned. There are quite a number of EU rules and pieces of legislation that were devised some time before the current EU alcohol strategy, some of which, such as the directives on alcohol taxation, have been in place for over 20 years. Public health was not a big issue for consideration at the time that they were devised, so we would like some further consideration of issues like that. We also think that there is still value in the EU, as an institution, recognising the evidence base for effective policies, in a similar way to the WHO.

**Lindsay Wilkinson:** I am afraid to say you will hear me saying quite a lot that I agree with what Crispin said. It has some potential, but it is always difficult as there are a lot of players involved in reducing alcohol harms, who could help to reduce them. Co-ordination is always difficult, but that does not mean that we should not try to do it any level where it is possible.

**Lord Morris of Handsworth:** Given the future intent, which is evident in your response, I have a question about the previous strategy, which stated an intent to mainstream the reduction of alcohol-related harm in other EU policies. To what extent has this been achieved? How could it be improved in a future strategy, such as the one you have just outlined?

**Crispin Acton:** The honest answer is that we in the UK Government are saying that there has been quite limited achievement in mainstreaming a Health in All Policies approach within the EU. That is why we are focusing on that as an important issue for a new strategy. I would not say that there have been no achievements at all, but it is not always clear whether those achievements are as a result of the European Union alcohol strategy. One positive example that I could give is to do with the common market organisation for wine. The reform of that regime has led, and is leading, to positive developments such as a reduction of subsidies for cheap spirits and the EU promoting quality wine much more. But I think it is probably coincidental that that is consistent with or supportive of a public health approach. It is a
positive development, but there are a lot more areas where we think the EU needs to do more work on this.

**Lord Morris of Handsworth:** How do you intend to promote the new strategy when it is developed?

**Crispin Acton:** The UK Government work with other member states, so there is quite a lot of common interest in this. The UK is interested in some policy issues while others are more interested in other ones, but the general view, which I think is shared by virtually all member states, is that the Commission needs to do more in the area of Health in All Policies.

**The Chairman:** Does anybody want to add anything? No? Lord Bridgeman, you wanted to ask a supplementary.

**Viscount Bridgeman:** Thank you Lord Chairman. This is really addressed to Ms Wilkinson. In the evidence last week, there was only a very brief reference to drug strategy and the crossover between drug problems and alcohol problems. Would you care to say any more about that?

**Lindsay Wilkinson:** Can you clarify exactly what you want me to talk about? I could speak for quite a long time about drug and alcohol strategy.

**Viscount Bridgeman:** These are two serious problems which I would have thought have a certain relationship. Reference was made to the fact that when alcohol consumption goes up, drug consumption goes down. Do you have anything to add to that?

**Lindsay Wilkinson:** Like a lot of social issues, alcohol problems permeate all aspects of society. I would highlight for example the relationship between mental health and alcohol or drug consumption, and the fact that those two are quite interlinked in a vicious cycle. If you have poor mental health you are more likely to drink, and if you drink to excess you are more likely to have poor mental health. There is a link with addictions and treatments for addiction. The treatments tend to be parallel but slightly different in the way they help people on their recovery journey. I cover both drugs and alcohol, and see some links between them. But there are some areas in which they are not related. For example, most of the drugs that we are talking about, apart from the legal highs, are illegal and therefore there is an issue around legality. There is also a difference in the types of crimes that tend to result from them: most drug crime is acquisitive crime, as people require money to feed their habit, while most alcohol-related crime is not about acquiring money but tends to be more to do with violence and other things. I can see that in some ways they run in a similar pattern, while in others they are rather different.

**Viscount Bridgeman:** What would be the added value of a new EU strategy as opposed to national strategies and/or the World Health Organization framework? Are any of the WHO principles particularly relevant to the EU context? In what way should an EU strategy differ from the WHO framework?

**Crispin Acton:** I will try to answer that. I think it is important to recognise that the current EU strategy was published in 2006. The World Health Organization’s global alcohol strategy was finalised in 2010. We also have a WHO/European alcohol action plan, which was agreed in 2011, so the WHO document post-dates the current European Union strategy. To put it simply, the WHO global alcohol strategy, in our view and in the view of most member states, is quite a definitive statement of what effective alcohol policies are about, and a new European Union strategy needs to take account of that. We do not think it needs to
duplicate the WHO’s strategy, but the European Union needs to focus on its current areas of competence, the health issues in all policies, which are really where it can make most difference, but taking account of the WHO approach.

The Chairman: Does anyone want to add anything? Would Ms Godman like to add anything from the National Health Service point of view?

Sarah Godman: I am here really as the national focal point for the EU’s health programme, so I would prefer to comment on the European funding.

Q16 Lord Sharkey: The last strategy was reviewed in 2009 and 2013 and there is the consortium review of 2012. Previous witnesses have told us that the reviews that evaluated the strategy did not look at hard data, such as those on changes in levels of alcohol consumption and alcohol-related harm. Do you think that indicators should be established right at the beginning of any new strategy to monitor its success, and if you think that is the case, to what extent should those indicators be based on the benchmarks in the WHO plan?

Crispin Acton: We agree that there should be indicators. It is difficult to say precisely what those indicators should be before we have a new strategy, but in principle we think there should be indicators to benchmark success. We also think that in principle they should reflect the WHO/European alcohol action plan indicators, because those are indicators that we have already agreed, as all member states have, and they are good indicators.

Lord Sharkey: Could I press you a little on what “indicators” might mean? In evaluation reports, “indicators” occasionally means some sense of whether, broadly speaking, things have happened as the strategy said. “Indicators” can also mean or mandate hard data.

Crispin Acton: That relates to your first question on the evaluation of the current strategy. Yes, we think indicators should relate to outcomes, including changes in levels of harm, so that would be consistent with the current WHO European alcohol action plan indicators. They should not just be indicators to show whether some effort has been made.

Q17 Lord Faulkner of Worcester: I am going to ask you about the new EU action plan on youth drinking and binge drinking. It has been criticised by professionals who said that it is wrong to concentrate on just one section of the population. Do you agree?

Crispin Acton: Yes. I would not say that the European alcohol action plan is of no value, but the important thing is that it is not a substitute for a new strategy. Part of the worry on the part of some health professionals and NGOs is that it could be seen as something that delays a new strategy or is seen as being in place of one. Clearly, that would not be appropriate because its coverage is not comprehensive. That said, some of the actions within it are worthwhile, and some are actions that we already do in the UK.

Lord Faulkner of Worcester: Can you explain what some of those are?

Crispin Acton: There are rather a lot of them.

Lord Faulkner of Worcester: What are your favourites?

Crispin Acton: That is a hard question. I shall take two examples. One example would be the action to improving the training of health professionals in understanding fetal alcohol spectrum disorders, which we have already taken some action on for a number of years. That is quite important because of the previous relative lack of awareness among health
professionals about these issues. This is very much a matter for member states, but it is important and somewhere where member states can learn from each other.

Another example is voluntary industry action, where there is a recommendation for challenge schemes for underage purchase. The UK industry, or parts of the UK industry, has a scheme called Challenge 25, which means that if you look as if you are under 25, you will be asked to prove whether you are over 18. We know that those schemes can be quite effective, although the coverage is not universal. Those are worthwhile things.

Lord Faulkner of Worcester: I am wondering whether there is a BIS view on targeting specific groups of the population rather than a whole population approach.

Susannah Simon: We did not look that, so there is not a BIS view on it.

The Chairman: Ms Wilkinson, do you want to add anything?

Lindsay Wilkinson: Any action to tackle health harms is important and therefore the action plan is a good thing, but if you focus on small sectors of the population there is a danger of people believing that those are the only things that are harmful. A lot of health harms occur in people who are not street drinkers or binge drinkers but who are drinking considerably more than the lower-risk guidelines. There is a danger that if you separate out subsets of people you miss the big message about a very large number of people who are drinking potentially harmfully.

Baroness Benjamin: Which area would you say that we should be concentrating on?

Lindsay Wilkinson: I would take a population approach, but quite a bit of action is required in relation to people who are drinking harmfully or hazardously and are not aware that that is the case. A lot of people genuinely do not realise that the quantity they are drinking potentially put them at a high risk of harm from alcohol.

Baroness Benjamin: I think that a lot of people who drink alcohol are in denial. How do you get to that part of the population? We have to have a strategy where you can feed into parts of the population who do not want to admit that they have an alcohol problem.

Lindsay Wilkinson: Inevitably there is not going to be a single answer to that. Health education campaigns such as Change4Life are good. The Change4Life campaign showed, in the same mode as other things in Change4Life, every day drinking and how it can creep up on you. It was not about tackling things that people might find difficult; it accepted that people might behave like this and might not really be thinking about the implications. A health education campaign is a big subject, and it is tough to get people to change behaviours.

Q18 The Chairman: Is there any crossover, in your experience, with drugs in what strategies have worked and what could be relevant for the alcohol strategy?

Lindsay Wilkinson: I would go back partly to my earlier answer around drugs and alcohol. They are rather different, inasmuch as drug taking—if we are talking about illegal drugs—is an illegal activity and therefore tends not to be as amenable to standard types of health education messages, because people have decided to do something that is not recognised by law as being permissible. The kind of people we are talking about who are drinking at harmful levels and may not accept it are people who do not necessarily consider themselves to be rule breakers or law breakers but are people who in many contexts would enjoy a
reasonable level of alcohol socially and benefit from it in terms of physiological well-being. There are slightly different sets of populations, especially when you come to think about changing behaviour. The place in which it comes together is in childhood resilience. There is very little evidence on how to stop children doing things such as smoking and other things that you do not want them to do, but there is quite a bit of evidence supporting the idea of supporting children’s resilience to know their own minds, to know when to say no, to resist temptation and generally to feel resilient in themselves in doing what they believe to be right and want to do. That is one point at which they come together.

Baroness Benjamin: Should this be something that schools take on as a role?

Lindsay Wilkinson: Absolutely. Resilience should be a core part of many schools’ approach to supporting children as they move through their lives. It might be around any aspect of resilience, including sexual health.

Lord Jay of Ewelme: Just to follow that up, you talked about the difference between drugs and alcohol as being that one is criminal and one is not. Are there lessons to be learnt from the campaign against tobacco over the years, which in some ways is more similar? At first it was not thought to be particularly dangerous and then it was increasingly thought to be more and more dangerous, so there was a stronger and stronger campaign. Are there lessons there for how we might deal with alcohol?

Lindsay Wilkinson: Tobacco and sexual health would come into the drugs and alcohol-type resilience question and resilience to enable children to resist pressure to do things that they do not want to do. There is quite a difference in many ways between tobacco and alcohol inasmuch as there is no safe use of tobacco, whereas if you drink within the lowered risk guidelines you have a limited risk of disbenefit from drinking alcohol.

Viscount Bridgeman: A rather surprising fact came up last week that binge drinking among middle-aged people is a much bigger problem than is generally appreciated. There must be different considerations, as middle-aged people who are that much closer to old age are now requiring more treatment and so forth. Do you agree that binge drinking has to be addressed right across the board with different age groups?

Crispin Acton: Yes, it does. I think there is more public awareness of binge drinking among under 25 year-olds, but it is a significant issue for middle-aged people, and it is not just an issue about anti-social behaviour. It has health risks as well.

Q19 Lord Jay of Ewelme: We touched a bit on the impact of alcohol misuse on crime, particularly domestic violence and drink-driving. Do you think there is adequate research on this? Should a new strategy focus on the impact of alcohol misuse on crime—in other words, on people other than the drinkers—or should it just focus on the drinkers themselves? Sorry, I am going on a bit. Is there evidence of the proportion of harm, as it were, done to drinkers themselves and the proportion done to those who come into contact with them? How important is the issue?

Crispin Acton: It is a big subject. It is clearly an important issue, and it is important to make the point that harm to others from alcohol misuse and crime and all forms of harm to others are relatively underresearched compared with health issues. That is something we are very aware of and the Department of Health would support some effort towards greater and better research in that area.
Lord Jay of Ewelme: Including from the EU?

Crispin Acton: Yes, including from the EU. It is important. One qualification is that it is a more important issue in some member states than in others. It is an issue everywhere, particularly in northern countries—the UK tends to have a north-European pattern of drinking—where there are more people who indulge in binge episodes, not just regular heavy drinking. In some member states, it will be a bigger issue than in the others. There is also concern in some Mediterranean countries that binge-drinking is being exported, or becoming a fashion, for some young adults in those countries. Issues such as domestic violence linked to alcohol are important issues everywhere.

Baroness Benjamin: Do you ever work with children’s charities? Many children’s charities are dealing with children who are being affected by alcohol misuse. Have you done any research? Do you link up with them at all?

Crispin Acton: Yes, we do. Over time, we have linked up with them and we are aware of the importance of the issue, particularly for adults who are dependent on alcohol, but there is probably a wider issue as well. A lot of work is being done to make treatment services aware of family issues. Services need to be family friendly and there needs to be an awareness of areas such as potential child abuse where alcohol can sometimes be an issue.

Baroness Benjamin: So that is children’s charities not just here in the UK but across Europe as well.

Crispin Acton: I have less knowledge of that. The Commission may well be in touch with Europe-wide umbrella groups. I have less awareness of what other member states are doing.

Baroness Benjamin: We have sexual exploitation across Europe, and a lot of children are involved. You find that alcohol abuse is also involved. That is the scenario. That is why I asked the question because there is no point having it in one country and not another. They are interlinked.

Crispin Acton: We are approaching it from the alcohol perspective, which is about trying to reduce the role of alcohol in such phenomena. Obviously the treatment and tackling of child abuse is a specific issue.

Baroness Benjamin: I think you misunderstand what I am saying. I am saying that alcohol is part of that, so you cannot separate the two and you need to work together. Have you thought of that type of strategy to work on rather than just saying, “This is in one box and that is in the other.”? I feel that everything is interlinked.

Crispin Acton: We have given some thought to it within the UK. There is probably more that we should do, but I am less aware of what other member states are doing.

Q20 Lord Judd: While public and law enforcement organisations take drink-driving very seriously, do you think that we face a difficulty in this area because those responsible for law enforcement are still not taking domestic violence as seriously as they should be taking it, so that we do not really know the extent of the problem with which we are dealing?

Crispin Acton: I am not really qualified to answer that fully because I am not an expert on domestic violence. I have some awareness of the evidence of the role of alcohol in domestic
violence, but I cannot really answer your question adequately. I would have to take that question away and perhaps give you some written information.

**Lord Jay of Ewelme:** I shall follow up on an aspect of my original question. You said that you would favour further research being done on the impact of alcohol misuse on crime and so on. Would you favour that being part of a new strategy? How would you see a new strategy, if there is one, covering the issue of harm to people other than drinkers themselves?

**Crispin Acton:** In principle we would favour that being part of a new strategy. A new strategy could be really helpful to raise the priority of that issue. It relates to the later question about research funding from the EU. We think that a strategy could be helpful in that respect.

**Lord Tomlinson:** I get the impression that our public health authorities give very mixed messages about the consumption of alcohol and getting behind the wheel of a car. Do you think that we would benefit substantially not by changing prohibition levels—although I think that consumption levels could come down by comparison with other European countries—but by giving a simple message that the only safe level of drinking if you are going to drive is zero? If you have clear messages, people understand them and you also have a basis on which you can get better information.

**Lindsay Wilkinson:** That is hard to answer, because ultimately it is a matter of government policy. It is for them to decide whether that is what they want their key message to be.

**Lord Tomlinson:** You misunderstand me. I am not necessarily talking about changing the policy, I am talking about changing individuals’ behaviour. If the Government give them a clear message that the only safe level at which to be behind the wheel of a car is zero, people are being challenged to use their own responsibility.

**Lindsay Wilkinson:** I will be seeing Public Health England in a couple of days, and I will mention that to them.

**Crispin Acton:** My understanding is that the general message in drink-driving campaigns in this country is “Don’t drink and drive”, so there is quite a clear message.

**Lord Tomlinson:** Then it gets confused. If it is 30 or 40, or whatever it is, rather than 70, it might be okay, and we still give planning permission for massive car parks next to pubs.

**Lord Wasserman:** There are implementation issues there. If you said zero, there would be appeals the whole time. People would say that they had drunk alcohol for other purposes. It would be endless. You have to have some minimum. I agree with you that in terms of the campaign it is “Don’t drink and drive”.

**Baroness Benjamin:** Are we trying to people to stop drinking too much or are we trying to get people to drink safely? When you have a “Don’t drink and drive” campaign, people drink more because they are not driving. We have crossed messages here. What are we trying to achieve? Are we trying to achieve safe driving when you do not drink, or are we trying to get people off the drink anyway? People think, “I can have two drinks if I’m driving”, but they have eight drinks because they are not driving.

**Crispin Acton:** I am not sure if you are asking me.
Baroness Benjamin: I want to hear your views on this. I have clear views. I think that a lot of people drink too much, but we are giving them mixed messages saying that if you do not drive, you can drink more.

Crispin Acton: There are at least two questions there. One is about the aim of a drink-driving campaign, and you are also asking about our overall aim in government in terms of alcohol. The two are specific. There needs to be clear, simple message. In a drink-driving campaign, the message is “Don’t drink and drive”. If you are not driving or you are not in a car, the message is more related to health and is about reducing your consumption to lower risk levels and perhaps drinking less frequently. I think the public can understand the distinction between the messages.

Q21 Lord Judd: In the context of some of these recent exchanges, when you see the pressure on health services across the European Union, do you think we are beginning to do enough to give hard-headed public information about the cost to the health service, the burden on taxation and the rest that result from irresponsible behaviour in this area? My question is related to that. If one is going to form effective policy, it is terribly important that we have the best possible information, analysis and research. Is the European Union doing enough research on the social harm and consequences of alcohol misuse? Is it doing enough proportionately with the resources that are available compared with some of the research in which it is involved?

Sarah Godman: The EU’s health programme has supported 37 projects since 2004 on alcohol-related harm in support of the alcohol strategy. The existence of the strategy has helped to focus the funding that is channelled through that programme. There have been projects that supported all areas of the strategy. It is probably also worth noting that the research programme, which has larger funds apportioned to it, has also funded a number of research programmes that underpin the research that is necessary for a lot of the public health work that is funded through the EU’s public health programme. The 37 projects funded through the EU health programme came to about €15 million of EU support. There are four strong significantly relevant projects funded through the research programme, which amounted to another €15 million of support. Those four projects had strong involvement from the UK, particularly from higher education institutions.

The EU’s health programme is a smaller programme. In 2014-20, it has approximately €500 million allocated to it, whereas the health, demographic change and well-being programme of the research and innovation funds—the EU’s research programme—has approximately €7.5 billion available in the same funding period. In that programme, the fund of €7.5 billion, the Council has recommended an ongoing area focusing on effective health promotion, disease prevention, preparedness, screening and research that tries better to understand health, ageing and disease. There is definitely scope for projects on alcohol harm-related projects or on understanding the impact of alcohol on health, ageing and disease.

It should be said that for all those projects the EU has taken a very broad, challenge-driven approach. It no longer has specific or prescriptive topic areas. It basically waits for excellent proposals. It is a competitive funding line. It is driven by the kind of proposals that it receives. If there are excellent research projects on alcohol, they have every chance of success. This programme is demand driven. It is supposed to be grass-roots research on expert opinion.
Lord Sharkey: We are not talking about clinical research are we?

Sarah Godman: The health, demographic change and well-being programme can be clinical research, but it is a broader programme.

Lord Sharkey: So €7.5 billion is available for research, much of it social research.

Sarah Godman: There is a recurring theme that is about health promotion, disease prevention, preparedness, screening and the sustainability of health services.

Lord Judd: Thank you for that reply. Would you agree—yes or no—that there is sufficient determination and will in the Commission, the Council and the Parliament to drive the inherent significance and importance of work in this area to be tackled at the level it should be, or is there ambivalence in the political community where people still rather like to be seen as being associated with alcohol as a popular way of appealing to the public? Is there a political or cultural difficulty about mobilising the resources for the work that should be done?

Sarah Godman: Funds are available. Potentially, all those issues may play a part, but there are certainly funds available at European Union level for this kind of research.

The Chairman: The question is whether there are enough. Do you think more money should be made available?

Q22 Lord Wasserman: I do not think it is fair to ask an official whether she thinks it is enough, but I would like to ask her to name two or three of these 37 projects. You could have 137 if you divided them up into small enough chunks, so to say that there are 37 as opposed to two does not mean anything. Can you name three or four of these projects or two or three of them? What kind of projects are they? I think that is why there is some confusion. Are they clinical projects about the relationship between alcohol and cancer, or are they projects about how we stop drinking? What kinds of issues are these 37 projects on?

Sarah Godman: I have some examples of the 37 from the health programme that I am very happy to give you. Take Care looks at good practice and strategies on encouraging responsible drinking in adolescents across European member states. Two or three projects are focused on marketing and commercials, particularly online material and the impact that can have on young people. There was a project called Let it hAPYN, which focused on youth empowerment and evidence-based alcohol intervention programmes for adolescents. At the other end of the spectrum, there was a rather nicely named project called Vintage, which looked at best practice in the prevention of harmful use of alcohol in older age. There were a number of peer education programmes relating to traffic accidents, both for young drivers and, more specifically, looking at volunteers. There was a programme called Heroes.

The Chairman: Will you let us have a list of them rather than going through them? It would be very helpful if you could submit that.

Sarah Godman: I have a list, yes.

Lord Sharkey: You mentioned a project on marketing just now. Is that project complete? If it is, could we have sight of it?
Sarah Godman: Yes, I think so. There has been one specific report tendered, *Assessment of Young People’s Exposure to Alcohol Marketing in Audiovisual and Online Media*. I believe that that is available.

Lord Wasserman: Who did it?

Sarah Godman: RAND.

The Chairman: Perhaps you can supply us with the projects that you are doing, and we can have access to the ones you have completed. Mr Acton, did you want to come in?

Crispin Acton: I wanted to add one point about whether the research money is adequate. It can be observed that the share of research funding for alcohol is smaller than its share of harm to health. That is correct, but I think I would have to defend the European Union a bit, as it is not just an issue in the European Union. In the UK, alcohol issues have probably had less than their fair share of research funding in the past. It is really about the increasing consciousness of the evidence of the broad range of health and other harms from alcohol. That takes time to have an impact. There will be an increasing share of alcohol issues in research funding.

Lord Tomlinson: We have heard quite a bit this morning about indicators that show that we are not quite clear about where we are going and about the lack of hard facts. I wanted to just pick up on this €7.5 million before I come to my question.

Lord Sharkey: Billion.

Lord Tomlinson: Billion, yes, although what is that between friends? This seems to me to be encouraging national practice, as there is no apparent requirement for these to be multinational bids. Or is there?

Sarah Godman: There is. The research programme and the EU’s public health programme both require at least three EU member states.

Lord Tomlinson: So do we get a bit of information about three, which is not necessarily relevant to the other 20-odd?

Sarah Godman: Having said that, one of the biggest projects funded by the research funds in the last FP7 was ALICE RAP, which did research into addiction—broadly, not just alcohol—and lifestyles in contemporary Europe. Around €8 million was given to that project alone. It had 42 participants, twelve of whom were from the UK.

Q23 Lord Tomlinson: That leads me on to my question. Are EU policies, in your opinion, underpinned by a sound scientific base, including adequate data collection, and is there sufficient evidence regarding the effects? Maybe I will just ask the first part initially: is there a sound scientific base, including adequate data collection? If there is, can you tell me where to find it?

Crispin Acton: Leaving aside the research-funded projects and concentrating on data collection, we would endorse the findings of the evaluation report, which essentially says that not enough progress has been made on common data collection across EU member states. That is a handicap because it reduces the ability to have comparable data. There are some real problems. If we move in member states such as the UK to collecting data on a different basis so that it can become comparable, the question is then whether we lose our previous data, such that we no longer have trends, or we have to have two sets of data
collection running. There are some real issues. Other member states, such as the newer ones, may not have a very good infrastructure at all for data collection.

**Lord Tomlinson:** Let me link that to the two specifics that I was going to raise. Whether there is sufficient evidence regarding the effects of advertising and pricing respectively on levels of consumption are two matters of fundamental interest to us. How is all this research money contributing to an understanding of that in an EU strategy?

**Crispin Acton:** The short answer on the evidence relating to the effects of advertising on levels of consumption is that we have to distinguish between overall levels of consumption and the effects of advertising on children and young people.

**Lord Tomlinson:** Can you deal with each of them, because the strategy should be tackling both?

**Crispin Acton:** There is good evidence. We had a systematic review in the UK of the evidence on alcohol advertising, which found good evidence for an impact on adults’ alcohol consumption. The effect was quite a small one, but the evidence for it is quite solid. For the impacts on children and young people, we have accepted in our national alcohol strategy that there is good evidence of an impact on children and young people’s alcohol consumption from advertising; but there are some important evidence gaps, so we do not have a fully quantified impact. There is very little evidence on effective interventions to restrict advertising. Those are important gaps. Some European research projects have contributed to the knowledge here but there is really a lot more to do, and the EU could play an important role.

**Lord Tomlinson:** I have one last point. If we have identified important gaps—and there surely have been gaps in the effects of the last strategy—how is the new strategy going to bridge the gaps that we have identified and know about?

**Crispin Acton:** The simple answer would be by giving greater priority to that issue.

**Lord Tomlinson:** Do you see that in the strategy?

**Crispin Acton:** We see it as an important thing to be highlighted in the strategy, yes. We have argued for that. To answer the question on pricing and the evidence relating to the effects of pricing on alcohol consumption, the simple fact is that it is the most researched area of alcohol policy. The systematic review carried out by Sheffield University in 2008 found 2,000 high-quality international studies on the subject of alcohol taxation and pricing, so we do not see this as really the most underresearched area. There is a lot of very good-quality evidence. One qualification might be that evidence about minimum unit pricing is somewhat dependent on the general evidence on pricing, and there is probably a need for a bit more research in that area based on countries that are already doing minimum pricing.

**Q24 The Chairman:** There is strong disagreement on the validity of data coming from the public health sector on the part of the advertising industry and so on. The RAND report has been criticised. Last week, when we heard from public health officials, they said what you said: that there is no dearth of evidence, and it all points in one direction. Yet there is a lot of criticism from the advertising and alcohol industries.

**Crispin Acton:** We do not have sufficient evidence to be able to reconcile the gap or to be able to support one side or the other fully. But we have clearly acknowledged in government
in the UK that there is an impact on children and young people’s alcohol consumption. But there are gaps in the evidence as to quantification and effective intervention.

**Lord Sharkey:** Is this not an urgent gap, which we should fill with some of the €7.5 billion that appears to be available?

**Crispin Acton:** It is certainly an important gap.

**Lord Tomlinson:** It strikes me that this is symptomatic of many problems that we have with European-funded research and other European activities. Do you not think that the research would be much more directly relevant and lead to comparable data if, at the beginning of a new strategy or the introduction of a new policy, there was a process of zero-based budgeting, so that you could do the cash evaluation before you decide where you are going to allocate the new cash?

**Crispin Acton:** That sounds sensible to me. Part of the issue is that the European Commission controls the funding of EU research. I do not know whether Sarah wants to add more to that, but as member states of the Committee on National Alcohol Policy and Action, we do not directly influence the funding of particular research projects.

**Q25 Lord Faulkner of Worcester:** Given the Department of Health’s success with its tobacco control strategy, which you will recall effectively started in recent times with a ban on advertising and sponsorship, is there not an overwhelming case for a similar approach to be adopted with alcohol?

**Crispin Acton:** As I think I have already hinted, the evidence base on tobacco advertising and alcohol advertising is not the same. There has been less research on alcohol advertising internationally; there has been much more research on tobacco advertising. I would rest on the gaps in the evidence base. It could ultimately be shown that there are similarities, and the interventions might be similar, but we do not have enough evidence to know that at the moment.

**Q26 Lord Wasserman:** This is a bit of light relief I think. I want to ask a question of fact about how the EU works. Do EU policy measures strike the correct balance between the EU competence for a single market and local states’ interest in public health?

**Crispin Acton:** This relates to having more focus on a greater Health in All Policies approach and to the history of policy development in the EU. Things such as the directives on the structures of alcohol taxation were devised at the time when the single market was being created, and about 20 years before the first European alcohol strategy. Some of the rules in that directive are consistent with a public health approach but some are not. It needs some reappraisal in our view.

**Lord Wasserman:** Are we focusing on this? Are we doing something about it or trying to do something about it?

**Crispin Acton:** It is something that we are strongly arguing for. Of course, there is a degree of inertia in the system, because it requires unanimous agreement to change the rules.

**Lord Wasserman:** Could there be pressure from industry?

**Crispin Acton:** Yes. What we are arguing for in the structures directive, which is for wine taxation in particular to relate more closely to alcoholic strength, is something that the UK industry would support.
Susannah Simon: I want to make a generic comment. Clearly, the single market is something that we see as very positive for the UK economy. But it is possible to derogate from it for public health reasons and it is therefore possible to take some national measures to mitigate some of these issues. These are areas where the EU will not take the measures—I think we will come on to that shortly when we talk about minimum pricing policy—so it is possible for member states to take action in certain areas.

The other point that is worth making is on regulation. It is a matter of practice to evaluate the regulations and see if they are relevant to the modern situation, which is something that we encourage the European Union to do across the board. I am not sure whether we have done this for this one—maybe we could go away and find out—but we could certainly add it to the list of things that we ask the Commission to consider when it is going through its programme of looking at whether regulations are fit for purpose.

Q27 Lord Faulkner of Worcester: Following up Ms Simon’s helpful lead on minimum unit pricing, what do you think would happen to the principle of subsidiarity if Scotland were to lose its case on its attempt to introduce minimum pricing?

Susannah Simon: I would rather wait to see what happens with that case and the detail of any decision before making any comment on subsidiarity because unless you know the detail I do not think that you can come up with a sensible answer because we do not know what the result is going to be. I understand that the national position is that we are in favour of the Scottish position and we think that there is a strong legal argument.

Lord Tomlinson: On what grounds are we supporting Scotland? Are we supporting Scotland on the grounds of subsidiarity or on public health grounds?

Crispin Acton: In the European Court case, we have to argue on legal grounds. The essential issue is between Articles 34 and 36 of the Treaty on the Functioning of the European Union. Article 34 is about quantitative restrictions on intra EU trade, and the issue is whether a minimum unit price is equivalent to a quantitative restriction. That can be discussed. Even if it is a quantitative restriction, Article 36 permits public health measures that interfere with intra EU trade provided that they are proportionate and not discriminatory. The UK Government are supporting the Scottish Government in the view that the Scottish Parliament’s legislation is proportionate and not discriminatory.

Q28 Viscount Bridgeman: This is really a wrap-up question on the last three questions on the relationship between minimum unit pricing and taxation. It appears that the European Commission is very biased towards an increase in taxation, whereas the House of Commons Select Committee on Health recommended a double approach using both those tools. You referred to Council Directive 92/83 when you wanted taxation related to alcoholic strength.

Crispin Acton: Yes. The directive already allows taxation to relate closely to alcoholic strength for beer and spirits but not for wine and cider. You can argue that that is illogical. The rules are quite different for different products in the 92/83 directive. We are arguing that it should be possible for duty across the board to relate to alcohol strength. That is quite important in terms of price signals to the consumer and incentives for industry to moderate the alcoholic strength of drinks. It is an important issue.

You asked about the relationship between minimum unit pricing and taxation. Are you asking about the effects of the two?
Viscount Bridgeman: I am asking for your view on the relative effectiveness of the two.

Crispin Acton: The effects are different partly because of the EU rules. If you have a tax on beer, it has to apply in the same way to all beer. You cannot have a higher tax for cheaper beer, for example. That is not permitted by the European rules. That is different from tobacco where that is possible. So whether it is a high-quality, expensive product or a very cheap product, the duty rate is simply according to the alcoholic strength of the beer. A minimum unit price is a Government intervening to say that for a unit of alcohol there should be a sale at no less than a particular price per unit. The effect depends on the level at which a minimum unit price is set. In the proposal from Scotland and in the previous proposal for England and Wales, it was set at a level where the cheaper segment of the market would be captured, so you can see it as a way of preventing sales of alcohol below cost. It does that in a particular way. The impact of a minimum unit price is, according to research, targeted more at heavy drinkers because regular heavy drinkers in particular tend to buy cheaper alcohol because that is what they can afford and because they are price sensitive. The other difference is that taxation brings revenue to the Exchequer and if you introduce a minimum unit price, you might in the short term lose revenue to the Exchequer.

Susannah Simon: The retailer does not have to pass the tax on to the consumer. It could choose to absorb it and still offer a cheap price and therefore you will not achieve your aim. That affects larger retailers. They are the most able to absorb the tax. Therefore, if you really want to avoid cheap prices across the board, the minimum price policy is likely to have more of an impact.

Q29 Baroness Benjamin: Picking up on what you have just said, all shoppers, those who drink a lot and those who do not drink a lot, like a bargain. Supermarkets have offers such as “Buy six bottles of wine and get 25% off”. With all that in mind, what are the potential effects and consequences of measures such as minimum unit pricing and a ban on the below cost sale of alcohol on the illicit alcohol trade?

Crispin Acton: I can try to answer, but I have to admit that we do not have a complete handle on this. I should also say that this was one of the issues that the Government said we were concerned about when we responded to the consultation in July last year. In England and Wales, a minimum unit price is still under consideration. There are a number of issues that were of concern to the Government, one of which was the possible effect on illicit alcohol. Essentially, we need to do further work on that. There are some similarities with taxation. If you raise tax, there can be an effect on the illicit market, but a minimum unit price works in a different way. The enforcement of a minimum unit price is at the point of retail. The enforcement of taxation is at wholesale. Tax is levied at wholesale, not in the supermarket. There is a difference there, and essentially we need to do more thinking and more work on that.

Q30 Lord Wasserman: Last week, there was an awful lot of talk about the alcohol industry. We had three academic public health people. That was all about the bad old alcohol industry and how powerful and tough it was and how aggressive it was about the results of research into harm from alcohol. I want to ask a general question. What role do you think this powerful industry should play in the development and implementation of EU strategy? Does it want to be involved? There are those who say it should not have any role at all. What is the view of this panel on how much it should be involved and why? Policy that is
developed without considering the industry is often never implemented, so there are arguments on both sides.

**Lindsay Wilkinson**: Our view is that decisions on policy and regulation are ultimately the responsibility of member states and Government and they cannot be entwined in other considerations, but we believe that alcohol manufactures and retailers can make a significant contribution to reducing health harms, which is why we have pursued having a responsibility deal. Alcohol manufactures and retailers can reach their customers in a way that other people cannot. Only they can reformulate products to remove alcohol, and they have a significant contribution to make, but it will never be the be all and end all. The recent WHO Europe progress report suggests that the alcohol industry is involved in community and workplace action in 20 member states, so it is not just the UK. We have a long history of working with the alcohol industry, and we find that it does some things that we are not able to do through any other means.

**Q31 Lord Sharkey**: The FCTC excludes the tobacco industry from any contact where policy is being formulated. Would you do the same to the alcohol industry?

**Lindsay Wilkinson**: I think we touched on this slightly earlier when we talked about what things are similar and what things are different. We see tobacco as a very different product. I wish I could remember exactly what the phrase is, but it is something like “there is no safe use of it if you follow the manufacturer’s instructions”. All tobacco use is harmful. We do not argue that all alcohol use is harmful. Therefore, we reckon that there are different ways of approaching those two things. We think that the industry, whether manufacturers or retailers, can make significant strides in supporting reductions in health harms.

**Lord Sharkey**: The question was not about support. It was about policy formulation. Would you admit it to conversations about policy formulation?

**Lindsay Wilkinson**: Ultimately policy formulation is a matter for member states and Governments. There is no reason why the industry cannot say what it believes we should do, but that does not mean that it is part of the decision-making about what happens.

**Q32 Lord Jay of Ewelme**: Would you consult it before coming to a conclusion about what the policy should be?

**Lindsay Wilkinson**: I suppose it depends on what the policy is. We might consult it, or we might tell it. We might do none of the above. I do not think you can talk about policy as a single thing. The industry is a significant contributor to the economy, and we would want to know what people think about the impact on the industry if we were to do something. It would be foolish of us not to try to take that into account. It may or may not influence what we eventually decide to do.

**The Chairman**: Are you making any assessment of the responsibility deal?

**Lindsay Wilkinson**: Yes, we have done several different assessments of the key aspects of the alcohol network that we believe will have the biggest gains. We are looking at the billion unit pledge, and we have already had the first interim monitoring report on that. We have another one coming out shortly, I hope. In fact, we are going to make that national statistics to make it a more widely accepted set of figures. We have independent evaluations on the labelling pledge about bottles and cans showing the pregnancy logo or warning, the lower
drinking guidelines and the alcohol content of the bottle. We have done several reports, and they are all available on our website.

The Chairman: Could we have access to them?

Lindsay Wilkinson: They are readily available. I would be surprised if they were not already in your Library, but I am sure we can do something about that.

The Chairman: Are there any other questions? Thank you very much indeed. It would be very helpful if you could send us the list of the projects and some analysis of the money and what aspects of it are going on clinical research on alcohol. It would be very useful to have supplementary evidence on that. If any of you wish to add anything to what you have said or want to send us some further information, please do so. Thank you very much indeed.
1. This evidence responds on behalf of the UK Government to the questions in the call for evidence for the Sub-Committee’s inquiry. The evidence here is consistent with the Government’s policy set out in the Government’s Alcohol Strategy, published in March 2012, and in the ‘Review of the Balance of Competences between the United Kingdom and the European Union: Health’, published in July 2013, referred to hereafter as ‘the Balance of Competences report’.

Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

2. National health policies remain within the jurisdiction of Member States (Art. 168 of the Treaty on the Functioning of the European Union (TFEU)) but the Union has competence to carry out actions to support, coordinate or supplement Member State action in order to protect and improve human health (Art. 6 TFEU).

3. EU competence on alcohol policy, therefore, exists largely to complement the actions of Member States to reduce harmful alcohol use. The EU has exercised this competence to date mainly through the EU Alcohol Strategy. The Strategy is an example of how the EU can have a positive role without the burden of legislation. Consideration is currently being given to what should replace the strategy and whether a new strategy should be established.

4. The EU has major powers in other areas, such as the Single Market. The EU has an official “Health in All Policies” approach, enshrined in the EU Health Strategy and in official guidelines for impact assessments. The TFEU sets the protection of public health as an overarching Union objective (Art. 9) to be pursued across all policies and activities (Art 168). The current EU Alcohol Strategy stated an intention to mainstream the reduction of alcohol-related harm into other EU policies.

5. Some EU legislation impacts directly on the ways Member States may legislate, for example:
   - The Directive on the structures of alcohol taxation means that duty for some products may not be related closely to alcoholic strength
   - Definitions of alcoholic beverages may in some cases prevent or inhibit reduction of alcoholic content by producers
   - Labelling is an EU harmonised area, where Member States would need to make a strong case for requiring any additional health information

6. The EU is the region with the highest alcohol consumption in the world – double the world average at 12.5 litres pure alcohol per head in 2009. The societal costs of alcohol consumption in the EU for 2010 were estimated at €155.8 billion.¹

7. The diversity between Member States in levels and patterns of consumption, in harm and in policy approaches remains important, despite some longstanding trends towards
convergence. For example, the Nordic and Eastern European countries saw a rise in consumption in the last ten years, while Western and Southern Europe generally saw a fall.\textsuperscript{33} This diversity means that policy priorities are likely to differ.

8. The current Strategy has been an important step in the work to reduce harmful use of alcohol in the EU, encouraging the development of more coherent national strategies among a number of Member States.

9. The UK Government believes that there is unrealised potential. In particular, the intention to mainstream the reduction of alcohol-related harm into other EU policies has not been realised, so that the EU is not supporting Member States’ ability to develop effective alcohol policies as well as it might. The real added value of a new EU strategy would be on what might be termed ‘cross border issues’, that is, seeking to build health considerations more clearly into existing EU legislation and rules. The need for Member States to develop comprehensive national strategies, proportionate to national needs, can be inhibited in some instances.

10. The Government would see value in helping to promote greater coherence in EU legislation and policies so that they enable Member States to support health improvement better, for example, in the EU Directive on the structures of alcohol taxation so that it might allow duty on wine and other products to rise in line with alcoholic strength.

11. A new EU Strategy can also be helpful in offering evidence-based options for action in different fields below EU level. It will be up to national, regional or local authorities to use the most suitable approach to reduce alcohol related harm.

12. Some alcohol related problems are not easily solved at a national level and the EU needs to play a role. EU action could be further justified in some areas of cross-border issues, e.g. on energy labelling for alcohol, which the UK Government supports in principle.

13. Other developing policy areas such as EU subsidies to wine production could benefit in future from fuller inclusion of health impacts as an important consideration, in our view.

14. There may also be a case for some EU action in other areas where it is hard for Member States to act, e.g. on-line advertising of alcohol, where better evidence, research, and well informed debate is needed on a fast developing issue. The EU has already been helpful in funding research in this area.

\textit{Are the EU’s alcohol policies underpinned by a sound scientific base? Are the EU’s alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?}

\textsuperscript{33} Status Report on Alcohol and Health in 35 European Countries, 2013, WHO Regional Office for Europe
15. We answer these two questions together, as they are linked, in our view. The history of alcohol policy at EU level is relatively brief, with a first EU Alcohol Strategy published in 2006. The first WHO Global Alcohol Strategy was agreed by all Member States in 2010 and the WHO European Action Plan on alcohol 2012-2020 was agreed in 2011 by 53 European States including all EU Member States.

16. The WHO Global Alcohol Strategy offers explicitly evidence based policy options for Member States. These two WHO documents include ten evidence based priority themes for effective policies in tackling alcohol related harm.

17. We would envisage a new EU Alcohol Strategy providing clear support for Member States who wish to use the WHO Global Alcohol Strategy as a basis for their own policies, to whatever degree, without duplicating this.

18. We welcome joint work in recent years by the EU and WHO Regional Office for Europe on the evidence underpinning effective policies and interventions, summarised, for example, in ‘Alcohol in the European Union, Consumption, harm and policy approaches’, WHO Regional Office for Europe and European Union, 2012.

Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

19. Structures to implement and support the current Strategy include:

- The Committee for National Alcohol Policy and Action (CNAPA), established to ensure coordination of government-driven policies between Member States and the European Commission and to contribute to policy development\(^{34}\).
- The European Alcohol and Health Forum (Forum). The Forum consists of stakeholders, mainly industry, and health NGOs who make voluntary commitments to work to reduce alcohol related harm.

20. The external evaluation of the Strategy in 2012\(^{35}\) supported the relevance and usefulness of the comprehensive approach of the existing Strategy, as well as of its priority themes. It, nevertheless, saw a need to improve the ways in which both CNAPA and the Forum function, to ensure greater effectiveness. The evaluation recommended that:

- consideration be given to enhancing CNAPA’s work on cross-sector policy issues through greater interaction with other policy areas, including both Commission services and national governments
- CNAPA adopt a multi-annual work plan, reporting on its implementation through short annual reports.

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\(^{34}\) Committee on National Alcohol Policy and Action – Mandate, Rules of Procedure and Work Plan

\(^{35}\) Assessment of the added value of the EU strategy to support Member States in reducing alcohol-related harm, COWI consortium, 2012
21. The evaluation considered the effectiveness of the Forum and recommended that consideration be given to:
   - Refocussing the Forum on fewer well defined action areas, more clearly aligned with the priorities of the alcohol strategy
   - Work on outcome and impact indicators to allow better monitoring and evaluation of commitments

22. The UK Government would argue that lessons might be learned from our own Responsibility Deal Alcohol Network, in the ways that voluntary commitments are negotiated and agreed and then subject to independent monitoring.

23. We would also argue that an example of greater strategic focus would be consideration of industry taking voluntary actions at European level that could have significant impact on health, such as reducing alcoholic strength of drinks. The UK Responsibility Deal Alcohol Network offers a precedent in this area.

24. The evaluation also recommended stronger links between CNAPA and the Forum. We would support this and would wish to give positive consideration to the other recommendations from the evaluation.

Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?

25. We believe that EU funding for research and collaborative projects has been most helpful in helping to build the evidence base and improve health outcomes in Member States.

26. The EU’s Health Programme for 2003-2013 has co-funded a number of projects to the value of about €8 million, which has contributed to the implementation of the aims of the EU Alcohol Strategy.

27. The EU’s research and innovation programme also funds collaborative research on alcohol related issues, including linking alcohol to health determinants, outcomes and wellbeing. Significant examples from a public health perspective are:
   - AMPHORA project (€4 million pan European alcohol public health research alliance, involving 5 UK partners)
   - AAA Prevent (€2 million project on effective environmental strategies for the prevention of alcohol abuse among adolescents in Europe)
   - CHANCES (a €15 million project involving 2 UK partners aiming at combining and integrating on-going cohort studies for evidence on ageing-related health characteristics and determinants - such as lifestyle and alcohol consumption and their socio-economic implications)
   - ODHIN (Optimising delivery of health care interventions), a 4 year European project, to improve understanding of how to translate clinical research into delivery of interventions, focussed on identification and brief interventions for alcohol.
28. The Commission has launched a Joint Action on alcohol and health to run from 2014 to 2016. This will include work on common approaches to the development of alcohol guidelines for the public and health professionals. The UK supports this as an associated partner, contributing from our own review of alcohol guidelines now under way. We believe it should be a good example of collaboration, with benefits for the UK and others.

Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

29. EU legislation and policies allow a great deal of flexibility to Member States to set the levels of alcohol duty. While the EU has powers to set minimum rates of duty, in practice these are set at very low levels – and in the case of wine at a zero level. The use of these powers does not in practice affect UK policy, which sets relatively high rates of duty compared with most EU Member States.

30. As already discussed, the UK does have some specific concerns on the Directive on the structures of alcohol duty (92/83/EEC), which prevents us from relating duty closely to alcoholic strength for wine in particular. We would also wish to see an adjustment in the rules to allow greater incentives for lower strength beers, for example.

31. In our response in July 2013 to the consultation on a proposed minimum unit price of 45p for England and Wales, we made clear that we remain confident of the legal basis for the policy and we will continue to support the Scottish Government in the current legal case. We should point out that the Court of Justice of the European Union (CJEU) has as yet made no rulings on legal questions related to a minimum unit price for alcohol such as that included in the Scottish Parliament’s legislation.

32. We summarise our view by quoting from the Balance of Competences report:

‘The UK Government would have reservations if a new EU alcohol strategy were to impose regulatory action across all Member States, especially in areas such as availability of alcohol (licensing), which should be matters for Member States. On the other hand, we would not wish EU policies, or the emphasis on free trade within the EU, to imply a lowest common denominator approach to national alcohol policies. Where the needs of a population justify specific policies, including innovative policies like the alcohol minimum unit price legislation passed by the Scottish Parliament, we believe EU institutions should be flexible enough to accommodate these where a clear case is made.’

Article 34 of the TFEU prohibits all quantitative restrictions on imports (or measures having an equivalent effect). Article 34 has been used to challenge national measures on tobacco and alcohol control. Article 36 permits public health measures that impose quantitative restrictions (or the equivalent), provided these are proportionate and non-discriminatory. It is important that there is a sensible balance between these two
requirements and that Member States are not unreasonably prevented from bringing in proportionate public health measures.’

19 September 2014
Q228 The Chairman: Good morning, Minister, and good morning, Mr Acton. We are very grateful to you for your time this morning. We have been informed that you wish to be away by about 11.45 am. We will try our best, but obviously we need to cover quite a bit of ground. As you are aware, this is session is open to the public and a webcast of the session goes out live on a video transmission. The transcript will obviously be sent to you. If you wish to make any corrections, please do so, and if there is any additional evidence you want to send us, please let us have it.

I will start by way of a general question. What is the Government’s view on the key achievements of the EU’s alcohol strategy for 2006 to 2012 from a public health perspective?

Jane Ellison MP: The Commission, as I am sure your Committee is aware, published a full evaluation of the strategy in December 2012. That obviously predates my time in this role; I became the Public Health Minister in October 2013. The advice that I have had is that it is a good-quality report, and we thought it was valuable. It evaluated against five themes of the current strategy.
In terms of the influence that it has had, it is obviously an advisory document. As a lot of these things can do, it can influence the direction of travel of policy. We see that it has influenced in a positive way the direction of travel on drink driving by perhaps getting member states to look more closely at a more common approach to maximum blood alcohol levels. Inevitably when one is reporting against a strategy one looks to one’s own performance against things like enforcement, so in some ways the strategy’s most useful role is in getting member states to look at their own performance against the standards that they have set themselves, because they have to report against it. I do not know whether Crispin would like to add any detail.

**Crispin Acton**: Just to add briefly to what the Minister said, yes, the main value is in helping member states to view their own strategies and encouraging them to have more comprehensive national strategies and to compare themselves against each other and reinforce their own capacity for policymaking. Comparative evidence and data are really useful across Europe, and we use them quite a lot.

**The Chairman**: What would you say is the biggest impact on the UK itself? We talk about general achievements, but what has the impact been on the UK?

**Jane Ellison MP**: From my own perspective in the time I have been Public Health Minister, I have not seen a huge impact on us, but that is because I think we probably took alcohol policy and the enforcement of various aspects of alcohol policy pretty seriously. I do not know whether perhaps in countries for which it was less of a priority the EU strategy has helped to raise it up in their own national priorities. It is quite a significant priority for the UK anyway, so I am not aware of a huge impact, other than to say that we report against it. We as a country take these seriously; when we are part of something we ensure that we have fulfilled our commitments. We also feel that we bring something to the table with some of these aspects of European public health by offering ideas about other ways forward and other ways of working.

**Lord Tomlinson**: I just want to ask a supplementary. Minister, I understood you to say that there was a need to move towards the harmonisation of blood alcohol levels. Is that ball in your court rather than in the European Union’s court? We are the ones so far out of line.

**Jane Ellison MP**: I think what I actually said, though, was that the strategy was seen to have had some influence on reducing drink-driving levels through a more common approach on maximum blood alcohol levels. It was not so much a reflection on how it had impacted the UK; it was more that it had driven a greater move towards commonality.

**Q229 Lord Tomlinson**: Do the Government believe that there should continue to be an EU alcohol strategy? If they do so believe, what are the arguments both for and against building future EU action upon the priorities and structures of the previous strategy?

**Jane Ellison MP**: Yes, we do think that there is an argument for a new EU alcohol strategy, and I think we said in the written evidence that there is the potential for the EU to support member states more effectively in developing their own national alcohol strategies. I think we think that the current priorities still have some validity and can be built upon, but we think that the new strategy could make a bigger contribution towards supporting member states’ policies on the reduction of harm by looking at the need a health in all policies’ approach in existing EU legislation and rules. I think we have given some examples of that. I do want to make sure that any new strategy gives us the capacity to act on our own and the
capacity to go beyond, because inevitably when one is looking for common ground at an EU level there are always going to be member states that are perhaps not doing very much, but there will also be those that want to go further and take their own action, and I would not want any new strategy to restrict that. In fact, I would hope that it would also give us room to explore what we have not yet been able to explore to our satisfaction.

**Q230  Lord Faulkner of Worcester:** Where do you reckon the EU alcohol strategy has had influence on UK policy, and where has it added any value to what we would have done already?

**Jane Ellison MP:** I have not personally, in the year or so that I have been the Public Health Minister, seen that direct impact, but that is because throughout this Parliament we have been working to the Government’s own alcohol strategy. But I think that operates at the higher level of ambition of the EU strategy. As I said before, I think that with all these things it depends a little on where you sit as the country on the spectrum of the subject in question. If you have an underdeveloped strategy, sometimes this kind of macro-strategy can help you to move towards a better position. If you have a fairly well developed strategy, it perhaps makes you keen to maintain that. You obviously have to report against it, but you also have a useful role within the overall strategy of looking to pull people on and to push people a bit further. I think we feel, for example—I think the Committee might get to this in other questions—that the way we have worked with the drinks industry through the Responsibility Deal has been quite effective for agreeing ambitions and asking them to report against it. I think we feel that we have something to contribute to how that might shape future EU thinking in that area. We also have some other areas in which we would want flexibility, ideally to do more, but again you might touch on those in other questions.

**Lord Faulkner of Worcester:** Have you seen any signs that the EU strategy has followed our national strategy? Have they learnt anything from things that we have tried here?

**Crispin Acton:** It is difficult to point precisely and exactly to lots of specific influences, because these things tend to happen over the long term and we tend to learn from other member states’ policies as much as directly from the European Commission. In terms of specific influences, I would still say that our record on drink driving in the UK is regarded as one of the leaders, and that would have been an influence on the current EU alcohol strategy’s emphasis on drink driving.

**Lord Faulkner of Worcester:** But is there any sign that the European countries are planning to follow our lead on disqualification for a conviction? That is one of the great differences:
they have lower limits but they tend not to disqualify, whereas we have a higher limit but do disqualify. Are we moving in that direction?

**Crispin Acton**: I cannot answer that precisely. There is definitely an emphasis on understanding that enforcement is important and that it is not just a question of what the letter of the law says about blood alcohol concentrations. We tend to have stricter enforcement in the UK compared with a number of other EU countries. They may each take slightly different models such as random breath testing, which we do not do so much in the UK, but a general understanding of the importance of enforcement is gradually filtering through, yes.

**Q231 The Chairman**: What has been the impact of the WHO framework, if any?

**Jane Ellison MP**: Looking forward to a new strategy, we are quite keen for there to be a degree of alignment. I do not think it would be helpful for us to work in the context of having an EU alcohol strategy that was in tension with that. We definitely do not want to see the two strategies duplicating each other. Obviously the WHO will provide a framework of policies that are backed up by evidence. I think we would see the new EU strategy as addressing areas within its current rules and areas of competence while taking account of the WHO view. I think member states have previously agreed what effective policies can be, but I do think that needs to be quite carefully framed to make sure that we do not end up with a national strategy, an EU strategy and a WHO strategy.

**The Chairman**: Is there any evidence that EU policymakers are taking the UK experience into account?

**Jane Ellison MP**: I have not seen any direct evidence of that, but I am not sure whether we would be able to comment over a longer time than I can comment on personally.

**Crispin Acton**: These things are difficult to point to specifically sometimes, but I would point to the time when the Government’s alcohol strategy was published in March 2012. Shortly before that the WHO and the EU jointly published its evidence document about alcohol harms and effective policies. That related to the WHO strategy and it influenced our own national alcohol strategy, and an influence in terms of a framework of policy can be seen if you look at the two documents.

**Jane Ellison MP**: My general experience in the time I have been doing this job—I have obviously been to a couple of health council meetings and more specifically to a meeting that was just about Ebola, which is obviously in my portfolio—is that if you stare at it you do not see anything move, but over time you can see how that influence plays out, not least by just putting things on to the agenda.

It has certainly been quite an interesting experience operating in the EU context as a Minister, because it is not like going to the Commons or whatever where you make your case, people vote and there is a very immediate outcome. It is an entirely different experience, and it is very often about the bilateral discussions that you have in the margins of meetings, the discussion that you have with the Commissioner, the extent to which you can influence something even being on the agenda and being a subject for discussion. It is a much more gradual process, which is why you have to kind of stand back and look over a Parliament or over several Parliaments to see influence.
Perhaps one of the questions to ask is: are there subjects that people were not talking about that we would regard as important that they are now talking about more and addressing, even if not necessarily to the same degree? I think the answer to that question is probably yes, and to that extent I think one can measure influence. That is my observation of how things work from a relatively brief experience.

**Q232 Baroness Benjamin:** A question that I put to all our witnesses who have given us evidence is on our “don’t drink and drive” policy. The message that it sends out is, “If you are driving, do not drink, but if you are not driving, you can drink as much as possible”. What is your thinking behind that kind of policy and strategy?

**Jane Ellison MP:** That is definitely not our policy or our strategy.

**Baroness Benjamin:** That is the message when you hear it. People think, “Well, if I’m not driving, I can drink as much as I like”. Do you think there should be a stronger message behind the “don’t drink and drive” policy?

**Jane Ellison MP:** I just do not accept the premise of your question, I am afraid. I do not see any evidence that that is the message that we are sending out. Nearly everything that we publish that has any mention of drink always says, “Drink responsibly”, and has the Drinkaware details on it. Actually, we recently reported back through the Responsibility Deal Alcohol Network on the level of understanding of Drinkaware. Through the research that we did, we found quite a high level of awareness and that quite a large number of people had accessed the information through that. Separate to any drink-drive message, an awful lot of work is going on through Public Health England and the Responsibility Deal Alcohol Network. We have just hit a milestone in labelling alcohol bottles with their carrying the Chief Medical Officer’s warning. I am not saying for a moment that it is job done; we know that too many people drink to an unhealthy extent, but we have some very clear messages about that. As I say, some of them appear to be bearing fruit. If you look at the most recent figures for young people, for example—I am happy to write to the Committee; I cannot cite them off the top of my head—they show that over time the younger generation has been abusing both alcohol and drugs less. People’s relationship with alcohol is a mixed picture, but I am sure that that is not the message that we are intending to send or are accidentally sending. There are lots of separate issues and messaging going on around drinking responsibly. As I have said, the Drinkaware stats show that its information is quite regularly accessed and quite a high level of awareness.

**Q233 Lord Blencathra:** We have heard some witnesses caution that, as well as supporting member states, EU action can also act as a barrier to effective national alcohol policy. The example they cite is of the Scots having gone for minimum unit pricing because an EU directive, bizarrely, prevents alcohol being taxed at its alcoholic strength—I presume that protects the French brandy producers. The other example that they give is that minimum unit pricing is argued to be a barrier to free trade. Do you agree that some EU action can prevent us adopting a practical national strategy?

**Jane Ellison MP:** I think there are some areas of frustration, which is why I said in my earlier answer that we need to retain the flexibility—I have seen it in other areas of my portfolio—to be able to go further. One of my particular interests would be in trying to use market forces more to drive a low-alcohol market. Some of that would be flexibility in taxation—that is in the Government’s alcohol strategy—particularly duty levels on wine. I have a lot of
discussions through the Government’s Responsibility Deal with manufacturers and supermarkets, which have invested a lot of time and effort into lower-alcohol products. Over time, we have seen the level of alcohol in wine creep up and up, so that the usual level is higher than it was 30 years ago. Nobody noticed that happening; it was not people deciding to drink more. I would love to see us being able to use markets more, with flexibility—a bit like we have done with beer duty—to create more of a demand for those lower-alcohol products. I am told by industry that there is ready potential for quite a big shopping revolution in people’s wine buying if we just had that ability. Some of these products are out there, but I think it would be very helpful to have that flexibility.

Lord Blencathra: Since you agree, what are you going to argue in Brussels to get that flexibility to be able to do it? What aspects of EU policy are you going to fight?

Jane Ellison MP: That is a specific example that I have just mentioned. It is one on which I have certainly had detailed discussions with UKREP, our permanent representatives, about. I have said that it is one of my personal priorities. This is not going to happen overnight, because there are very entrenched reasons why it is as it is, but I have said that it is one of my priorities and it is something that I have written to the Treasury about and spoken in debates about. I want to make sure that it is firmly on the agenda as one of the UK’s asks.

Lord Blencathra: To be added to Mr Cameron’s red-line list?

Jane Ellison MP: That is for the Prime Minister. His list is his list. As I say, it is in the Government’s alcohol strategy that we would like to have that greater flexibility and it is something that I have tried to give a bit more profile to. It is certainly something that I have spoken to UKREP about, being one of the things on which I would like us to begin the conversation again. I know that the conversation has been had before and it is not an easy ask, but we want to be able to have it. You have pointed to some other examples, such as our supporting Scotland on where it is going with its policy. I would want it to have that flexibility to do that. I do not know whether Crispin wants to add detail to that.

Crispin Acton: The Minister has talked about the tax structures rules. There are some other EU rules that inhibit national policies, particularly things that the UK Government are interested in, such as the definitions of alcoholic beverages—you cannot market wine if it is below 8.5% ABV, with a limited exception—and issues around labelling, which is an EU-harmonised area. It is very difficult for us, for example, to require calories to be indicated on alcohol labels. The EU is doing some work on that at the moment.

Lord Tomlinson: Can you repeat what you said about calories on labelling?

The Chairman: Could you all speak up a bit?

Crispin Acton: Yes, I am. Labelling legislation is regarded as an EU-harmonised area. If national Governments wanted mandatory calorie labelling, for example, which we have previously said we are interested in, we would have to ask for the EU’s permission. It is another area that we are interested in.

Jane Ellison MP: That was very much in the news recently, as Committee Members will know, when the Royal Society for Public Health did a survey and received a huge amount of public interest in the issue of calorie labelling. Labelling comes up all the time. One of the reasons why we have pursued a voluntary approach on labelling so vigorously through the Responsibility Deal is that we are very aware of the time that it would take, even if we were successful in getting that flexibility, to get that through. We have been able to report some
really important steps forward with the voluntary approach. Sometimes, on labelling in particular, I struggle to get colleagues in the Commons to understand that there is this EU competence. We have had several Private Member’s Bills and 10-minute rule Bills, and I think there is another in the pipeline, calling for the Government to do this, that and the other with labelling. It is a slightly tricky area, but, as I say, we have been able to make some significant and pretty swift strides through voluntary action, but it is one the cases that I cite when I argue that robust voluntary action can sometimes get you further faster than taking a legislative route.

**Q234 Lord Judd:** In the work on any possible new strategy, do the Government favour a whole-population approach, or do they favour a focus on targeting alcohol-related harm, or perhaps do they think about a combination of both?

**Jane Ellison MP:** I think, pragmatically, it tends to be a combination of both. It is clearly up to member states how far each one’s strategy adopts the population or individual approach, but I think that in practice most people will use a blend of the two. In the UK, in our own alcohol strategy, we have adopted a mix of some population and some individual approaches, and I think that is true of the Scottish Government as well. We were quite clear in the strategy document, which is something I speak in Parliament about and report against in discussions about where we are with alcohol, that there were some things on which it made sense to take a kind of environmental approach, such as making sure that we did not have an unhealthy environment that promoted harmful drinking—to go back to Lady Benjamin’s point. Government can regulate where appropriate. We have rebalanced the licensing system in England and Wales since 2010, we have relatively high alcohol taxes, but we also feel as a Government that the individual and industry have real responsibilities and are not powerless to act. Of course, as a Health Minister I would say that the health service has a vital role. I really do not think that you can say that it is an either/or. In reality, to be effective, you would need a combination thereof.

Quite an interesting report came out recently. It was on a different topic, but it shared some of the methodology. You may have seen a McKinsey institute report on obesity that came out. It was a very big piece of research work and it more or less confirmed this idea that there are no silver bullets. It looked at that combination of population-level action plus individual actions—they split things between conscious and unconscious. They basically said that across the world where they had measured the most effective action—in that case, it was on obesity, but there is definitely a read-across to other areas of public health policy—it was almost certainly where several policies all came together and were tiered on top of each other. There was no one thing in and of itself that worked. That was quite helpful, but it is in the way of campaigning and the way of political debate that people often like to present their own approach as the silver bullet. I think in reality that it is always a bit more complicated than that.

**Lord Judd:** Would you agree that we have a cultural issue in the whole approach of people towards alcohol and that we also have a great need for social education, as on smoking, about what the implications are?

**Jane Ellison MP:** We certainly need to take action. We need to be conscious as a nation, but also at individual, government and industry level, of what harmful drinking is and what the consequences are. In the same way that we have seen—although smoking levels are at their lowest—an extremely wide understanding of the impact of smoking on health, we need to
get to a much better understanding, inasmuch as everyone has a basic understanding, of the impact of drinking on health and long-term outcomes. I have been speaking to a lot of the big health charities recently about the extent to which prevention, education and understanding consequences of things other than just tobacco can be put more front and centre so that people realise that there is a consequence for their health. I just do not think it is as well understood. We are beginning to get there. There are signs of encouragement among younger people, looking at the change during the past 20 years on smoking, drinking and, in fact, drug-taking. I think there are some signs of encouragement, but we have a way to go.

Q235 Lord Wasserman: We talk about a whole-population approach as opposed to focusing on particular harms, but I find that I get a bit confused about this. What are we really concerned about? Are we concerned about the total level of consumption or about irresponsible drinking, binge drinking or drink-driving? Some of our witnesses have said, “Let’s just focus on total consumption. Bring it down and everything will be fine”. Others say, “No, there is nothing wrong with drinking even if consumption went up, provided that people did it responsibly and there was less binge drinking”. I think there are two different objectives and that you have to be very clear about each one; it is not just a bit of one and a bit of the other. The policies will be different depending on what the main objective is: total national consumption or focusing only on things that are really harmful and that make problems for people, in terms of health, violence or crime and all the rest. What is the Government’s view?

Jane Ellison MP: One of the challenges in taking an either/or approach—and this is what I find in my discussions with some people within the alcohol industry—is that, first, I do not think that anyone thinks of themselves as a binge drinker. It is always the sense of how much people are drinking themselves. There is quite a lot of evidence to suggest that that is widely underestimated. There is always a danger when one is talking about harmful drinkers and binge drinkers. I had a conversation recently with someone within the industry who had the potential to be quite influential in a particular area of policy and I was quite interested to discover that there was a complete misunderstanding between us as to who we were talking about. His view was that we were talking about harmful drinkers when we referred to harmful drinkers, whereas we were talking about people who were just drinking more than is good for their health as defined by medical guidelines. That is one of the slight problems: if you talk about trying to deal with harmful drinkers, most people would think that you were talking about someone else. It is just as important for people who might over the period of their middle years, for example, not realise that they have crept up to drinking every day and regularly exceed the suggested limits. We want to talk to that person, too, and that is why you have to talk in terms of population measures and those more general terms, because otherwise there is a danger that people just think, “They’re not talking about me”. The manufacturer to whom I referred thought that we talking about an entirely different group of people. He was talking about a very narrow group of people and we talking about a much broader one, but terms had become mixed.

Lord Jay of Ewelme: How do you raise the social consciousness about that kind of issue, and do you think there is a role for the EU to play in that in its alcohol strategy?
Jane Ellison MP: I do not have a clear view about whether the EU has a role at this stage, other than in the things that we have already talked about: setting the terms of the debate and setting the ambition. Again, I might ask Crispin to answer that.

In terms of getting the message across and talking about it, I think we are in a better place as a nation. I think we are having that discussion more and more, and as I say I am very happy to write to the Committee with the research data that we got from some of the Drinkaware statistics recently. I was quite encouraged by the extent to which people had said that they had seen something or had accessed that information, or whatever. As I say, the statistics on much younger people give us room for cautious optimism.

I think it is an ongoing challenge and an area where the Government give considerable challenge to industry through the Responsibility Deal. We have seen some good moves, but as a Conservative I would say that it is also about individual responsibility and people taking responsibility for their own health as well, as long as we can get the message out there. This is partly why I have begun to talk in recent times to some of the big cancer charities, for example, because I think that people are very well aware of links between tobacco and some forms of cancer but there is a much lower level of awareness of the links between excessive alcohol consumption and diseases such as cancer. Were that better understood that might help us to get that message out more widely. Perhaps Crispin would like to come in.

Crispin Acton: I would just add one specific point about where the European Union might be able to help—or is helping, potentially—and draw attention to the European Union’s joint action on alcohol and health, an important part of which is looking at more common approaches to developing lower-risk guidelines for alcohol consumption. This links to our own review. We had a UK-wide review on alcohol guidelines that is overseen by our Chief Medical Officer. Clearly we will learn from what other countries are doing, but that is a specific area where the EU is doing useful work.

Baroness Benjamin: The media, I think, can play a role. I am not sure if you ever work with media, because if you have you will know that soap operas, for instance, always have storylines about alcoholics. Interestingly, there was a comedy show last Friday called, I think, “Going Out”, about an alcoholic’s father. In fact, it turned out that it was the children who were drinking too much, but they did not see it as, “You are talking about me”. They were drinking a bottle of wine between them every evening, but they did not see themselves as alcoholics. Do you feel that getting storylines through the media, not just about alcoholism but saying, “Yes, it is you we talking about”, is important?

Jane Ellison MP: There is clearly always a role for the media in that, but there is always a delicate balance to be struck; nobody wants to feel that their entertainment industry is an outlet for government policy, and I am not sure how many people would tune in if they thought that everything had a public health thread running through it, although it can clearly have an influence. I know, for example, that Public Health England—again in a slightly different sphere—is working with Disney on the physical activity agenda for children. That has proved extremely effective for integrating that. So there are definite roles for media partners. I am not aware that we have been asked by anyone to influence a storyline about alcohol, but a lot of producers, particularly of long-running soap operas, are very conscious of the role they play and often work with charities or are sometimes sparked by a personal story. I responded to a debate on pancreatic cancer in September that had been inspired by the “Coronation Street” storyline about a character, Hayley Cropper, who died of pancreatic cancer.
cancer. The actress who played her was in the gallery. You can see a very clear influence there. I cannot give you an example from the alcohol area, but there are clearly examples in relation to FGM. The “Casualty” episode that went out a couple of years ago was co-written with a group of campaigners in Bristol, and the scriptwriter worked with them and captured the personal story of a couple of the girls. So it can be very influential, although I cannot give you an example relating to alcohol. It would not be something that I would proactively approach, as that does not feel like the right way, but if someone said, “We’d like to do this. Can you point us in the direction of people who can offer expertise and support to make sure that we have got the facts right?”, we would be more than happy to assist in that regard. Is that a fair position, Crispin? I do not think that we would proactively seek those opportunities.

**Crispin Acton**: Not usually. We are approached sometimes by programme makers. I would add that Public Health England leads on social marketing on alcohol, so you might want to ask them about this as well.

**Lord Faulkner of Worcester**: I have a quick question. Are you concerned about the exposure of young people to the advertising and sponsorship of alcohol in things like television sports coverage, and the fact that a number of sports competitions are sponsored by alcohol companies and there are still a lot of drink commercials on television?

**Jane Ellison MP**: We have agreed some kind of framework for responsible advertising in action. Some work was done there, and again we can write to the Committee with more details. We clearly do not want children to be influenced in the wrong way, but it is really important to make a distinction between alcohol and tobacco inasmuch as alcohol can be consumed responsibly at a level that is not harmful to health. That is the major distinction with tobacco, because there is no safe amount of tobacco. Tobacco strikes me as a product that, if we invented it now—now we know how many people die as a result of tobacco consumption—we would probably take quite a different view of things. We are where we are on that, but I do think it is quite important from a public health point of view not to merge all the things that can have a harmful effect and view them all in the same way. There is still quite an important distinction to be made, because there is a responsible and not unhealthy level of alcohol that you can consume. Clearly, it needs to be done in the right way. The national debate sparked when well known sports figures make comments about drink or whatever shows that we are still very conscious of the aspect of being a role model that comes with high-level sport. Perhaps we could write to the Committee with details of the most recent action that was taken by the Portman Group.

**The Chairman**: In view of the exchanges so far, it seems to me that there is confusion about whether the approach is a whole-population approach or whether it targets alcohol-related harm. Is that causing tension between the industry and the public health officials, because in some of the evidence that we have taken there has been a real tension here? I think the confusion has almost led to a constraint on the policy becoming effective, and the message that we are getting is that it would be very helpful to get some clarity about what the objectives of the next strategy are going to be. Or will it be a combination of both?

**Jane Ellison MP**: I think we are clear, Madam Chairman, that it is a combination of both.

**The Chairman**: There does not seem to me to be clarity at the EU level and with all the actors who are involved, so the contribution that I am urging you to make is about clarity.
**Q236 Earl of Stair:** Do the Government intend to commission some research into the effects of advertising on the young, or the likely consequences of minimum unit pricing? Many of the people we have taken evidence from before have agreed that there needs to be a standard policy on whatever is done with a new review. The one weakness has been the fifth priority of the EU alcohol strategy: establishing a common evidence base. I think that is a point that you, Mr Acton, raised when you gave evidence just before. How can such evidence be peer-reviewed to make it trusted by all the stakeholders who are involved in the review?

**Jane Ellison MP:** It is a difficult area. I do not think that we see it as primary aim to obtain universal consensus on evidence, because I think we fear that we would never act if that was the bar that was set. It is almost inevitable that there will be disagreements about evidence, and even if we have really good evidence, such as on the relationship between high levels of alcohol consumption and increased health risks or the relationship between price and consumption, it might not be accepted by some. So I think it is always the case that even when one group says, “We are absolutely convinced that this is solid evidence”, there will be others who will dispute it. I worry sometimes that saying that we must all agree the evidence base can sometimes be an obfuscating factor if somebody wants you never to reach a conclusion. We must not trap ourselves in the view that until we can all agree the evidence base we cannot move forward, because that means that all you can do is constantly dispute the evidence base as a reason for never advancing your policies. As I say, in other parts of my portfolio I see that being quite actively pursued as a policy.

Obviously, government’s role is to use and, where appropriate, commission the best quality and the most objective evidence, and to seek independent advice to help us to do that—and to be seen to seek independent advice, given that the evidence base on which you make government policy is often challenged, particularly if there are people with a particular interest in it, whether commercial or whatever. We need to do that, and we do that in England through the National Institute for Health and Care Excellence and Public Health England. I have worked closely with Public Health England over the last year on agreeing some of the priority areas where it is evidence-gathering on our behalf with a view to advising us going forward.

**Earl of Stair:** Do you think you would get more consensus on the evidence if you were to break it down into different sectors—the young bit; drink driving, which we talked about earlier; and various other different sectors—and approached it from that point of view with the industry and various interested parties?

**Jane Ellison MP:** That is an interesting idea. In any areas of my portfolio there are definitely population groups, usually the young in particular, for whom it is easier to get consensus on the evidence. That goes to back to my point about the fact that if people do not really agree with your policy, disputing the evidence base for it is a pretty effective way of trying stop you making policy in that area, which is why we tend to make more progress on young people and protecting their health—because people are far less motivated to question the evidence base. I do not know whether Crispin wants to comment in any more detail about the idea of taking things more in units of policy.

**Crispin Acton:** Yes. As the Minister says, there is some potential there. I would just comment that we need to distinguish between areas of policy that are under-researched and those where there is lots of evidence. In the evidence session before, we commented that there is
a lot of evidence on alcohol, taxation and price. There are a lot of areas of alcohol policy that are under-researched, including harms to young people. Although having a lot of evidence does not guarantee consensus, if you have very little evidence there is still less chance of consensus.

Earl of Stair: It makes it easier to boil it down and to focus on the areas that need to be given more attention.

Jane Ellison MP: Some of the evidence is hard to gather, such as evidence on fetal alcohol syndrome. We know that the WHO is now looking at commissioning a prevalence study. That is a really difficult area, and I have done a couple of debates about it. We are getting quite a lot of questions about it, and there is considerable parliamentary interest, but it is a very difficult area of policymaking because the evidence base, even at a worldwide level, is poorly established at the moment.

Q237  Lord Blencathra: Minister, I think that nearly every witness we have had, whether from the industry, independent, or from a health association, has criticised the level of EU research. Some have implied that it is a bit dodgy: the same people researching the same old stuff, which is no use to anyone. But no one is asking why. Why have children stopped drinking so much? Why are alcopops coming down? My question is based on what you have both said to the Committee in the last few minutes about national research needing to target some of these things. Will you make representations in Brussels to try to focus EU research collectively on the same lacunae and get them to research what we really need to discover in Europe about the changing patterns of drinking?

Jane Ellison MP: We would be keen to see the EU focus on areas that have been under-researched and where the research would be the most helpful. That is certainly something that we would expect to make representations about. Crispin might be able to say whether over the course of this Parliament we have made those representations.

Crispin Acton: Yes, I would say so. I would not be as negative as in some of the comments that have been made about EU-funded research on alcohol. There are big evidence gaps still to be filled. Some of the research that has been funded so far, such as on alcohol harms in the workplace, has been useful and is probably influencing work that we are doing in the UK through the Responsibility Deal on workplace and alcohol.

Q238  Lord Tomlinson: Most of the evidence that we were given, both here and in Brussels, suggested that of the fairly large—not massive—sum that the Commission spends on public health research, it was nearly all demand led. There was no process for identifying where the gaps in our knowledge were, and for forcing the focus of research to be on filling them. It was nearly always demand led. Very good research may have been done, but it frequently replicated knowledge that already existed and did not plug the gaps.

Crispin Acton: I would just comment that there is meant to be a process whereby member states influence the priorities for public health research, which is EU funded. It is quite complex, but perhaps it would be useful if we wrote to the Committee about that.

Jane Ellison MP: That sounds like a very fair point.

Lord Tomlinson: It seemed to me that the research programme was dictated much more by universities and academic groups who were bidding for research money rather than by a need to fill gaps in the corpus of knowledge.
Jane Ellison MP: I have a comment about research generally. It is an interesting point: if people are essentially bidding for funding for research more generally, sometimes they are drawn to areas where they know that there is a lot of very good primary evidence and that they will be able to produce something in a short time. But with things like a long-term study on fetal alcohol syndrome, for example, where people would have to accept that they may only produce results over 20 years and it would be much more difficult to gather the primary evidence, I suspect that is less attractive sometimes. I think it is a slight structural challenge very often with the way in which we do the research and incentivise people to do that, whereas it is often from such long-term studies that we learn very profound things. The funding structure is sometimes challenging.

Q239 Lord Judd: I am interested that your own ministerial responsibilities, as I understand it, cover tobacco, drugs, alcohol, diet, obesity and physical activity. There is surely a great interrelationship between all those. Would you agree that when we are addressing the sectoral issues, as we have been doing in our questions today, it is important also to reflect on the general style of life and what is the good life and what is not that is being portrayed in our media?

Jane Ellison MP: I do think that we are learning more and more that working in silos does not get the best results in lots of areas of policy, and we are more successful where we try to look at individuals or whole families or whole communities and understand what is really going on that might be causing people to do less well than they could do. There is certainly more work that we could do in the round on getting people to have a better understanding of what a healthy lifestyle is, how to manage their own health and how to be more aware of it, rather than just having messages about drinking, alcohol and physical activity. I have in mind something like the NHS Health Check programme, where people are invited when they hit a certain age to come in for a general lifestyle review. It is relatively early days for that programme, but the ability to sit down and look at one’s health and lifestyle in the round and get advice about areas that might need adjustment or challenge is generally the better way to go at an individual level, because there is, exactly as you say, a huge interrelationship between all those things.

Going back to an example from earlier in our evidence session, we talked about calorie labelling on drinks. I have been in discussions where we have been preparing for debates and talking about this issue of calories in drinks. Everyone goes, “That’s obvious. Let people know the calories in drinks and then they will all know to avoid it”. Then someone else says, “Actually, we’ve got evidence that there are some younger people who might think, ‘Well, I don’t want to get fat, but I want to carry on drinking, so I will just have drink and I will replace food calories with drink calories’”. Suddenly you think, “Ah, it’s not that simple”. There are lots of areas where our different areas of policy interact so much that you really have to try to take a whole-person approach and just get people to understand what the balance is.

Q240 Lord Sharkey: I wanted to ask about the EU Alcohol and Health Forum and the CNAPA. Do you think that these two bodies should remain in place in a future strategy? Or should they be replaced or supported by new or different structures?

Jane Ellison MP: As public health is a member state responsibility, there is a primary role for CNAPA as the body that links the member states and the Commission, but we see a need to
enhance that role. It should be made clearer that its members need to represent their Governments as a whole and the Commission should enable it to work across all the relevant Commission services, including those concerned with tax or agriculture. We gave an example earlier in our evidence of why the tax area is particularly relevant. That is consistent with the official evaluation of the EU alcohol strategy.

**Lord Sharkey:** When you say that they should represent their Governments as a whole, what do you mean? Are they not currently doing that?

**Jane Ellison MP:** It goes back to my point that lots of other factors can influence health policy alone, so it is important that people come with a general view from their Government, not just a narrow view from one part of it, when, somewhere else, another part of government is being represented differently. We need to understand what the view is of that member state.

**Lord Sharkey:** When it comes to the alcohol and health forum, some witnesses have said that one problem with the body is precisely that the alcohol producers have a large influence there. Do you think that is a problem?

**Jane Ellison MP:** I think we believe that the model might be done better. I think we feel that it would useful for that forum to look at and perhaps follow the way in which we have constructed the Responsibility Deal. We do not negotiate the policy objectives through the Responsibility Deal; we agree what we think are the objectives that meet public health policy and then we have a series of pledges to which industry signs up and against which it is then judged. That is a different and perhaps more appropriate model for engagement with industry at a policy level. Crispin has seen it in action over a longer time, but I think that he feels similarly.

**Crispin Acton:** I obviously agree with those points. We think that the links between member states and the alcohol and health forum could be a lot better. For most of its existence, there has been almost semi-exclusion of the member state role. Although we have been notified of forum meetings, sometimes we do not get the papers, so we cannot decide how important it is to attend. There is no formal process for seeking member states’ opinions on forum commitments, so that is another area that could be improved.

**Jane Ellison MP:** There are also some areas where it would be good to see the forum looking at things that appear to be effective in member states and seeing whether they can be writ large. An example that we would take is the reduction of the alcoholic strength of drinks. We have got the billion unit pledge, which industry has signed up to, to take a billion units out of the nation’s alcohol intake by 2015. The evidence suggests that we are on course to do that. That is being achieved through a reduction in the alcoholic strength of drinks. That would be a considerable public health gain if it was writ large across the EU and you could get industry across the piece to sign up to it. That is a very considerable health gain for relatively low impact. It can be done; it is being done here. If it could be done on a wider scale, there is no downside to that that I can see.

**The Chairman:** Lord Jay.

**Lord Jay of Ewelme:** You have really covered the question that I was going to ask so, as time is short, we should perhaps move on.
Q241 Baroness Benjamin: The problems that are associated with alcohol abuse are quite different across the country, from region to region, as we know. They are even more diverse across European member states, with the high level of cultural differences. From the evidence that we have heard from past witnesses, it is believed that the underlying model of co-operation that has been built up between public health and industry in this country should be shared with other member states. What lessons do you believe can be learnt from the UK Responsibility Deal Alcohol Network, particularly regarding the monitoring and enforcement of voluntary commitments?

Jane Ellison MP: It is obviously a little early to draw firm conclusions inasmuch as we have committed to external monitoring of success against Responsibility Deal objectives and that process is ongoing, but in the time that I have been a Minister I have been encouraged by what I have seen. There are some areas where there is still a long way to go, but there are some areas where co-operation has been important and we have seen some real results from the deal. I have already mentioned one of the areas, where more than 30 alcohol retailers and producers pledged to remove 1 billion units of alcohol from the market—that is around 2% of the market—by the end of 2015. I also mentioned that we have the first interim monitoring report of progress against that, which showed that in the first year of that four-year pledge there was a reduction of 253 million units of alcohol. That is quarter of the pledge that industry committed to achieve. We talked earlier in the session about labelling and, again, I can give you some encouraging results there. Ninety-two companies committed to having 80% of bottles and cans displaying unit and health information and a pregnancy warning on their labels by the end of 2013. Again, we had an independent report on it, which was published in November this year, which showed that just under 80% of bottles and cans of alcohol on our shelves now have the correct unit and health information—that is, the CMO’s lower-risk drinking guidelines—and a warning about drinking while pregnant on the labels. That has been delivered more quickly than if we had done it by notifying national legislation to the EU. So there are some areas where we have been able to make some quite swift progress. There is some evidence that we are very happy to share. It is all in the public domain and we would certainly encourage others to look at it. Equally, we would be open to seeing where other people have had successes that we can learn from.

Crispin Acton: I would just add that the monitoring that the Minister has been talking about in relation to the delivery of the billion units pledge and the labelling pledge is happening across whole industry sectors in the UK, so it is really quite a big piece of work and is not being replicated at EU level currently.

Jane Ellison MP: We are also seeing some intense action with the local alcohol action areas. The ongoing dialogue with industry has its critics and no one will pretend that there are not areas in which one might want to make more progress. Nevertheless, through that dialogue we are also seeing the opportunity for people to support some of that local work and to become more ambitious for where we might go next. I have been encouraged by it and I think there is an argument for seeing whether, in particular in the areas that appear to be making the most progress, there is room for wider action.

Lord Blencathra: Are you saying that if the industry voluntarily puts calorie or other health information, such as number of units, on a label, it does not fall foul of EU single market or labelling rules?
Crispin Acton: Yes, I am saying that it does not fall foul of those rules. It is something that we have discussed with the European Commission, which accepts that it does not fall foul of those rules, because it is voluntary.

Q242 Lord Wasserman: When we have a strategy, we have to have some objectives and we have to be able to measure them. We talk about an awful lot of European strategies in this Committee, but every time we talk about them we find that they are never measured, so that at the end of the day we do not know whether anything has happened. No one has ever bothered to write objectives, targets and numbers into these strategies, so I hope that we will have some. I would like to know whether you have any views about the kind of objectives and performance measures we should have. You mentioned, Minister, cutting down the number of units of alcohol as a great success, saying that we have managed a billion, or some large number, and talked about labelling, saying that a large percentage of bottles have labels on them. But those are really not outputs; they are inputs. That is not saying that anything good or bad has happened, but what is the purpose of having labelled bottles, even if 100% of bottles are labelled, if liver cancer or liver disease has soared? What if the number of deaths from alcohol consumption had gone up even though every single bottle was labelled—the whole thing was covered by a label with an enormous message from the Chief Medical Officer? Similarly, we may have had great success by cutting down by 10 billion, but death rates are up again. What are we going to measure? Are we going to measure these intermediate outputs, which are much easier to measure, I agree, or are we going to set ourselves an objective in the alcohol strategy of reducing deaths, disease or violent crime? I am concerned with the policing, so I am concerned about the so-called night-time economy, with people coming out and beating each other up. So where are we going? Are we going to go for intermediate outputs about consumption, or are we going to go for the big-picture items—deaths, harm, violence and so on?

Jane Ellison MP: I think they are related. For example, you are right to say that labelling is not an end in itself, but it feeds into the view that education around the appropriate amount of drink to take in is just one strand of any strategy. No one pretends that it is the only strategy; it is only one of the strands. Labelling is part of how we deliver education about the right level. There are still large numbers of people who do not know what a unit is and could not tell you at the end of an evening what they have had. So the work around labelling really sits with educating people so that they can make decisions about things. I take your point that it is not the end in itself, but it is one of the means by which we are delivering one strand of it. Again, I am not sure whether you are talking about the UK or the EU strategy in terms of—

Lord Wasserman: I was asking what we would push for if we had a European alcohol strategy. Would we say to them, “Let’s not waste any time. There is no point in getting together and developing a strategy if it is only a bit of paper that does not have any numbers in it. After all, there are language problems. We want some hard numbers: 28 countries and these are the numbers that we are going to go for. We are going to go for a reduction in liver disease and, if we do not get that, it is a failure”? Do we have hard evidence that labelling really makes a difference, or is it just something that we think probably makes a difference?

Jane Ellison MP: On your wider point, I think we would see it as helpful that any new EU strategy included some indicators. Our own alcohol strategy is based on health and other outcomes, whether it is harmful consumption, alcohol-related deaths et cetera. We are also
conscious that the EU strategy needs to reflect the indicators in the WHO alcohol action plan as well, rather than having a completely different set of indicators. We would essentially agree with the premise of your question, which is that it is useful to have some indicators rather than more general ambitions.

Crispin Acton: I would add that we already have commitments, through the WHO non-communicable diseases action plan, to reduce alcohol consumption by 10% between 2010 and 2020. That is part of the contribution towards reducing premature mortality from non-communicable diseases by 25% by 2025, which is a voluntary commitment that all member states have entered into. We would see those as broad, overall goals and we would not want to have different goals in an EU alcohol strategy; we would want actions that contribute towards those goals.

Jane Ellison MP: For overall targets or goals, it would be much more sensible to harmonise around those that already exist, for obvious reasons, in setting long-term policy.

The Chairman: Good. I think that that is all from us, so thank you very much indeed for your time this morning and for responding to our questions.

Jane Ellison MP: Thank you. I look forward to reading your report.

The Chairman: Thank you. If you will let us have the information about Drinkaware and so on, that would be very helpful.

Jane Ellison MP: Certainly.

The Chairman: Thank you.
At the hearing of the House of Lords EU Sub-Committee into the EU Alcohol Strategy on 10 December I undertook to provide additional written evidence on a number of subjects, namely:

1. Evidence on the reduced consumption by young people of alcohol, drugs and tobacco;
2. Access data to the Drinkaware website;
3. Details of the most recent actions on alcohol advertising; and
4. The mechanisms available and UK attempts and ability to influence research priorities at an EU level.

I shall address these in turn.

Evidence on the reduced consumption by young people of alcohol, drugs and tobacco

The following graph shows the percentage of 11-15 year old pupils ever having tried alcohol, smoking or illegal drugs, as reported by the Smoking, Drinking and Drugs Use among Young People in England surveys. These show that the numbers ever having used these substances have been steadily falling for a number of years, for example in 2013, 39 per cent of 11-15 year old pupils said they had drunk alcohol in the last week – compared to 61% in 2003. However, the reasons for this decline are complex in nature and will need further investigation.

Percentage of 11-15 year old pupils who have ever tried alcohol, tobacco and drug use.

It is also important to note that it is not all as straightforward as the averages would imply, for example, although average alcohol consumption has fallen consistently we can see that the amount that is drunk by those pupils who do drink has fallen more slowly.

**Mean Alcohol Consumption by 11-15 year olds in England in the last week**

![Graph showing mean alcohol consumption by 11-15 year olds in England from 2003 to 2013.](image)

Method was revised in 2007 and revised method estimates are not comparable with estimates based on the original method.

**Source:** Smoking, Drinking and Drug Use Among Young People in England - 2013 available at [http://www.hscic.gov.uk/catalogue/PUB14579](http://www.hscic.gov.uk/catalogue/PUB14579)

The "by all pupils" figures are not directly available from Smoking, Drinking and Drug Use Among Young People in England - 2013 but are estimated by multiplying the figures in tables Table 4.12a and Table 4.12b by Table 4.5b.

The UK also still has some of the highest levels of childhood binge drinking in the EU. The ESPAD survey found that in 2007 54% of UK children aged 15 to 16 had reported binge drinking in the last 30 days, compared to an ESPAD average of 43%. By 2011 this figure had dropped to 52% for the UK but to 38% for the ESPAD average.

**Access to the Drinkaware website**

There have been 10.1 million visits to the Drinkaware website in the past year, of which 8.1 million have been unique visitors. In the same time period 992,000 people completed the unit calculator. The 2013 Drinkaware KPI survey by Ipsos Mori shows that 93% of 25-44 year olds were aware of units, rising to 97% of 45-65 year olds. Of 25-44 year olds, 35% knew the lower risk drinking guidelines for women and 34% knew the lower risk drinking guidelines for men. The figures for 45-65 year olds were slightly lower, with 29% knowing the lower risk drinking guidelines for women and 27% knowing the lower risk drinking guidelines for men.

**Recent actions on alcohol advertising**

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[36] European School Survey Project on Alcohol and Other Drugs.
On alcohol advertising, the 2012 Government Alcohol Strategy made commitments to:

“Work with the ASA and Ofcom to examine ways to ensure that adverts promoting alcohol and not shown during programmes of high appeal to young people”; and

“Work with the ASA to ensure the full and vigorous application of ASA powers to online and social media and work with industry to develop a scheme to verify people’s actual ages which will apply to alcohol company websites and associated social media.”

Discussions with the ASA and others are continuing on how to best take this forward, including how to make best use of emerging evidence on exposure and consumption.

In the meantime, ASA, Broadcast Committee on Advertising practice (BCAP) and Ofcom have explored the enforcement of the current rules around high appeal programmes in some detail, looking at the impact of programmes with large child audiences on overall exposure levels and the consequent risk of harm, given the evidence of advertising’s impact on awareness and consumption.

This culminated in an exchange of letters between the ASA Chief Executive, CAP Chairman and Ofcom Chief Executive. These letters, and further information about what action was taken and has been committed to (including further ASA monitoring exercises to ensure alcohol ads are being appropriately scheduled), is available on the ASA website, a link to which has been sent to the Sub-Committee Clerk.

Similarly, the ASA has continued to apply the alcohol rules in the advertising codes online, including to social media and continue to take action where advertisers have got it wrong, including on Facebook.

The Department of Health has also worked with the alcohol industry to produce best practice guidance for operators, principally through the Portman Group. The Portman Group has a Code of Practice on the Naming, Packaging and Promotion of alcoholic drinks, which covers information on labels, claims made in relation to alcoholic products and promotional material other than for paid advertising. Department of Health officials worked extensively with the Portman Group in the recent revisions of this Code to help ensure that they kept within the spirit of the voluntary agreements between Government and industry as well as within the letter of the law.

Department of Health officials also had input into the development of the Portman Group Code of Practice for Alcohol Sponsorship, which covers sponsorship of teams, individuals, events and competitions and supports the Public Health Responsibility Deal Pledge to commit to “…further action on advertising and marketing, namely the development of a new sponsorship code requiring the promotion of responsible drinking…”.

With regard to research priorities at EU level, Horizon 2020 (H2020) is the European Union’s overarching, multi-disciplinary research and innovation funding programme which will run

37 Fifth edition, 2013
38 First edition, 2014
from 2014 to 2020. It will see the EU contribute more than €70 billion over the coming seven year period to support the EU’s position as a world leader in science, help secure industrial leadership in innovation, and help address major societal challenges.

The societal challenges addressed by the programme cover six key themes, including; health and demographic change and well-being, which could include alcohol related work.

**Influencing research priorities at an EU level**

Health research and innovation is a big priority for the EU and health is the top priority of the ‘Societal Challenges’ strand of H2020 with approximately €7.5 billion dedicated to funding this area between 2014 and 2020.

The ‘health, demographic change and wellbeing’ theme will cover activities from basic research to deployment of innovative solutions with a new focus on impact and innovation-related activities. Through H2020, the Commission is promoting an approach which is driven by Europe’s most pressing societal and health challenges, encouraging the involvement of clinicians and patients and bringing together resources and knowledge across different fields, technologies and disciplines.

EU Member States have set the high level agenda for the research priorities in H2020 and the legislation behind the programme provides a supportive regulatory basis for projects regarding alcohol and alcohol related harm.

With regard to next steps, the Commission will draw up a 2 year work programme and from that text will launch a call for proposals on specific topics annually, and the best proposals with the highest scores will be funded. The European Commission are currently drafting the work programme for 2016-2017. In general, there is an increased weighting on the ‘impact’ of all projects – and therefore projects which could have a big societal impact in line with the topics will be those to receive higher marks and will therefore be the projects most likely to be funded.

There is an opportunity for the UK to influence the annual programming through the Commission’s Programme Committee on the Health, Demographic Change and Wellbeing programme. This position is currently held by the MRC. They are open to advice and guidance from UK organisations and we understand that there is potential for UK organisations wanting more European research on alcohol related issues to influence some specific wording in the text of a topic.

There is also ERANET – the Joint Programming Initiatives, about which more information can be found on the Europa website, and a link to the relevant pages has been sent to the Sub-Committee Clerk. These research initiatives are on topics where EU Member States want to work together to pool their research facilities. The Joint Programmes can often receive European research funds. There is one on Alzheimer’s and neuro-degenerative diseases, for example, and another on nutrition.

The European Union’s third Health Programme aims to support EU Member States to work together to promote health, prevent diseases, and foster supportive environments for
healthy lifestyles across Europe. In order to do this, they EU funds collaborative initiatives that identify, disseminate and promote the up-take of evidence-based and good practices for cost effective disease prevention and health promotion activities. Harmful use of alcohol remains a thematic issue to be addressed by the EU Health Programme. The overall budget of the EU Health Programme over the 2014-2020 period is 449.4 million Euros.

The Department of Health is on the Programme Committee for this programme and as such the European Commission will consult them on their annual work programmes for distribution of funds.

I hope that this information is helpful

Submitted January 2015

JANE ELLISON MP
Transcript to be found under Department of Business, Innovation and Skills.
John Duffy, Statistics and Policy Consultant; Chris Baker, Consultant; Professor Theresa Marteau, Director, Behaviour and Health Research Unit, University of Cambridge; and RAND Europe—Oral Evidence (QQ 63-73)

Transcript to be found under Chris Baker.
WEDNESDAY 19 NOVEMBER 2014

Members present

Baroness Prashar (Chairman)
Viscount Bridgeman
Lord Tomlinson

Examination of Witnesses

Dr Ruxandra Draghia-Akli, Director, Health Directorate, DG Research, Maria Vidal, Head of Unit for Medical Research, and Karim Berkouk, Deputy Head of Unit, Chronic Diseases and Ageing

Q140 The Chairman: Thank you very much for your time this morning. I am Usha Prashar. I chair the EU Sub-Committee in the House of Lords on Home Affairs. You have been given the background that we are holding an inquiry into the alcohol strategy. Two of my colleagues, Lord Tomlinson and Lord Bridgeman, are Members of the Committee, but not all of the Committee could be here and we are taking a note for their benefit. As I said, we are very grateful to you for your time this morning.

It would help us if you can tell us a little about the work of this division, and what you do, before we get into specific questions about our inquiry on the alcohol strategy.

Dr Ruxandra Draghia-Akli: I would suggest starting with a round of introductions. I do not know if you need to take those particular notes, but we can wait. I am Ruxandra Draghi. I am the director for health research in DG Research & Innovation.

Maria Vidal: Maria Vidal. I am head of unit for medical research, looking at the challenge of ageing and how remedies may be concentrated on major chronic disease or non-chronic diseases in general.

Viscount Bridgeman: I am Robin Bridgeman, a Conservative Member of the House of Lords and a Member of this Committee.

Karim Berkouk: Karim Berkouk. I am the deputy head of unit for the same unit, on chronic diseases and ageing.

The Chairman: As you heard, I am Usha Prashar, Chair of this Sub-Committee.

Lord Tomlinson: I am John Tomlinson, a Labour Member of the House of Lords and a Member of this Committee, as well as a former Member of the European Parliament.

Dr Ruxandra Draghia-Akli: It is very nice meeting former colleagues.

Lord Tomlinson: It is a long time ago. I had 15 years but I finished 15 years ago.
Dr Ruxandra Draghia-Akli: You sound relieved. To start responding to your first question, we are in the directorate that oversees health research in the Directorate-General of Research and Innovation. The purview of our directorate is in fact in the area of research and innovation not in the area of policy per se. Those are the colleagues from DG SANCO. The area of health, as you know very well, is under the purview of the various member states.

In the directorate we oversee a number of programmes on research and innovation, for instance everything that is linked to collaborative research and transnational research in the area of health and, in particular, we obviously address the challenges at the European level—member states and associated countries but also obviously with an eye on global collaboration also.

We have a part of the programme that relates to partnerships, such as public-public partnerships, where the Commission acts as a glue for programmes that are initiated at the member state level. Some of the very formal types of partnerships are created under Article 185 of the treaty. For instance, examples of those that are under the purview of our directorate are the European and developing countries clinical trial partnerships. This is a programme addressing clinical trials for HIV, malaria, tuberculosis and other neglected infectious diseases in partnership with sub-Saharan African countries, where the member states are putting in half of the funds—both in kind and in cash—and the Union provides the other half. Another public-public partnership is the active and assisted living programme, which is more of an ICT type of programme, which is basically ICT-driven technologies for the elderly.

We also have a big public-private partnership, called the Innovative Medicines Initiative. This is a partnership between the European Federation of Pharmaceutical Industries and Associations and other industries that would like to participate in, for instance, diagnostics, imaging or animal health and, again, the Commission. We represent the Commission side of things. This is again a very large initiative.

The programme is currently structured under the big programme of research and innovation called Horizon 2020. This new programme for research and innovation is structured under three pillars, the first of which addresses excellent science. This is essentially what is happening in the European Research Council, with which you are probably familiar. The training grants, such as the Marie Curie grants, and the research infrastructures are all entering into this excellence pillar.

The second pillar addresses industrial leadership. There we have activities in which we participate very actively. For example, an instrument that is geared towards addressing the needs of small and medium-sized enterprises is called the SME instrument. It is very similar to the SBIR grants in the United States that you may be familiar with.

We have a programme called Fast Track to Innovation, which is basically about collaborative research but where the goal is to push products through the research innovation process towards the market. A big part of that is the new financial instrument that the Commission put in place for the new Horizon 2020 programme. These are essentially not grants but loans, guaranteed by the Commission, which are given out either, for smaller projects, through the European Investment Fund by the national banks or, for larger ones, by the European Investment Bank.
The third pillar is the societal challenge pillar. The health, demographic change and wellbeing challenge, which we are managing, is one of these societal challenges and, from our perspective, the largest one is not large enough. We believe that we should be more preoccupied with the European level of health, demographic change and wellbeing, but this is the reality. There is an essential difference between the programme in the previous frameworks and Horizon 2020 as far as health research is concerned.

You may be familiar with this in particular, because you might have seen these types of programmes in the past. They were very much disease-by-disease geared, so you had things like brain disorders, cancer, cardiovascular disease and public health issues or whatever. That is not the case any more. The structure of the challenge is very different. It is essentially a horizontal type of approach; horizontal but at the same time integrating and fostering this idea of interdisciplinarity or multidisciplinarity. It takes on issues such as health promotion, so it supports promotion, prevention, early diagnosis, early treatment and then—if we are there, and we are there—treatment and cure. So this takes any disease into account.

As far as the thematics, per se, again they are very horizontal. Before I tell you what they are, let me tell you why they are like that. In the 21st century, we are moving from what has been essentially a Hippocratic type of medicine, very much phenotypic, to understanding the causes of diseases—through our previous work in genome and now recently the impact on the environment on the genome, to everything relating to the epigenome and the metagenome. Then there is microbiota—we have more bacteria than one can imagine and they have a big impact on our health, so all those sciences have to be integrated. To take it from where, essentially, you have cardiovascular disease to saying, “You have cardiovascular disease and diabetes because of X cause, and need to take all the other measures, such as promotion, prevention and so on, related to that cause rather than to the disease”.

As a consequence, the programme is structured to understand the causes of diseases and takes into account that, for instance, certain environmental factors such as alcohol will have an effect on many pathways. We are looking at integration of issues of public health and public health interest in all these aspects, going all the way to regulatory sciences. So that is the approach, which is meant in the end to be much more comprehensive.

As a consequence, in the past—I can give you an example—we had a number of projects in this particular area. This time around, in the call that we put forward in 2014 and 2015, this idea of understanding disease—for instance understanding addiction behaviours—is not spelt out as such. But it is obviously inclusive and in our calls all these transversal factors that are affecting individuals and many different layers are, indeed, underlined.

Q141 The Chairman: That is extremely helpful. As you know, we are focusing on the alcohol aspects of this, so it would be useful to hear about the previous alcohol strategy from 2006 to 2012. What sort of scientific evidence was it based on? Was it couched in your previous strategy and research? What is your assessment of what has been achieved through that strategy, particularly in the five priority areas?

Dr Ruxandra Draghia-Akli: I can give you the answers in the area of research because that is what is under our—

The Chairman: That would be very helpful, because there is a lot of discussion around research in this area and controversy about whether it is reliable or not.
Dr Ruxandra Draghia-Akli: The short answer to your question is, yes. The 2013 independent review of the strategy carried out by the Commission confirmed the overall added value of the EU alcohol strategy. In fact, in the area of research, that report concludes that the type of research that has been undertaken in the previous framework programmes provided very strong evidence to the member states, and what I would call investment by the Union in the various projects linked to alcohol has increased throughout the years. In the sixth framework programme, we were talking about approximately €30 million. In the seventh framework programme, there was approximately €54 million or something like that—almost €60 million.

The Chairman: Was this health-related or alcohol health-related, if you see what I mean?

Dr Ruxandra Draghia-Akli: Basically they were projects that were in our area, so health related, but the focus was on alcohol. Karim is right: €63 million. Let me go to the actual list of projects because I do not remember them all by heart. Perhaps, Maria, you can give a couple of examples until I find them.

Maria Vidal: Alcohol-related harm has been an important priority for us, since 2002 and even before, throughout the framework scheme. Since then, of course, finance for the framework programmes has been increasing and with that our contributions to the different areas of research. For instance, as part of the sixth framework programme, where we had some €30 million, we supported this programme called DRUID. I do not know if you have ever heard of it. I do not know how you say that in English.

The Chairman: Tell me a bit about it.

Maria Vidal: That was the largest ever survey on road safety and drinking that has ever been set up on Europe with more than 50,000 people.

The Chairman: Was that done by you directly or—

Maria Vidal: When we are talk about EU research projects—

The Chairman: You do it.

Maria Vidal: It is collaborative research that we support as the European Union. You are addressing this question later, and Ruxandra will explain it. But this is funded by the Union. In the areas that we were supporting in relation to alcohol prevention, we had a lot of different projects where we were trying to assess the types of prevention attitudes and approaches that could be taken by public health systems. We have also been doing a lot around the biology of ageing, addiction, and the mechanism of addiction—it is not alcohol only, it is the link between alcohol and nicotine and the link between alcohol and transport, driving, and behaviour and all these areas that are interlinked, as Ruxandra explained, with Horizon 2020. The programme has a comprehensive approach and, in addition to supporting research, we want to be much more ambitious and put the programme at the service of policy. This is the overriding aim in addition to supporting research.

Q142 The Chairman: So you do this to inform policy?

Maria Vidal: We want to provide evidence-based policy, constantly. That is the main aim of our approach. The seventh framework programme for us was historically a big change because we were moving from genomics—genomic research was a big hit at the beginning of the 2000s—to translational research, with the accord of all member states and science in general that you have to translate. It is nice to have basic research but you need to translate
results. If you want to have better therapeutic approaches and if you want to have consistency in incorporating knowledge, you need to go into the clinical area and you have to move to the national health services to implement this. We moved and we started to support approaches that had much more; a clinical part with a lot of effort on clinical trials, as Ruxandra mentioned. A very good example is the EDC clinical trials for developing countries, but also public health. We strongly increased the portfolio of public health research projects that are being supported by the directorate. By including that, we move to a bigger total, almost €60 million. In addition to our own areas, which are very important, we are looking at the biology of alcohol and genetics, because genes do a lot to influence people’s patterns of behaviour and addiction behaviour. There are also for instance projects looking at the specific patterns of habits in children and the elderly population. Of course, we can provide the Committee with information on all these projects.

The Chairman: That would be very helpful.

Maria Vidal: Also different approaches are needed to assess, for instance, how to deal with countries in transition—the specific patterns in these countries on behaviour and so on—and how to assess inequalities, because of course the big link between socioeconomic status and patterns of behaviour is related not only to alcohol but to nutrition, to health and to education. This is all interrelated and we are targeting youth health research to try to identify interventions to limit alcohol consumption. At present we are supporting a very interesting project about the epidemiology of alcohol consumption across the life span and how people behave in relation to alcohol as they age—it is not the same when you are in your 20s compared to when you are in your 60s—and the impact of this behaviour on quality of life and the presentation of disease. This is one of the largest epidemiological projects taking place in Europe now.

Q143 The Chairman: Can I clarify one thing? You said you drive the research but it is in collaboration with others. Do you set its parameters as a priority and then ask people to tender, or do you seek collaboration and go out to people that you want to collaborate with? How does the collaboration work?

Dr Ruxandra Draghia-Akli: We foster the collaboration, and either fund or invest in it. Let me explain the process, so that you have very clear picture. We do not do research in-house at all, so we are very different from the institutes of health or even the UK MRC. It is different. We do not do anything in-house. What we are doing is, basically, first preparing work programmes. Programmes are always prepared with large consultation. We have, for instance, an advisory group that comprises 30 high-level European scientists in all fields of activity, including public health and epidemiology. They are giving us advice. We have formal consultation with member states, each of which sends us their priorities. We integrate those, because obviously our work programmes cannot address the priorities of one country or another. It has to be something that is important at the European level.

We receive major inputs and studies from large societies. For example, every year the cardiology society, the neuroscience society and the whatever society put out their annual reports and their studies, sometimes addressing a particular question. For instance, a couple of years ago the medical councils looked at the performance of clinical trials in Europe. All that is put together and out of that comes the priority for a year or two years from now. Those are again formally consulted on with the member states, which have to vote. We
cannot have a work programme without all the member states agreeing whatever we put in that work programme. We launch—

Lord Tomlinson: All of them agreeing? Do you require unanimity?

Dr Ruxandra Draghia-Akli: No, you have to have a majority, although I do not remember what sort.

Lord Tomlinson: A qualified majority?

Dr Ruxandra Draghia-Akli: A qualified majority, but essentially they have to be projects. I cannot remember ever that there have been—maybe occasionally you may have a country that would not like one project or another. They are typically in some very specific areas such as embryonic stem cell research, but it has nothing to do with other things.

So we put the calls out. The collaborative teams are formed by the scientists outside the organisation. They are academic investigators, so universities, small and medium-sized enterprises, patients’ organisations and industry coming together and putting together these proposals. They submit the proposals to us by the deadline of a call. We receive very many. For example, for the call of 2014, we received almost 1,900 proposals. For the call of 2015 that we are going to fund next year—we have received the first stage proposals—we have received 2,100 proposals. So you see a bit?

The Chairman: I see a bit, yes.

Dr Ruxandra Draghia-Akli: All those are collaborative projects. We do not review them in house because we believe that we have to use the highest standards of international peer review. We have a very large database of experts. We create expert panels in the various areas of activity that match the work programme and send all the proposals for international peer review. Typically, each proposal is seen by five different reviewers who are going to score it. In the first step of evaluation, two criteria will be evaluated: excellent science—we cannot fund very bad science—and impact. So what would be the impact on the citizen and on accomplishing the goal of those projects?

Based on that, we select a number of projects that are going to pass to the second stage. We had a blip in the first call of 2013 because we received too many proposals, before and since there were about three times more proposals than we can fund past stage 2. At stage 2 the consortia receive a letter saying, “You have been selected to submit a full proposal” because in stage 1 there is a very short proposal of about seven to 10 pages. They submit four proposals. The process is repeated. You go to international peer review. The external reviewers are at the end of the process, meeting in Brussels to establish priority lists of those recommended for funding. At that stage, we consult the programme committee again. So we consult the member states saying, “These are the projects that we intend to fund. Do you agree or not?”. They typically unanimously agree.

The Chairman: After all this, if they do not agree—

Dr Ruxandra Draghia-Akli: Exactly.

The Chairman: I want to ask one final question before I hand over to my colleagues. I want to come back to one point. You said this research informs policy. Projects were listed. Can you tell me: what were the pieces of research that informed the first strategy and what research is likely to inform the next strategy?
Dr Ruxandra Draghia-Akli: That is a very good question. You have to understand that projects in this programme are typically three to five years. The projects we have funded in the sixth framework programme have ended. That was an opportunity to provide the evidence that was relevant to the strategy. About half of the projects that have been funded in FP 7, which just ended in 2013, are not yet finished. So the results or evidence that would be created out of those projects will impact in the future. The same thing goes for whatever we would fund from now on. So there is a lag. Here we are talking about research innovation activities. Typically, for research to create evidence that is developed enough to have an impact on society takes between five and 15 years. That is the reality of research. We are very different from the policymakers, who are always looking at the evidence that is available at a particular point in time. With the help of our programme committees and our advisory groups, with scientists, we are looking at what will probably be necessary in five to 10 years and try to anticipate that.

Q144 Lord Tomlinson: Before we come on to specifics, I am somewhat puzzled by the framework within which we are approaching the new EU alcohol strategy. As far as I understand it, the last strategy expired in 2012. Here we are having a large number of research projects being evaluated in 2014 and 2015 and yet we do not have the new strategy. We are still negotiating with people in terms of the alcohol strategy, which is what we are specifically interested in. Perhaps inevitably, we have received, particularly from the industry, a lot of criticism of the research behind the alcohol strategy. For example, one industrialist suggested to us that, “EU funding is repeatedly allocated to the same actors despite the quality of their research outputs being questioned”. As we have pursued that question we still—I must not talk in terms of “we”, in terms of “I”—have a problem in trying to understand how it is that you can call for tenders for research without having a specific goal of filling gaps in the existing research. I would have thought that, in relation to alcohol, there is a lot of research that has already been done by the World Health Organisation and national Governments. You must have some idea where the gaps in the research knowledge are. Would it not be more directly beneficial to getting a comprehensive view of the problem if, in calling for bids for research, you called for it in specific areas that plugged the gaps in our knowledge?

Dr Ruxandra Draghia-Akli: Let me be very clear, what I was talking about was general.

Lord Tomlinson: Yes, that was general, and what I am trying to get at—

Dr Ruxandra Draghia-Akli: The short answer is that we do not call for specific areas, so cancer will compete with the alcohol strategy and with the epidemiology in whatever infectious disease. The only criterion that impacts the selection of the projects is excellence and impact on the public and, obviously, because we are talking about public money, at the second stage the management component is going to come into play. So if a consortium is going to be completely dysfunctional or it does not have an organisation, a dissemination plan or whatever, it is not going to be selected. But when we are talking about understanding disease, that can be related to chemicals in the environment, to alcohol and to everything because, as I have mentioned from the very beginning, we need to look at things much more comprehensively. That is why we believe that the previous type of research, which was very sliced, is not in line with scientific advances of all the “omics”.

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To be very precise about the alcohol strategy, we are not calling per se for topics related to alcohol but, for instance, we do look—and we have invested enormously—into issues related to brain function, which includes addiction.

**Lord Tomlinson:** Because that is where the demands of the researchers have led you.

**Dr Ruxandra Draghia-Akli:** Without understanding the mechanics behind how the brain functions you will not be able to design strategies that are going to the core of things. You may tackle the effects of whatever that might be—alcohol, chemicals, stress, behavioural, nutrition—but you will not be able to understand properly what the real causes are.

**Viscount Bridgeman:** Is this the horizontal approach that you were talking about earlier on?

**Dr Ruxandra Draghia-Akli:** Yes.

**Viscount Bridgeman:** As I understand it, that gives you much more flexibility in your own thinking, linking the various problems.

**Dr Ruxandra Draghia-Akli:** Exactly. It is not necessarily our thinking but where modern science is going. If we look internationally at the forefront of medical research, it is all going in this direction.

**The Chairman:** I understand that. That horizontal approach, as we understand it, will lead you to health-for-all policies that will impact many different things. It is more integrated, but if you are going to have a specific strategy for alcohol, then you need to have more targeted approaches too. So how do you manage the two in terms of policy, because you are doing this research to inform policy? I am not clear in my mind how what you do links to policy formation.

**Dr Ruxandra Draghia-Akli:** Here we need to understand that, at the European level, we do not fund research only for policymaking. I think that the evidence that comes out of these projects can be used for policy-making, but we fund the entire scale of research from very basic research: the Nobel Prize winners to the very applied research interventions in public health. The strategy is not created by us; we provide all these elements from the evidence that is in fact a result of the project, but it is for either DG SANCO or, more importantly, the member states to take those elements and create a strategy for alcohol, for mental health, for cancer screening or for whatever. We are not prescriptive in those strategies.

**Q145 Lord Tomlinson:** If I look at the alcohol strategy for 2006 to 2012, and then I look at the fact that here we are nearly at the end of 2014 and we are still consulting on the next strategy for alcohol, it gives me the impression that that strategy is not regarded as particularly important. You have let one strategy lapse—it has come to the end of its finite life—and you are still not yet anywhere near completing the consultation on the next strategy. We will not get the next alcohol strategy in any way before 2015, and we have had those gap years, 2012 to 2015, where in practice the strategy has not existed or we have just let it carry on.

**Dr Ruxandra Draghia-Akli:** As I mentioned previously, we are DG Research and Innovation. Everything related to policy-making is within the purview of our DG SANCO colleagues. But in this particular area, it is the purview of the member states. We do fund excellent research.

**Lord Tomlinson:** But have the other DG, which has responsibility for making policy, and the member states, who have responsibility for making policy, not been shouting, “Where is our new alcohol strategy?”
**Dr Ruxandra Draghia-Akli:** No, they have not.

**Lord Tomlinson:** They have not? That is in fact quite an important fact, is it not, if they are not shouting for it?

**Dr Ruxandra Draghia-Akli:** No, it is not, because there are another 45 or 125 strategies for everything else in the medical area. I think that Maria—

**Maria Vidal:** In January 2014, the Commission launched the new joint action on reducing alcohol harm, which will last three years. There is a meeting organised by Eurocare in the frame of the European alcohol policy, which is organised by member states. They do it in a capital each year, on 27 and 28 November, and the aim of this joint action that has started continues to intensify. It has taken stock of what the European alcohol strategy has built up. You know that there are two main arms. There is this committee of the member states and then there is the European forum—as Ruxandra said, the remit of DG SANCO—where all member state stakeholders, from NGOs to patient associations and so on are together. The strategy will be presented, for instance, at this meeting that is taking place here in Brussels, I think, on 27 and 28 November. The joint action aimed at reducing alcohol-related harm is supposed to be consolidating work on three areas: monitoring drinking habits and alcohol-related harm, guidelines for low-risk alcohol consumption and good practices in the provision of information to protect children and youngsters and prevent alcohol-related harm.

In addition, also in January, there will be a Commission action plan that will last for two years, in preparation for whatever is going to be the future of the Commission which, of course, we cannot pre-empt. It will be specifically devoted to something that all member states consider essential, which is youth drinking and heavy episodic drinking. It is also very important—this is also one of the questions that you mentioned before about age—that the Commission’s specific action plan takes a very broad view of the age group in this. It goes from the unborn child—because it is very important to consider the effects of mothers drinking, the behaviour of mothers during pregnancy and so on—to children and adolescents, but also young adults up to the age of 25.

This is similar to what we are doing, for instance, with our definition of paediatrics. When we do research on paediatrics we take the largest view. There is the WHO definition of course but some member states are different. For some member states, at 16 you go to the normal clinician. In other member states it is 18. So we go up to 18 in our research projects to allow for all these differences. There are six areas in the action plan. It is 28 member states plus Norway, Iceland, health and consumer institutes, the alcohol and beverage industry, the hospitality sector, and the advertising industry. In this action plan these are all considered important stakeholders to participate, so these things are already going on. It is about reducing heavy drinking, reducing accessibility and availability, reducing the exposure of youth to alcohol, reducing the harm from alcohol during pregnancy, and ensuring a healthy and safe environment for youth, while supporting monitoring and increasing research. These are the six main aims of these two important complementary efforts.

**Q146 The Chairman:** So these two events you think will inform the future strategy?

**Maria Vidal:** They are developing it.

**Dr Ruxandra Draghia-Akli:** They are developing it. So, as I was saying, this is another reason why it would not be a true statement to say, “We are interested in this strategy or that
strategy or that strategy”. We are in fact interested in having a holistic approach because in the end our motto is, indeed, “Health for all. Health is wealth”. We believe in particular that we cannot impact policies directly in this area, because they are within the purview of the member states. But everything that we do will help to provide unbiased evidence to address step-by-step, throughout the course of life, the different types of policies. But then that evidence will have to be taken into account.

**Viscount Bridgeman:** You are talking about health for all, but our specific remit is alcohol itself and this is where your detailed exposition is very helpful.

**Dr Ruxandra Draghia-Akli:** We can provide you with all the information.

**The Chairman:** It would be very helpful to have that. Anything else you want to ask?

**Viscount Bridgeman:** No, that is it for the moment.

Q147 **The Chairman:** Can I ask you another question? Unfortunately we are not able to see DG SANCO because they are in Luxembourg. They could not come here. But it is a question that you can answer. Can you enlighten us with any pieces of research that you have done that have been used by them in their policy development?

**Dr Ruxandra Draghia-Akli:** Very often we do—

**The Chairman:** Particularly in relation to alcohol.

**Dr Ruxandra Draghia-Akli:** In relation to alcohol, as I mentioned, in the older projects from FP 6—because, again, the projects must be finished in order to provide material—we did have projects that showed the impact of alcohol from a public health perspective, such as the prevalence of cancer. Projects looked at the neurobiological component and at addiction, as well as at the liver, the pancreas, strokes and the impact on those conditions. As Maria very elegantly presented, there was also road safety and, very importantly, the coordination activities around youth. So those are projects that have ended that provided evidence throughout previous years.

Q148 **Lord Tomlinson:** We heard from the representative from the WHO about cofinanced research and that you were engaged in a substantial amount of cofinanced research with the World Health Organization. Who leads on that? Do they decide the topic or do you, or is it jointly determined? Because in most of the other research that you talk about it seems to be researcher-led. They put forward the proposal. If you do anything in terms of cofinancing with the WHO, how is that research determined or is it outside your control all together?

**Dr Ruxandra Draghia-Akli:** The WHO participates in some of the collaborative research, but it participates with the researchers. Again, we are here to set up the process but we do not do research directly. So if the WHO deems it necessary to participate in the partnerships that are put together by the researchers, then it can very well do that. In the previous framework programmes, it is true that the direct cost of some of the activities were not covered by us with 100% of, so some organisations had to come up with cofinance. But again it is project related. So whatever they were doing, it is in the context of their collaborative research.

**Karim Berkouk:** I think we had 30 projects in FP 7 where the WHO was a partner in the consortium, mainly on infectious diseases I have to say.

**Dr Ruxandra Draghia-Akli:** Yes, infectious diseases.
Karim Berkouk: Their cofinancing is very limited. It is like 10% to 15%, as was mentioned. The main bulk of the money comes from the Commission.

Q149 Lord Tomlinson: I will come back to the formal question that we asked. In terms of EU-funded research projects—we are particularly interested as I say in the alcohol area—I assume that the outcomes of that research is systematically monitored. You have given us some indication of that this is the case. Are those findings of the monitoring of research publicly disseminated? Are they publicly available?

Dr Ruxandra Draghia-Akli: Yes.

Lord Tomlinson: How would they get it on your website?

Dr Ruxandra Draghia-Akli: There are many levels. All these projects have a dissemination and a communication section. So the dissemination occurs by different means, such as presentations at conferences and publications—we have copies of the publications. Depending on the area of activity, although this is not linked to the alcohol strategy, one can have patent applications. They report, for instance, if a university creates a spinoff company to exploit, let us say, medical devices or things of that nature, which happens very often. That is for their internal processes but we have those projects in an accessible database. It is called CORDA, and everyone can go and look at it. They look at the deliverables of the projects and the milestones, and the report that come out of those studies. The next question might be: how do you make sure that they report? They do not get their money if they do not report. So it is very easy.

Q150 Viscount Bridgeman: Can I ask, at the next stage, how long the monitoring go on for? Is there a point where you sign off a project which you have helped to finance?

Dr Ruxandra Draghia-Akli: Yes. The final payment comes with a final report.

Karim Berkouk: To give some overall figures, I think 350 projects were closed in FP 7.

Lord Tomlinson: On alcohol?

Karim Berkouk: No, just generally. Maybe afterwards we can try to look specifically at the project on alcohol.

Lord Tomlinson: That would be helpful if you could do it, yes.

The Chairman: That would be very helpful.

Karim Berkouk: About 1,200 articles were published. On average the impact factor of the journals is about nine, which is extremely high and shows the quality. There is a lot of knowledge there, in terms of innovation. I think about 30 spin-offs were created out of these 300-something projects, and probably more than 300 patents were submitted. In Europe we are very good at creating knowledge but not so good at exploiting it. That is why now in Horizon 2020 we are moving towards SMEs because whenever you have SMEs in the consortium they are thinking about what happens next with the knowledge that is being generated.

The Chairman: You call that innovation.

Karim Berkouk: That is the context.

Dr Ruxandra Draghia-Akli: Yes.
**Maria Vidal:** Then there is widespread dissemination. Everything is accessible. There are no loopholes. We organise press releases constantly to communicate to the audience outside. We do brochures and we organise events; a lot of events in different areas. We participate in all the events. We go very often to the European Parliament to respond to the interest expressed by MEPs in different areas. You know that there is a very organised group for cancer but there is also one for chronic diseases. They organise awareness meetings, in which we always participate. Then, at the internal level, at the level of institution, we feed back these results to all the Directorates-General concerned, from DG SANCO to DG Enterprise and DG Transport—

**Dr Ruxandra Draghia-Akli:** DG Employment and DG Justice.

**Maria Vidal:** That is because alcohol is an overarching area with a different evidence base to provide. We have a different way to go in terms of policy. You were asking about concrete things. I mentioned a project, Amphora, which was about alcohol. It was called Alcohol Public Health Research Alliance. It was a very important project because it provided a lot of evidence. One thing was that brief interventions for risky drinking and pharmacological treatments for alcohol disorders are effective. You have to provide the evidence for that, but then you have to find the means to develop these types of approaches in member states, which is of course the task of member states. For instance, in general, increased urbanisation results in increases in overall alcohol consumption. All this is information but how do you deal with that? This is about urban organisations and territorial organisations, member states and so on. So there is also a limit to what you can install, in terms of regulations, directives and so on, and things that have to be permeated through national health and other systems at national level.

**Q151 Lord Tomlinson:** Can I just finally—I promise then to keep a bit quiet—ask one specific question? In order to help us and the report that we are producing on the next alcohol strategy, could you give us from the last strategy, the 2016 to 2012 period, three or four examples of research in this area which you have been engaged with and which you think have had significant effect either at the level of policy-making in the Commission or in the member states? Could you pick those out? It does not necessarily have to be now, but could you let us have a note of what you would consider the three or four most significant uses of research money that have helped in the development of the alcohol strategy over that period of five years?

**Dr Ruxandra Draghia-Akli:** We can provide you with the results of the projects.

**Maria Vidal:** It would be easier for us not to frame this in terms of the EU alcohol strategy but to concentrate on explaining how, in research, we have been constantly trying to develop the state of knowledge that is needed in the most important of these types of areas. Do you see what I mean? For instance, to illustrate that, we have a project called NeuroFAST. It has 13 partners so it is more than the member states.

**The Chairman:** What is the name of the project again?

**Maria Vidal:** NeuroFAST. It is about the integrated neurobiology of food intake, addiction and stress and about investigating the neurobiology underlining addictive behaviour, in particular genetic and environmental risk factors. This is much larger than the EU alcohol strategy. But at the same time it is at the core of many of the priority areas that member states want to tackle about alcohol. So for us, and I think for you, it would be interesting to
have some idea of the whole area of research on alcohol-related harm by looking at the areas in our strategy that fit with that. We are also advancing areas that are not even in the strategy itself, because it is a moving world. For instance, after the internet appeared, it had—it is still having—a lot of impact on risk behaviour in general. That did not exist, or was not such an issue, in 2006 when the alcohol strategy was launched. So I think it would be useful for you because the—

**The Chairman:** It is more informative.

**Maria Vidal:** Yes. For us, it shows how research is outstandingly important to provide the evidence base in any policy-making area. Of course, in such an area—

**Lord Tomlinson:** I will buy that, and if you could produce three or four of your best examples that would be very helpful.

**Viscount Bridgeman:** What you want, John, is a linking of the story, do you not?

**Lord Tomlinson:** Yes, that is right.

**Viscount Bridgeman:** Taking the story forward from the 2012 strategy into what you are doing, which you just described.

**Maria Vidal:** We could do that.

**The Chairman:** That would be extremely helpful.

**Lord Tomlinson:** Back many years ago, when I was in the European Parliament, the budget committee wanted to do an evaluation of one of the energy projects, the energy demonstration programme. When we had finished looking at it in some detail we found that it bore no relationship whatever to the needs of the industry, the needs of consumers or the needs of the member states. It got it completely wrong. I do not believe that is the case here, but it would help to get specific details of specific programmes so that we can ask ourselves the sort of questions that you might ask in a cost-benefit analysis.

**Dr Ruxandra Draghia-Akli:** I think that if you asked this question in about 10 years’ time, we would have a different answer because the background information about neurobiology or addiction, and neurobiology generally, would have progressed so much that we would have a much better understanding and our activities could be much more targeted.

Secondly, I think that the big opportunity of Horizon 2020 is the fact that we have moved towards an integrated view of the world, so what we hope to have by 2020 is to have an integration of the disciplines in the project. Up to now the projects were more segmented, but for instance now we call almost by name, so that the behavioural sciences are integrated into many of the projects where they have never seen neurobiologists, psychologists or whatever. That will also change how the community works. To be extremely honest, at the end of the day, in Research & Innovation we can provide all the evidence in the world but if the member states and, in particular, we as individuals are not ready to take up that evidence we will do absolutely nothing. It can be wrapped and packaged and it can be extremely eloquent. How many years now have we had the black box on the cigarette packages “Smoking kills”, in big, letters? There are still quite a number of individuals that do smoke.

**Q152 Viscount Bridgeman:** I think that this slightly links in with the question of whether the research could be improved by more uniformity in the meaning of terms, such as child or
young person. I am not quite sure whether there is anything behind that question, but it is all about communication and communicability, is it not, in these projects and so forth?

**Dr Ruxandra Draghia-Akli:** You were referring to earlier and the way we described the groups from birth to adult.

**Maria Vidal:** The Commission has just launched a joint action defining this in a way that takes it into account. Definitions are also the responsibility of member states. From a legal point of view, there are regulatory issues, from the police to whatever. Healthcare is organised depending on what is considered a child and what is considered an adult or a young adult and so on. So by taking this very broad approach they may start to provide a more harmonised approach.

**Viscount Bridgeman:** It is an organically growing skill I suspect this one, is it not?

**Dr Ruxandra Draghia-Akli:** I do apologise, but I have another meeting at 11.30 am. It is in a different building. I do not know exactly what—

**The Chairman:** It is about 11.10 am.

**Dr Ruxandra Draghia-Akli:** I will have to go. I hope that we have responded to your questions.

**The Chairman:** It has been very useful, but perhaps you can provide some of the information that we have asked for.

**Dr Ruxandra Draghia-Akli:** Sure, absolutely no problem whatever.

**The Chairman:** That will be extremely helpful. We are very grateful to you and your team for the time you have given us.

**Karim Berkouk:** To summarise then, it is a list of projects that we have financed on alcohol—some of the alcohol projects, if they are finished—and three examples of alcohol projects that are useful for making policy.

**Lord Tomlinson:** Yes, that can significantly impact upon the policymakers.

**Dr Ruxandra Draghia-Akli:** Okay. Will do.

**The Chairman:** Thank you very much indeed. Sorry to have kept you slightly longer than we anticipated.
The European Alcohol Policy Alliance (EUROCARE) is an alliance of non-governmental and public health organisations with 57 member organisations across 25 European countries advocating the prevention and reduction of alcohol related harm in Europe. Member organisations are involved in advocacy and research, as well as in the provision of information to the public; education and training; the provision of workplace programmes; counselling services and residential support.

The mission of Eurocare is to promote policies to prevent and reduce alcohol related harm, through advocacy in Europe. The message, in regard to alcohol consumption is “less is better”.

Eurocare has prepared this consultation response in close collaboration with our UK members Institute of Alcohol Studies (IAS) and Scottish Health Action on Alcohol Problems (SHAAP).

Response to call for evidence

Q 1. Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

Eurocare is a strong supporter of effective alcohol policy in Europe and has been calling for a renewed EU Alcohol Strategy since 2010, when the previous Strategy was approaching its expiration date. Eurocare has coordinated the European work on the advocacy for a new EU Alcohol Strategy, and among those activities are an event in the European Parliament (June 2012)\(^{39}\) and preparing the Eurocare Recommendations for a future EU Alcohol Strategy (June 2012)\(^{40}\), as well as gathering more than 90 signatures from public health organisations across Europe calling for a new Alcohol Strategy (November 2011)\(^{41}\). Eurocare sees the failure to establish a renewed Strategy in 2012 as a significant setback for achieving progress on reducing alcohol harm in Europe. Eurocare has expressed concerns about the limitations of the interim EU Alcohol Action Plan, which seeks to address a much narrower element of alcohol harm, covering young people and heavy episodic (binge) drinking, and has made repeated calls for a new comprehensive strategy that would take a whole population based approach and thus include policies that would impact all Europeans affected by alcohol problems, including adults of working age and those affected by third party harms (e.g. victims of drink drive accidents and domestic abuse).

We believe the next EU Strategy should be based on the evidence-based framework for effective alcohol policies outlined in the World Health Organisation (WHO) Global Strategy to reduce harmful use of alcohol (2010) and, more specifically, the WHO European Action Plan to reduce the harmful use of alcohol 2012-2020 (2011). Both of these strategies have

\(^{39}\) http://eurocare.org/media_centre/previous_eurocare_events/eurocare_eu_alcohol_strategy


\(^{41}\) http://eurocare.org/resources/policy_issues/eu_alcohol_strategy/eurocare_papers/ngos_call_for_a_new_eu_alcohol_strategy_november_2011
received unanimous endorsement by all EU Member States and are based on the best available scientific evidence of policy effectiveness. The ten policy areas for action outlined in these two strategies are:

1. Leadership, awareness and commitment
2. Health services’ response
3. Community action
4. Drink-driving policies and countermeasures
5. Availability of alcohol
6. Marketing of alcoholic beverages
7. Pricing policies
8. Reducing the negative consequences of drinking and alcohol intoxication
9. Reducing the public health impact of illicit alcohol and informally produced alcohol
10. Monitoring and surveillance

Item 5, 6 and 7 denotes a “best buy” policy identified by the WHO. The WHO has identified, in line with the international evidence, the three “best buy” policy interventions that are most cost-effective in reducing harmful consumption of alcohol are controls on price, availability and promotion of alcoholic beverages.

Eurocare acknowledges that the responsibility for delivering public health policy lies primarily with individual member states. Each country in the EU has different requirements and cultural backgrounds and there is no one-size-fits-all strategy that can be applied. The EU Alcohol Strategy should therefore seek to support and complement comprehensive national alcohol strategies by focusing on policy areas where the EU mandate can add value, for example in relation to trade and cross border issues. It should also provide Member States with the freedom to implement national policies that prioritise the health and wellbeing of their citizens. An EU Alcohol Strategy could therefore address the following policy areas:

**Price**

Acknowledgement and acceptance of the evidence to support price controls in order to reduce the affordability of alcohol as one of the most cost effective interventions to tackle alcohol harm

Enabling and encouraging Member States to regulate domestic alcohol prices through taxation, minimum unit pricing and other fiscal measures where appropriate

Reviewing the EU directive on alcohol taxation to allow Member States to implement pricing policies that incentivize the production and consumption of lower strength alcoholic beverages (especially for wine products)

**Marketing**

Review the EU Audio Visual Media Services Directive to establish a framework for regulating exposure of children to alcohol marketing activities in digital media. This would apply across the EU and therefore prevent cross-border discrepancies that can undermine national policies in Member States
Enabling and encouraging Member States to adopt statutory and co-regulatory frameworks for marketing and advertising, and discouraging self-regulatory frameworks that have been shown to fail to protect children from exposure to alcohol marketing.

Availability

An EU directive could establish a common minimum purchase age for alcohol, set at 18 years. The EU Services Directive should be reviewed to enable licensing authorities to fully recover the costs associated with enforcing licensing regulations through license fees.

Labelling

Establish an EU-wide requirement for all alcoholic beverages to list their ingredients, allergen and calorie information, in line with EU current regulations on the Provision of Food Information to Consumers.

Establish an EU-wide requirement for all alcoholic beverages to carry independent health information for consumers, for example in relation to drinking during pregnancy, drink driving and risk of dependency, liver disease and cancer.

Drink Driving

A harmonised Blood Alcohol Content legal limit across the EU would prevent cross-border discrepancies for drink driving incidents, as would a harmonised penalty system.

Workplace policies

Encourage a uniform approach to alcohol policies in the workplace across the EU, combining legislation, alcohol-free workplaces, and interventions aimed at those employees whose drinking patterns have an impact on performance at work.

Inequalities

Alcohol related harm hits harder in lower economic groups, despite higher consumption levels in higher economic groups. Alcohol must be included in the work on health inequalities being one of the top risk factors for ill health and premature death.

Monitoring and Surveillance

Greater resources could be dedicated to data collection throughout the EU relating to alcohol consumption and related harms, including third party harms such as drink driving accidents, alcohol-related assaults, injuries, domestic abuse and sexual assaults. Better data on the impacts of alcohol will enable policymakers to identify policy needs and monitor and evaluate policy effectiveness.

A primary aim of an EU Alcohol Strategy must be to ensure that a Health in All Policies approach is taken with decisions at the EU level, and that the health and wellbeing of EU citizens is prioritized over trade and economic operator interests. An important objective within this aim must be to address the health inequalities, both within and between Member States, which are exacerbated by harmful alcohol use.
Q 2. Are the EU’s alcohol policies underpinned by a sound scientific base?

There are many elements of the previous EU Alcohol Strategy that were underpinned by a strong evidence base of effectiveness. The comprehensive framework of policies outlined acknowledged the breadth of scope required in order to reduce alcohol harm across the EU population. Similarly, funding streams were established to advance the work of alcohol researchers and develop the evidence base for effective policies, through projects such as AMPHORA and ALICE RAP. Funding was also allocated to NGOs in order to build capacity amongst civil society actors, thus following an evidence-based approach of good governance in policymaking.

However, the previous EU Alcohol Strategy could have been more ambitious in its objectives to be more in line with evidence of effectiveness, and its expiration in 2012 presents a real threat that EU alcohol policies are not currently being prioritised according to the scientific evidence of the burden of disease in the region. The EU is the heaviest drinking region in the world and a significant proportion of alcohol harm is experienced by adults of working age through chronic health conditions including liver cirrhosis, cancer, stroke, heart disease and also mental illness and dependency (WHO EU Alcohol Action Plan, 2011). The focus of the current EU Alcohol Action Plan is on young people and binge drinking, and whilst the latter will capture the adult population to some extent, the Plan does not include recommendations for interventions aimed at reducing health problems caused by regular heavy consumption amongst middle-aged adults, who have the absolute highest rates of disability and premature death due to alcohol. For example, the recommendations for alcohol workplace policies refer only to those targeting young people, and lower blood alcohol content levels are recommended for young drivers and professional drivers of public transport services for children. Therefore it could be argued that the current EU alcohol policy is not underpinned by the scientific evidence relating to the health needs of all EU citizens, or the most cost-effective approach to tackling alcohol harm.

Within the narrow scope of the EU Action Plan on Youth and Heavy Episodic Drinking, there are several recommended policies that are based on good scientific evidence of effectiveness. These include supporting the implementation of fiscal and pricing policies to discourage heavy episodic drinking, promoting and ensuring the implementation of screening, early identification and brief advice in relevant subgroups and settings, use of effective enforcement measures to reduce availability of alcohol to underage people, use of legislation and co-regulation to reduce the exposure of young people to alcohol advertising and the establishment and enforcement of lower blood alcohol content levels for young and professional drivers. There are also several recommendations for improved and harmonised data collection, monitoring and surveillance of alcohol harm and interventions, which will help to improve the evidence base for effective EU policies in the future.

The Science Group of the EU Alcohol and Health Forum was established in 2008 to provide scientific guidance to the Forum. Since its inception the Group has produced two reports, relating to adolescent exposure to alcohol marketing and alcohol policies in the workplace. However, as outlined below, the function and role of the Science Group could be improved upon in order to ensure that EU alcohol policies are underpinned by an up to date evidence
base of effectiveness moving forward, and that the evidence advising such policies is independently verified and free from commercial vested interests.

Q 3. Are the EU’s alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?

The absence of a current EU Alcohol Strategy means that there is no comprehensive policy framework in existence at the EU level that can be compared to the WHO Global Alcohol Strategy or WHO EU Alcohol Action Plan. The interim EU Action Plan on Youth Drinking and Heavy Episodic Drinking has a narrower scope, however, as stated previously, there are operational objectives within this that adhere to WHO recommendations based on the best available scientific evidence. These include:

• Encourage health related information including alcohol related risks on alcoholic beverages to help consumers make informed choices. Also, ensure that containers of alcoholic products carry a warning message determined by public health bodies describing the harmful effects of drinking during conception and pregnancy
• Support and implement fiscal and pricing policies to discourage heavy episodic drinking
• Promote and ensure the implementation of Screening, Early Identification and Brief Intervention in all relevant subgroups and settings
• Promote, ensure and enforce adequate level of controls in on- and off-premises relating to underage sales
• Use existing legislation and co-regulation to reduce young people’s exposure to alcohol advertising
• Reduce alcohol related traffic accidents by establishing lower BAC levels (for young drivers and profession drivers for public transport services for children)
• Make data on alcohol related harm available as a basis for policy making

Policies outlined in the previous EU Alcohol Strategy that were in alignment with WHO frameworks, but are absent from the Action Plan on Young People and Binge Drinking include:

• Recommendations for a drink driving legal blood alcohol content (BAC) limit of 0.5mg or less for all adults, combined with the enforcement of frequent and systematic random breath testing, supported by education and awareness campaigns involving all stakeholders
• Setting a minimum purchase age of 18 years for all alcoholic beverages, including beer and wine
• A key omission from the EU alcohol policies at present is a set of specific, measurable and timely targets or indicators, outlining the EU ambitions for reducing alcohol harm. This is in contrast to current WHO strategies that include the following goals:
  • To achieve a 10% relative reduction in the harmful use of alcohol, as appropriate in the national context, by 2025 (WHO Global Action Plan for
Prevention and Control of Non Communicable Diseases 2013-2020 – baseline data from 2010

- Offer brief advice programmes to 30% of the population at risk of hazardous or harmful alcohol consumption; or offering early identification and brief advice to 60% of the population at risk (WHO European Alcohol Action Plan)
- To achieve a 25% global reduction in premature mortality from non-communicable diseases (NCDs) by 2025 (World Health Assembly Political Declaration, May 2012)

Eurocare believes that a new EU Alcohol Strategy should compliment existing WHO strategies by including targets and indicators that have been endorsed by Member States.

Q 4. Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

Eurocare believes that the mechanisms created in the previous EU Alcohol Strategy still have an important role to play in working to reduce alcohol harm in Europe, however the roles of the Committee on National Alcohol Policy and Action (CNAPA) and the EU Alcohol and Health Forum (EAHF) need to revised to reflect the requirements of a new, more ambitious strategy that puts Health in All Policies at the heart of it focus. In addition, Eurocare advocates for a framework for a civil society dialogue process which does not include economic operators.

As CNAPA is the body representing Member States, it is essential that its role be strengthened to reflect its position as the driving force for the design and implementation of a new EU Alcohol Strategy. One way of doing this could be to make CNAPA as a working group within the structures of the Council of the EU. This group can build on the experiences from the Horizontal Working Party on Drugs (HDG), which is the coordination body meeting on a monthly basis to discuss drug-related issues. The HDG prepares all relevant legislation and political documents adopted by the Council, such as the EU drugs strategies and action plans.

It could be argued that to date CNAPA’s view has not been awarded sufficient attention, with several calls for a renewed EU Strategy since 2010 failing to result in action from the European Commission. CNAPA has recently been tasked with drafting a scoping paper, outlining the principals required for a new EU Alcohol Strategy. This will be presented to the new Commissioner following their appointment. It is essential that the views and priorities of CNAPA are given active consideration in developing and implementing European alcohol policy.

Conversely, the EUAHF has been awarded greater priority in the EU alcohol policy process that its remit requires. Despite the EUAHF having no official role in policy development, views of forum members were sought throughout the development of the EU Alcohol Action Plan, and objections from economic operators to scientific reports produced on behalf of the Forum have been upheld. Eurocare is a member of the EUAHF and sees value in maintaining
a mechanism whereby NGOs and public health bodies can discuss with the European Commission how economic operators can contribute to actions that will reduce alcohol harm. However, we believe that the role and function of the EUAHF should be guided by the WHO guidance, which states alcohol industry activities should be restricted to their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages and that they should have no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests.

We therefore believe the EUAHF should become a more focussed body, with an agreed workplan that is aligned to a set of core objectives laid down by CNAPA. Economic operators can commit to take action that will achieve measurable objectives, in line with such a workplan. NGOs and public health bodies can support this process by ensuring that commitments are based on evidence of effectiveness and are subject to robust monitoring and evaluation processes, and that there is transparency in all Forum activities.

The function of the Science Group of the EUAHF would be better placed if it reported directly to CNAPA. This would enable policy discussions on the evidence to support interventions to reduce alcohol harm to be free from commercial conflicts of interest. It is not appropriate that economic operators with pecuniary interests in policy areas such as price and marketing should be involved in the presentation of scientific evidence to policy makers. The Science Group of the EUAHF should therefore be re-established as an independent expert group, free from membership from economic operators.

In addition to the existing structure of CNAPA and EUAHF, Eurocare advocates for the establishment of a framework for a civil society dialogue on alcohol related issues. There are several options on how to structure this dialogue, and one of them could be to extend the scope of the existing EU Health Policy Forum and include the process within this forum.

Q 5. Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?

The previous strategy established funding streams for alcohol research, including the Alice Rap and AMPHORA projects, however the absence of an EU Alcohol Strategy presents the threat that research grants will not be made available to investigate alcohol harm.

Whilst there are funding streams available within EU programmes for alcohol research, there is an urgent need for better data on alcohol in Europe and coordination of alcohol research, both of which should be addressed in a new EU Alcohol Strategy. The European Commission’s evaluation of the Alcohol Strategy to 2012 highlighted that less than 3% of the total budget of the Health Programme for 2008-2013 and less than 1% of the budget for health under the Seventh Research Programme were allocated to alcohol. This is not sufficient given the harm cause by alcohol.

The European Commission’s Committee on Alcohol Data Collection, Indicators and Definitions outlines three key indicators for monitoring changes in alcohol consumption and alcohol-related harm. These indicators measure:
• Volume of consumption (total recorded and unrecorded per capita consumption of pure alcohol in litres by adults (15 years and older), with sub-indicators for beer, wine, and spirits);
• Harmful consumption pattern (intake of at least 60 g of alcohol on a single occasion at least once per month during the previous 12 months); and
• Health harm (years of life lost – YLL attributable to alcohol, with sub-indicators for alcohol-attributable YLL from chronic disease and injury).
• The WHO European Alcohol Action Plan recommends that regular reports on alcohol are prepared covering the following five topics:
  • Drinking among adults, including trends in alcohol consumption, types of alcohol consumed, socioeconomic variables, demographic characteristics, drinking and pregnancy, adults’ drinking behaviour and knowledge of alcohol, and geographical patterns of alcohol consumption;
  • Underage drinking, including trends in alcohol consumption, types of alcohol consumed, socioeconomic variables and drinking among different ethnic groups, associations with other substance use, and drinking behaviour and knowledge of alcohol;
  • Drinking-related ill health, including hazardous, harmful and dependent drinking, consultations about drinking with health professionals, alcohol-related hospital admissions and alcohol-related mortality;
  • Availability and affordability of alcohol;
  • Costs to society, including expenditure on alcohol-related harm, alcohol-related crime and alcohol-related traffic accidents; and
  • Policy responses, including all the policy outcomes of [the WHO] Action Plan relevant to a country related to leadership, awareness and commitment, health services’ response, community and workplace action, drink–driving, availability, marketing, pricing, reducing intoxication, and reducing the impact of illicit and informally produced alcohol.

At present several Member States collect relevant data on alcohol harm and consumption, however there are many countries where sufficient data is not routinely available. We recommend that an EU Alcohol Strategy includes funding mechanisms for data collection for the above indicators, so that alcohol harm and policy progress can be monitored and evaluated across the EU.

Q 6. Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

Tensions exists between the promotion of free trade (under Article 34 of the EU Treaty) and the conditions upon which Member States can restrict free trade, including the protection of public health (outlined in Article 36), through fiscal measures for alcohol within the EU. Current EU regulations have the ability to undermine Member States’ efforts to implement pricing policies designed to protect public health. The abolition of the duty paid allowance system effectively undermined countries with higher taxation rates for alcohol, and
Scotland’s plans to introduce minimum unit pricing for alcohol could potentially be thwarted by a legal decision made in the European Court of Justice.

In 2012, the legal challenge to Scotland’s plans to introduce minimum unit pricing, launched by the Scotch Whisky Association and Spirits Europe, generated an unfavourable and ill-informed opinion from the European Commission. This did not correctly differentiate between the roles of minimum unit pricing and taxation, and recommended that taxation alone could achieve the same objective of reducing consumption of cheap, strong alcohol amongst harmful drinkers. However, the EU Directive on alcohol taxation actually prohibits the implementation of a taxation system for all beverages based on their alcoholic strength. Indeed, this is one of the many reasons why the Scottish Government turned to minimum unit pricing as a policy solution to the problems caused by cheap, strong drink in Scotland. Minimum pricing and taxation are complimentary policies and are not mutually exclusive.

Questions have been referred to the European Court of Justice (CJEU) for clarification by the Scottish Courts in the legal challenge. If the CJEU responds unfavourably against minimum pricing, which has been ruled by Scottish Court of Session as a proportionate response to a public health need, this will raise a key issue regarding the role of the European Courts in re-assessing evidence considered by elected legislatures within Member States. This would raise questions about subsidiarity and the margin of appreciation between Member States and the EU and could potentially have adverse consequences for wider public health policies than alcohol.

18 September 2014
TUESDAY 18 NOVEMBER 2014

Members present

Baroness Prashar (Chairman)
Viscount Bridgeman
Lord Tomlinson

Examination of Witnesses

Mariann Skar, Secretary General, Eurocare, and Eric Carlin, Scottish Health Action on Alcohol Problems.

Q99 The Chairman: Can I repeat my thanks to both of you? As you have been sitting listening, you know the format that we follow and you also heard who we are, so I will not reintroduce ourselves. Is there anything you want to say to us by way of introduction?

Mariann Skar: I can say thank you very much. It is a very good opportunity and, as European alcohol policy allies, we are very pleased to be here and meet you and also that you are doing this inquiry on the EU alcohol strategy. It is important.

The Chairman: Would you like to make any comments?

Eric Carlin: Yes—the same thing. Thank you very much for allowing me to join. Mariann and I work very closely together on alcohol policies. It is a great opportunity for us to be here together. I also would like to say it is useful to have your written evidence produced. It was useful to be able to go through and see what arguments have been prepared in advance in terms of our own preparation.

Q100 The Chairman: The purpose of it is to get the debate going. I would just like to start by asking you what the key achievements of the EU alcohol strategy from 2006 to 2012 were. Did it achieve its overall objective of reducing alcohol-related harm?

Mariann Skar: I can start. One of the main achievements is the way it has increased partnerships and networking across Europe. That we are sitting here today shows that. We have members and it has increased the meeting points and the possibilities to work together. It has increased knowledge and I think one of the most fundamental issues is that we can exchange knowledge and share good practices. That is maybe my number one. Has it achieved everything? No, but it is on its way and I think that is why it is so important to get a new strategy because we have started and you cannot stop it mid-air. We have to continue...
on this good path. Consumption is going down, but we are still drinking twice as much as any other region in the world. There is still a lot to do.

One of the good achievements is we have increased age limits across Europe, so we are now much closer to 18. Today it is 20 countries. It was far lower before. More than 16 countries have introduced stricter opening hours and 14 countries have restrictions on sales of alcohol in petrol stations, which we think is very important because that is the one place we do not want alcohol to be sold—when you are driving a car and so on. There is a widespread voluntary labelling about drinking during pregnancy, drink driving and the age issue is slowly getting better.

**Q101 The Chairman:** Is it different in countries?

**Mariann Skar:** Yes, it is different in countries, very different, and it is also different from the producers’ side. Some are putting it on and some are not. So we have a long way to go. We want regulations here so that it is 100%. France is the one country that has started on this, showing the way from 2007.

I also wanted to mention marketing because Lars Møller was saying that is the one place where not much has happened and that is true, but there is a lot going on and the discussions on marketing have increased tremendously over the last years when several countries have discussed whether to have restrictions or not and we have a lot of restrictions. 11 member states have prohibition on advertising spirits on TV; 16 have watersheds, so advertising is not allowed during certain hours. We had the loi Evin in France, and things are pretty similar in Sweden and Norway, which is in the European Economic Area. In 2015 Finland is introducing new legislation stopping advertising on gaming apps. They are the first country to introduce restrictions on what is happening on the internet, so we are looking forward to seeing what happens. Lithuania is another country that has been following this or is discussing stricter regulations. They have not done it, but they will.

**Q102 The Chairman:** Do you attribute these to the alcohol strategy or are there other factors at play?

**Mariann Skar:** I would say both, but the strategy puts the focus on it and it increases the discussions. It is always difficult to say if it is one or the other, but at least it puts member states together: NGOs, public health experts and other stakeholders, industry and so on. I think it pushes.

**Eric Carlin:** I am sorry I missed my cue earlier on. I came in too early. Picking up on that, what we think is that the fact the alcohol strategy exists keeps in the public profile that alcohol harm remains significant and interventions can take place that can reduce those harms. Just its very existence makes a statement that has an impact and including the same people, like us, working together. However, I think it is difficult to say what would have been achieved if it had not been in place and I think it is unfortunate that there were no SMART targets for the strategy.

Can I just pick up some specifics related to having the strategy? We strongly agree with the WHO’s statement about all children and adolescents having the right to grow in an environment protected from the negative consequences of alcohol consumption and, to the greatest extent possible, from the promotion of alcohol beverages. We strongly think that is a human right that young people should have. Two specific actions that have come from the
strategy were the review in 2009 by the science group of the European Alcohol and Health Forum of the evidence, looking at the impact of marketing on the volume and patterns of drinking alcohol, concluding that alcohol marketing increases the likelihood that young people will start to drink and, if they are already drinking, they will drink more in terms of amount and frequency. That was a very useful and important report.

Subsequently there was the RAND report in 2013 on alcohol marketing, demonstrating that adolescents in the UK and the Netherlands were more likely than adults to be exposed to advertising on television. You will have read these reports, so I will not go through all the findings, but two things were quite interesting. These reports are constantly challenged by industry representatives, who do not like the findings. The other thing is that the findings were different in Germany from the findings in the UK and the Netherlands for this report and, rather than interrogate what the different circumstances were, the industry chose to just rubbish the report and say it was not valid and we should not pay any attention to it. I think that is unhelpful because if there are different circumstances where things can be better we ought to be learning from those.

Mariann Skar: On other areas, we wanted to point to drink driving, but Lars Møller went through it quite well so we do not have much to add. We see progress and we are calling for harmonisation because we cross the borders with our cars quite frequently, especially those who live close to a border.

Q103 The Chairman: Looking back, do you think the five priorities of the last alcohol strategy were the right ones? Did some work better than others?

Mariann Skar: Some worked obviously better than others. I would have preferred the WHO to focus far more on advertising, price and availability. I think those are the main things, but we also want to focus on cross-border issues such as labelling, which we think is extremely important.

Eric Carlin: I think there are some changes that have happened over the period of the strategy and you are hard-pushed to say are definitely causally related, but one figure is that the European Road Safety Observatory estimated that road fatalities in 24 EU countries dropped by 44% between 2000 and 2010. Now, that is quite a startling change and it must be related to regulation and enforcement of drink-driving limits.

Q104 The Chairman: What do you think the new EU alcohol strategy will be and where should the emphasis be? Should there be a specific alcohol strategy or should more emphasis be placed on health in all policies in terms of a mainstreaming approach instead?

Mariann Skar: We absolutely want health in all policies but we think those two things can be combined and we do think it is extremely important to have an EU strategy.

The Chairman: You would like both?

Mariann Skar: We want both, yes. Eurocare has been calling for a new strategy since 2009—we had an evaluation on the ways forward within that strategy and later on—together with more than 20 European NGOs and 18 national NGOs. We have just now launched a new call, so you are getting us fresh here, with what we recommend to be within that strategy from our side.
**Eric Carlin**: Like Mariann, I do not agree with the implication that we need to choose between an EU strategy and mainstreaming through health in all policies. However, I think your questions correctly identifies a problem that exists within the Commission, namely that the alcohol strategy has been located within and led by DG SANCO, but it should be an overarching strategy owned by member states and by the whole Commission. We are very clear that alcohol-related harm does not seem to be taken into account when issues like cross-border trade, taxes and agriculture are discussed and regulated by directorates of the Commission who are not directly working on health.

You may have it presented to you that there is an absolute divide between business interests and health interests and we would challenge that. We believe that concerted action to reduce alcohol-related harm creates a healthy, happy, active workforce and that is good for business. We think there needs to be a culture shift within the Commission that understands that and takes it on board.

Can I give you an example of where we think that was not taken on board? It was in the Commission’s response to the Scottish minimum unit pricing court case in 2012, which was ill-informed, inaccurate and plainly wrong and strongly influenced by industry lobbying. From the discussions that we have subsequently had with DG SANCO officials, it appears that they were not even involved in preparing that response. Now, because Eurocare are taking a lead and a consortium of NGO partners across Europe has picked up the responsibility of clarifying and informing the Commission and member states about the policy and its appropriateness—legal in Scotland since 2012, voted through Parliament without a single opposing vote and specifically intended as a Scottish policy for a Scottish context—DG SANCO now say to us that they support the policy. However, I think it is pretty unlikely that the Commission as a whole will radically change its position because the industry is far better placed and better resourced in terms of lobbying than we are.

**Mariann Skar**: Eurocare are slowly getting more into the other DGs, so we do work on health. We are part of the civil society dialogue on trade and agriculture and in DG Connect on better regulation and so on. We are participating as far as we can manage with a team of three people.

**The Chairman**: What you are saying is you would like a more specific alcohol strategy that has an impact on work across borders where it has impact on pricing, taxation or whatever. So the specific strategy could be used as a leverage to mainstream those things. Is that what you are saying?

**Mariann Skar**: Yes, on all the cross-border issues. That is the main thing.

**Eric Carlin**: Absolutely.

**Q105 Lord Tomlinson**: Chair, I have a couple of general questions before coming to a couple of specific ones. Why do you think the last strategy died in 2012 and we went all the way through 2013 before getting round to trying to resuscitate it in 2014? If it was a very important strategy, why were we so disdainful about it?

**Mariann Skar**: That is a very good question, because the interesting part is that in 2012 Eurocare was not the only NGO that called for it. My friends behind me here also called. Even industry was sending press releases calling for the Commission to move forward. A number of member states were calling. If I have the numbers correct, 13 or 14 Health
Ministers wrote to the Commissioner asking for this. I think the Commission was simply dragging its feet or was not willing to do it.

**Lord Tomlinson:** Does that not give you an indication of the utility they felt lay behind the strategy or was it just indolence on their part?

**Mariann Skar:** To be fair, they had a number of strategies in place. There are two different schools of thought here also. There were maybe some who did not want so many strategies. There was a health strategy, a nutrition strategy, an alcohol strategy and an inequality strategy. There were a number of them. Maybe they had to think about how they should move forward, in all fairness, but they were a bit too slow for my liking.

**Lord Tomlinson:** I will not press it any more.

**Eric Carlin:** There are a couple of things here. We are members of the European Alcohol and Health Forum and we were consistently told through that group that the strategy continues even though the strategy date ends, so until we have a new strategy the old strategy continues. Of course, it did not make sense, but they would say this to you and repeat it to grind you down to the extent that you said it made sense.

**Lord Tomlinson:** It was very much, “The strategy is dead, long live the strategy”.

**Eric Carlin:** Exactly. We have had a series of meetings with Eurocare and with Commission officials including with the previous Commissioner, Commissioner Borg, and our understanding was that there was not sufficient agreement around what should go in a strategy across the Commission. There was so much division that they could not proceed with introducing a new strategy. We were then browbeaten down to accept a far more restrictive short-term action plan focusing on areas where they thought they could get general agreement even if it was not comprehensive. As NGOs we accepted that as a temporary measure, but it does not fill the place. We need to have that more comprehensive approach.

**Q106 Lord Tomlinson:** The other question is a purely factual one so I do not want any quantification of it. As European NGOs, do you receive any subvention from the Commission?

**Mariann Skar:** Yes, 25% of our funding comes from the Commission.

**Eric Carlin:** We are UK based. We are a partnership of the medical royal colleges in Scotland, such as the Royal College of Physicians of Edinburgh.

**Q107 Lord Tomlinson:** I will come to the specific questions that I wanted to raise. From a public health perspective, what do you believe is the added value of an EU strategy as opposed to national strategies on the one hand or a WHO strategy on the other? Are you aware of any cases in which the previous strategy had, for example, a direct effect on national policies?

**Mariann Skar:** We want both a national strategy and a European strategy. What we saw was, after we got a European strategy, several other countries came after and got a national alcohol strategy. We do believe that these two are closely linked and they should be based on the WHO’s recommendations. You ask if I can prove that this has happened. It is always a matter of policies, politics, what is going on and what happened.
When I ask my members how this EU strategy has been working in their countries, I get different answers depending on which country they come from. My vice president is from Estonia. He says that this has been extremely important in driving discussions on alcohol policy in Estonia. They still do not have a national strategy, or they just got it, but it has been helping them tremendously. If you go to my Swedish members, they say this whole EU strategy is rubbish. It is not targeted, it is not important and the areas it is discussing are not of value.

**Lord Tomlinson:** But that is because of the absolute clarity of their domestic policy.

**Mariann Skar:** Exactly. In other countries you do not have that and then this strategy has been helpful and has been pushing the matters forward.

**Eric Carlin:** As I say, we represent the medical royal colleges of Scotland and so, with a public health hat on, we would say clinicians have a long and proud history of campaigning on issues like sanitation, housing and employment as well as on specific diseases and health determinants such as alcohol and drug use. We absolutely believe that reducing disadvantage and influencing the whole environment in which people live is going to be important if we are going to make headway on health issues. We also understand that that is one of the founding principles of the European Union. Article 36 makes clear that member states are permitted to take action to protect the health and life of humans, even it that includes intervention in the free market, and we think that is absolutely important.

The WHO has said national and local efforts produce better results when they are supported by regional and global action within agreed policy frames. That is the concept of subsidiarity and we absolutely agree that every member state should remain free to develop and implement its own health policies, but the EU policy complements national actions. That is all I have to say on that question.

In terms of the Eurocare recommendations, they do lay out a list of what we think needs to be in a new EU strategy. I would ask you to pay attention to those. I think it is pretty boring for you to have me read out a list when you can read them yourself.

**Q108 Lord Tomlinson:** That is fine. You have already partly answered this one by your reference to Sweden. Is it possible and acceptable to adopt a standard set of common priorities that are relevant across EU countries, given the very different cultural, economic, political and social contexts? What differences in drinking patterns do you see between northern, southern and eastern European countries? I use “European” somewhat wrongly because I am referring to European Union countries.

**Mariann Skar:** It is as you say: there are differences in levels of consumption. It is also very easy to go into stereotypes and say that the Italians are like that and the Polish are like that and so on. It is a dangerous way to go, but we have to remember that people are highly mobile today. People move around and learn from each other and we can see that in the drinking patterns. In the Nordic countries and the UK, binge drinking has been part of the culture for some time while in the south people traditionally drink alcohol with meals, but this is changing. Our Spanish members and the Spanish ministry are very concerned now about binge drinking among young people. We also have this exchange of knowledge here, not always the positive but also the negative ones. In the north, people are drinking more and more every day, including binge drinking. For instance, in Norway consumption has gone steadily up. It is still very low, but it is going up.
Lord Tomlinson: With oil incomes, they can now afford to buy it.

Mariann Skar: It is highly priced, but it is still affordable. It depends on affordability. Different drinking patterns do need different solutions. You have the minimum unit price in Scotland, which is one very good example. People do cross borders and as, for example, with drink driving there are areas where policies or principles are often very transferable from one country to another even if the drinking patterns are different. Did I answer your question?

Eric Carlin: Can I pick up on and add to that? Just because principles are transferable does not mean they need the same health policies in every country, but policy needs to be evidence based and it needs to be democratically endorsed by elected parliaments rather than being influenced by threats, bullying and lobbying by global alcohol producers, as we have had happen in Scotland with minimum pricing.

Can I just say something else in addition to that? You have to recognise that you have a global alcohol market and global marketing, but that does not mean producers in every country operate in the same way. We have had a very good partnership with C&C, who produce Tennent’s lager, which is the largest-selling lager brand in Scotland. They support minimum pricing because they do not believe that you have to have an unethical business model to run a successful business.

Viscount Bridgeman: What is the outcome of the Tennent’s case?

Eric Carlin: C&C support us. They have spoken on platforms saying they believe that minimum pricing is an evidence-based health policy by a democratically elected Government and it is appropriate to support it and it should not be opposed by the global alcohol producers in the way it is being opposed.

Q109 Viscount Bridgeman: This is very much against the background of Dr Møller’s very positive comment on the absence of marketing in the strategy document. The first three of my questions are: what is your opinion of the gaps in the evidence available regarding pricing and levels of consumption, advertising and levels of consumption and availability and levels of consumption? There is a fourth one that I might ask later, but what is your comment on those first three?

Eric Carlin: I think Dr Møller made very clear that the three best buys for the WHO, which are evidence based, are controls on price, availability and marketing. In terms of evidence of that, if you look at the problems we have in Scotland, alcohol is 60% cheaper than it was 30 years ago and, according to RAND Europe, the cost falls over recent years have been greatest in the Baltics, the UK and eastern Europe—so the issue is where it has come from—and least in Italy, France, the Benelux countries and Germany. The price falls and harms have followed each other pretty closely.

Viscount Bridgeman: I did not quite get the distinction between those two groups.

Eric Carlin: Where alcohol is more affordable, harms have increased, broadly. We also believe there is a need for better data on alcohol in Europe. I am sure you have heard that consistently. Several of the recommendations within the Eurocare paper refer to that. Also, in relation to pricing controls, some parts of the industry constantly go on about having no evidence in relation to minimum pricing, the research is flawed and there is no empirical evidence. I even noted in some of your written submissions they were suggesting that the
University of Sheffield agreed with them in relation to that, so I am pleased that the University of Sheffield made a submission and made clear what their position was.

Q110 Viscount Bridgeman: The fourth one was harm caused to others than the drinker. This is an interesting line, is it not?

Mariann Skar: It is a very interesting one. That was the reason for a lot of alcohol policies previously, in the early 1900s, where the focus was far more on harm to the others—to the family, children and the economic atmosphere. Today we have more focus on the harm to the individual rather than society. When we look at the harms to others, both the family and the children, we know there are a lot of children who are affected by alcohol. We know a lot of young people are troubled by it. We know that the cost to society and the workplace is tremendous: €156 billion, so it costs society.

Viscount Bridgeman: I suppose that would also include the unborn child, would it?

Mariann Skar: Of course. There is low awareness about that, also. As you mentioned previously when you were talking to Dr Møller, women are drinking more and that, of course, will have an impact on the dangers for the unborn child. That makes it even more important to focus on it.

Q111 Viscount Bridgeman: I have another rather specific question. If there is another EU strategy, is there a need for a “scientific group”? How should this be organised and administered?

Mariann Skar: We think how it will be organised is extremely important. We had the other science group, which we were very happy with. It started out with 20 appointed researchers from different areas both from the economic operators’ perspective and a public health perspective. They were rather mixed and they disappeared during the time and there is a lack of funding today. We have a governance group within the European Alcohol and Health Forum where we are discussing this. Because evidence is always contested among our stakeholders, between the NGO sector, public health experts and the economic operators, it is good to have a scientific group one way or another to go through the evidence or to give their comments—as they did on the marketing paper and on the workplace—however that is organised. We did make a paper together with some NGOs on how we wanted it and I have brought it with me here. Time has evolved, but the main thing is we do believe it is good to have a science group, whether it is EMCDDA or the Joint Research Centre or whether we let the Commission use their own. It is not so important how it is organised, but we should have somebody that is relatively independent.

The Chairman: I was about to say that it is not about how it is organised. The independence of this particular group is quite significant. How they are selected, appointed and managed is quite significant.

Mariann Skar: Yes, that I can understand.

Eric Carlin: We did look at your report in relation to drug issues and you strongly praised the European Monitoring Centre for Drugs and Drug Addiction in that report and we suggest that a model along those lines would be very useful. How you organise that within resource constraints and organisational constraints I do not know, but I think the model is a good one.
Q112 **Lord Tomlinson**: Is it not the case that President Juncker has decreed there will no longer be a chief scientific adviser? What sort of signal do you think that gives to people who are involved in wanting a scientific base in terms of decision-making, or is that too political a question?

**Eric Carlin**: We are very political.

**Mariann Skar**: We are political, but we do not support him on that issue. You have policymaking—that is one thing—but you still need some evidence behind your policymaking, and then you have to take a political decision.

**The Chairman**: Has he indicated what he intends to replace it with if he is getting rid of the chief scientific adviser? Is he thinking of doing something differently?

**Mariann Skar**: I do not know. I am not sure what he is thinking. It is rather early days now to see how it will evolve. I do not know. There might be others who know better.

Q113 **Viscount Bridgeman**: We now come to a question that has exercised us a lot in evidence about the involvement of the industry. Dr Møller was very positive about the WHO approach. I am well aware that in present company we have representatives of the industry, but what role should the alcohol industry play in the development and implementation of the new EU strategy? What is your experience of co-operation between industry and the public health sector under the previous strategy?

**Eric Carlin**: We have prepared a response on this together, none of which should be surprising. We welcome the WHO’s guidance that the industry’s participation be restricted to the role of developers, producers, distributors, marketers and sellers and they should not have any role in the formulation of alcohol policies. In explaining that, we have to acknowledge that public health and NGO stakeholders and economic operators have important competing interests: they make a profit from sales while we work to prevent alcohol-related health and social harms. That means that we often support actions to reduce availability and consumption, which places us in direct opposition to them.

The UK has not been very good on this recently. There have been problematic relationships recently. I think you must be aware that the new UK Civil Service head, John Manzoni, was forced to give up his £100,000 directorship of SAB Miller after public health advocates protested. I think he still holds on to it until next year, but the basis on which he was retaining it was that there was no conflict between Government policy and alcohol industry interests. We also had that situation with David Frost, the chief executive of the Scotch Whisky Association, who was in charge of TTIP negotiations for the UK Government while he was waiting to take up his post. We think those relationships are problematic.

More specifically, at the EU level the commitments to the European Alcohol and Health Forum have largely been untested and are unproven in relation to their efficacy both in relation to the principle of whether they are right things to do and whether they are being done well. We and Eurocare have decided to try to be part of that group and to be as positive as we can be within that context, but the industry representatives are often bullish in rubbing what we present as valid research and in attacking health positions. I will give you an example of that.
We had a meeting of the European Alcohol and Health Forum on 6 November this year and spiritsEUROPE challenged the appropriateness of Eurocare’s commitments, suggesting that health advocacy was not an appropriate commitment. At that very same meeting, Carlsberg laid down its commitment to do more messaging in leisure festivals and sports contexts. We have serious concerns about Carlsberg motivations in doing that and we do not agree that alcohol advertisements should be permitted in sports venues. We also believe that the targeting of festivals is targeting young people, including underage young people. Under the guise of promoting responsible drinking, advertisers are often promoting drinking per se to non-drinkers and normalising as drinking contexts venues that might not otherwise be drinking contexts.

In conclusion, there is a cynicism that we think hangs around these kinds of actions that undermines the trust and goodwill that is necessary if we are going to be able to work together constructively with the industry.

Q114 Viscount Bridgeman: Thank you. I think that it is common ground between everybody that policy is formulated and decisions on policy taken by national Governments. Within that framework, what should be the role of public health professionals and non-governmental organisations in formulating alcohol policy at the European level?

Mariann Skar: We believe that it should be politicians who decide the policy, take the leadership and have the responsibility. Of course, we think this can be better informed. We see the role of public health experts and NGOs as to inform and that is our main role. It is to gather as much evidence as possible and to inform, while the policymaking is at the political level and should be done by decision-makers and policymakers.

Eric Carlin: We believe that it is the responsibility of national Governments elected by the population to formulate policies. The public health professionals and NGOs can support this by: facilitating dialogue with civil society; advocacy on behalf of individuals and groups, especially the most marginalised groups; reviewing the evidence base for intervention without any ulterior—i.e. profit—motives; drawing on grassroots programme experience to recommend effective approaches; and also supporting evaluation. In terms of how to do that, it is important that NGOs have consistent support, and policymakers need to understand that they are not doing favours to NGOs by having us in on this policy process. Your policy will be better by having us there, including when we challenge Government decisions. That leads to better policy.

We have been lucky in Scotland that we have that relationship with the Scottish Government and they have also understood that we need to work collaboratively with our European partners. That is how we have achieved this good relationship with Eurocare, but we should be aware that, in terms of resources, my organisation has two part-time staff, including me, and Eurocare has three staff. If you pit that against the resources of the alcohol companies and lobbying companies, even in Brussels, it is clear there is a democratic deficit.

Q115 The Chairman: You have made reference to the European Alcohol and Health Forum, which both of you participate in. Can you tell me how it works and how effective it is?

Eric Carlin: That was to be one of my follow-up questions, if Mariann did not have anything else to add. One of the things I think you should be aware of is that, although there are challenges and conflicts of interest, we have made progress. If you go back to 1993, the European Commission funded the Amsterdam Group to publish a publication called
Alcoholic Beverages and European Society, which was described as a comprehensive review of the role of alcoholic beverage in European society and as a reliable source to devise balanced and socially-responsible alcohol policies. Within its recommendations it suggested that the EU dialogue on alcohol should exclude scientific researchers and all settled society organisations including medical bodies. We have made progress from where we were. Therefore, we welcomed the establishment of the forum. It has been good in terms of giving opportunities for NGOs to come together at regular intervals to exchange ideas and plan. It has been good to hear about what the economic operators say they are doing, but we do believe there is an urgent need to review how it operates. We talked about involvement in policymaking. It is not meant to be a policymaking body, but it does veer into policy discussions.

The Chairman: What are its terms of reference?

Mariann Skar: It has a charter where the main thing is we do voluntary actions. All partners in the forum have to commit to do a voluntary action and then it is up to the partners to describe what voluntary action they choose to do.

Eric Carlin: But it does not have an ongoing workplan. It needs an ongoing workplan. It needs to have achievable, measureable outputs. The commitments need to be evaluated in terms of whether they are worth while doing in the first place and whether, when they are done, they are done in ways that are meaningful what happens from that. We understand that the Commission needs to speak to industry and we have made recommendations about how we separate out those discussions, so we are not conflicted in the way we feel and we do not feel that much attention has been paid to those recommendations. We have recommended that NGOs can meet separately, formally, with Commission officials specifically to make recommendations on policy. We think we have a role in that in a way that economic operators do not. You have also raised the issue of the science group's function.

Q116 The Chairman: In terms of the next alcohol strategy, do you think this forum should continue? If so, what should its focus be? You have made recommendations, but is there something the group itself is looking at in terms of what input you make to influence the next strategy, in terms of what its role might be?

Eric Carlin: I think we need to have a discussion about this. I do not think this is straightforward. I think that it is not aligned to different strategies, so it is not like 10 strategies. I think we have to have a strategy in place and then look at where it is useful to have the input from NGOs and where it is useful to have the input from industry and how to best facilitate that. I think that requires us getting some heads together rather than a simple answer because if a simple answer could come up with it, it would have come up with it before now.

Can I say something about CNAPA, because CNAPA is related to this? I also note this is where there is some commonality between what the industry people have submitted to your Committee and what the health people have submitted. I think everyone has said that CNAPA needs to be looked at and the forum needs to be looked at. I think member states need to prioritise and nominate officials to CNAPA who are equipped to speak on behalf of their Governments and to act to ensure that they gain cross-government support for the policy positions that they take.
I think the relationship between CNAPA and the Commission needs to be revised and improved and a new energised and empowered CNAPA needs to make clear to Commission officials that the Commission’s role is to support CNAPA’s policy decisions, not to block, undermine or even partially disown them as sometimes happens—for example with the new action plan, where a bit of a battle went on behind the scenes to get the Commission to include mention of the action plan within the recently produced document which considered the governance of the European Alcohol and Health Forum. The Commission needs to own the action plan and, hopefully, the forthcoming strategy.

Also, to come back to this thing about independent scientific advice, CNAPA needs to be supported by independent advice and the Commission needs to prioritise establishing arrangements to facilitate this. I think the discussion that went on behind the scenes very recently was, “This is CNAPA’s action plan; it is not the Commission’s action plan”. They have now changed that and it is the Commission’s action plan, but that is not helpful.

**The Chairman:** Are there any questions? Is there anything else you want to add?

**Mariann Skar:** I just want to say that I brought with me here our recommendations, our NGO comments on the future strategy, our recommendations for changes for the forum, something about minimum unit pricing called *Scotland the Brave!*—*Alcohol Policy in Scotland* and something about the meeting we had here in Brussels on the minimum unit price, together with the industry.

**Eric Carlin:** That is a demonstration that industry and health can work together.

**The Chairman:** For a short staff that is very impressive.

**Eric Carlin:** We do not get much sleep.

**Mariann Skar:** It is a lot of papers.

**Lord Tomlinson:** She wanted to go home lighter than she arrived.

**The Chairman:** Thank you very much indeed for your time. It has been very valuable and we are very grateful to you for your evidence. Thank you.

**Mariann Skar:** Thank you very much for having us.

**Eric Carlin:** Thank you.
WEDNESDAY 19 NOVEMBER 2014

Members present

Baroness Prashar (Chairman)
Viscount Bridgeman
Lord Tomlinson

Examination of Witnesses

Giovanni La Via MEP, (EPP, IT) Chair of ENVI Committee, Glenis Willmott MEP, (S&D, UK) Member of ENVI Committee, and Valentina Barbuto, Parliamentary Assistant to Piernicola Pedicini MEP (EFDD, IT) who is a Member of ENVI Committee

Q153  The Chairman: Thank you and your colleagues for your time this afternoon. We are very conscious that you have a very busy schedule so we are all the more grateful that you have given us time. Maybe I can start by introducing my colleagues. Lord Tomlinson is a Member of the Sub-Committee and a Labour Member of the House of Lords. Lord Bridgeman is a Conservative Member of the House of Lords and a Member of the Sub-Committee.

I do not want to say a great deal by way of introduction other than that we have launched an inquiry into the alcohol strategy and that we are looking at how the strategy from 2006-2012 worked and what the strategy might be for the future. We are taking evidence and we have talked to a lot of people in the UK and from the industry. Yesterday, we took evidence from industry here, Eurocare and so on. This is our discussion with you as MEPs. It would be useful if we can start by looking at what you would like to see in the next strategy, how the other one has worked and what your input is into the development of the next strategy.

Giovanni La Via MEP: We are working beside the Parliament to give assurance to all European citizens on the safety of food and that we will increase the level of assurance. It is clear that we are working on labelling and the origin of food for giving additional information to European citizens. As you know, in the next month our decision made in 2011 on the labelling of food is going to enter into force and with these regulations we are going to have additional information for the European consumer. That is the first point.

It is clear that we are discussing among us other points that are not at this stage agreed and on which there are different opinions. On the origin of raw material, some Members of the
European Parliament from the southern countries and from some other countries in central Europe want to see the origin of raw material also in the transformed agri-food sector. Other Members do not want to see the origin and they want to say only that we are going to use EU raw materials. On this subject we advanced a discussion inside the Parliament but we have not agreed a decision.

Other important issues are related to the content of food because, as you know, we have clear opposition to the UK’s proposed traffic lights. Inside the European institutions we say with all respect that it is not important how much fat, sugar or other elements we have in one food but it is important how you combine your diet. If you start consuming half a kilo of cheese every day it is clear that in a short time you are going to have a lot of health problems, but if you are going to use 30 grams of cheese one day yes and one day no, it is not a real problem for your health. Then it is not a problem of food; it is a problem of how you are going to combine your diet. For this reason, in the Parliament but also in the Commission, the European institutions, we are going to say that it is not possible to evaluate single foods without seeing what is the composition of the diet. On this, we have an open issue with the United Kingdom Government on traffic lights, as you know well.

There are also some issues that are related, for instance on labelling in the alcohol strategy. At this stage, the food producer, the wine producer and the alcohol producer are not obliged to put the energy value on the labelling. This is also a wide and clear discussion in the Parliament. Probably we will have discussion on this point in the next six months and I do not know what the final decision will be.

Also on this point there are many differences between wine country producers and wine country consumers, but it is clear that it is not so easy to find a clear majority and a clear common position in all 28 member states. From my personal point of view, if we are going to explain to European citizens what the content is in terms of energy of the alcohol limits, it is clear that we have also to explain to them what we are putting inside: if we add sugar, if we are going to discuss only wine producers with grapes or if we have some other additions. If we want to be clear with the consumer, we have to show the whole and then the consumer will be able to choose, to make a clear choice with a wide range of information. This is my personal point of view but we have to discuss this and probably we are going to have a long discussion in the chamber.

_Glenis Willmott MEP_: I think you were asking about the alcohol strategy specifically. Food labelling is a slightly different thing.

_The Chairman_: Yes, I was.

_Glenis Willmott MEP_: Let us look at the achievements that we think the alcohol strategy brought. We have the alcohol strategy from 2006 to 2012. It certainly increased cooperation among member states, which I think is a good thing. More countries now have national alcohol strategies in place. Ten countries adopted or revised a national strategy after 2006, so that has to be seen as a positive thing. The Committee on National Alcohol Policy and Action, one of the bodies set up to support the strategy, has helped to build a consensus across the member states. About 50% of member states now have restrictions on price promotions of alcoholic beverages and about 50% have a licensing system in place for on-premise and off-premise sales. All member states do awareness-raising activities that they would not have done in the past. There are age limits on purchasing alcohol in all member states and age limits for drinking alcohol in more or less all of them.
Should there be another alcohol strategy? That is a key question. I think there should be. Our priorities should be protecting young people, children and of course the unborn child. We need to look at what more we can do. We do a lot now, but how do we reduce injuries and deaths from drink-driving? How do we prevent alcohol-related harm for adults in the workplace? How do we make sure we inform, educate, raise awareness, and how do we develop a common evidence base? They are all worthwhile priorities and I think we should continue all of those, but we need to look further at the role of alcohol because it has a huge part to play in other diseases: obesity, mental illness, cancer, diabetes and we could go on.

As well as marketing, advertising and pricing of alcohol to address some of the areas highlighted by the WHO as key policies, a strategy would also give member states a chance to discuss perhaps national policies, perhaps minimum pricing. I know it is controversial but I think it should be discussed. We should at least have the discussion about its effectiveness and that should be done from a health perspective rather than a trade perspective. We need to get something in place because the previous strategy has finished and we have nothing in place at the moment. The sooner we get on to having a strategy the better.

Q154 The Chairman: What role do you think that the European Parliament should play in the formulation of the next strategy? What should your role be in that?

Glenis Willmott MEP: We should play a big role in it if we want to get that harmonisation across member states, and I think we all have the same problems. In days of financial restraint, it is a burden on our health services. It is not just about citizens’ health; it is also about the impact it has on the health services as well, so the more we can learn from each other the better. It is not putting legislation in place; it is about talking, looking at best practice and co-operating with each other. We are very well placed to do that because we have 28 member states here that we talk to regularly on health matters. We have a big role and it would be good if we probably worked more closely with people like yourselves in order to make sure we have a strategy in place that is suitable, fit for purpose and is going to make a difference.

Giovanni La Via MEP: I wanted to add that in one of the last meetings of the committee we discussed this issue with the European Commission. We were not very convinced by the answers to our questions coming from the European Commission on the implementation of the alcohol strategy and for this reason we decided to make a formal oral question to the European Commission with a resolution. We are going to work on the text of our resolution with some suggestions and requests for the European Commission and we are going to work on this resolution in the next three or four months for a final vote in the plenary in March or April, when we try to finalise the work that we have done.

Q155 Lord Tomlinson: Glenis, you pointed out with great clarity that the strategy finished in 2012 and here we are getting towards the end of 2014 hoping that we might get a vote on a new strategy in 2015. Why did the two-and-a-half-year gap emerge? Was it just overlooked? Was it a conscious decision of the Commission not to make proposals? Was it diffidence on the part of the European Parliament, which maybe thought it did not want another one? Why the gap if it was such an important strategy?

Glenis Willmott MEP: First of all, I do not think it was diffidence on the part of the Parliament. I have worked for many years on alcohol strategy and it is something I feel passionate about, but we were running out of time to get anything new in place. That was
the problem, because the strategy finished in 2012 and then we were coming up to the European elections, so to get a new strategy in place was difficult. Maybe we ought to look at the period the strategy covers. It should cover the whole Parliament and slightly beyond that in future so we have time to have a new strategy in place.

I think there is broad agreement across the political parties—I am sure you will tell me if I am wrong—that we want some sort of strategy in place. We were very disappointed by the Commission’s answer when we brought representatives to the committee and asked them what is happening to the alcohol strategy. To be honest, they just prevaricated and did not really give much of a clear answer, which is why we are now going to put this question in the committee because we think it is important that we do have some sort of strategy. More and more people are becoming aware of the harm that alcohol can do. I have heard colleagues from some parties say we are just trying to stop people enjoying themselves. We do not want to stop people having a glass of wine if they want to. It is about being sensible about this and accepting the fact that alcohol does do harm and it is not just about abuse. We hear a lot about abuse of alcohol. It is about misuse and it is being able to get the message across to people that we are not talking about alcohol abuse—that is an issue and that has to be dealt with—but it is that people are not aware enough that sometimes they are misusing it.

So I think it is very important. But I do not think there is a lack of will on the Parliament’s side. The one good thing I would say is that we now have a Commissioner for Health who is a physician, a doctor who worked with me on clinical trials legislation, so I feel that we have someone now who understands and knows the subject and may be as passionate as some of us about having these strategies in place.

Lord Tomlinson: That is very helpful.

Giovanni La Via MEP: I wanted to add that it is not the first time that we are going to put a question to the Commission on this point, because we have done so in 2013 and 2014. We are going every year to ask the Commission to implement and come up with a new alcohol strategy and we keep asking for information that we need to know that is the result of the previous alcohol strategy, but it is clear that the information that the Commission gave us in answer is not very clear. We listened the last time to something general without details or data and we stress every time for the Commission to give more information but also to come up with a new proposal for the alcohol strategy for the next years.

Q156 The Chairman: Could I ask one point of clarification? Last time I was here when I just saw you briefly you said that you were thinking of this resolution not exceeding March but there was some discussion with the representatives of the Commission and that is why you launched the initiative on binge drinking. Is that something that was pushed by you or pushed by the Commission?

Glenis Willmott MEP: The initiative on binge drinking was not mine. My initiative has always been on raising awareness and the misuse of alcohol and the link with obesity, heart disease and so on. When I did the food labelling and I was the shadow rapporteur for my group—I actually agree with traffic light labelling, by the way, but that is by the by—I tried to get calories labelled on alcohol. I feel that if we are serious about a link with obesity, which there obviously is, people need the information to make choices. They can ignore it, they do not have to take any notice of it, but if that information is not on the alcohol they are
drinking they have no idea that a glass of wine is the same as eating a chocolate bar or a glass of beer is the same as half a pizza or quarter of a pizza or whatever it is. They need to have the information and then they can decide that they want to ignore it and drink as many glasses of wine as they want, but they have the information to make an informed choice. I was very keen to get calories labelled on all alcohol but unfortunately I did not succeed, I hate to say.

Q157 Lord Tomlinson: Can I ask one more question about the bodies that we have? Are the EU-backed Alcohol and Health Forum and the Committee on National Alcohol Policy and Action still the appropriate mechanisms to facilitate the discussion on the exchange of best practice? What are the advantages and disadvantages of industry involvement in the formulation and implementation of alcohol policies?

Glenis Willmott MEP: It is not a body that we work with. It is only what we have been told really, but we are told that its role could be further strengthened. I know that some people advocate it becoming a full working party under the council structure, similar to a horizontal group on drugs, the working party on drugs, and they think it should be something like that. Personally, I do have concerns about industry involvement. In the past in the UK when we have had those sort of initiatives it has been clear that a lot of the NGOs have walked away from discussions when you have had industry involved because they do not feel that perhaps they have health as the top interest. I am trying to be diplomatic. Certainly the WHO guidance states that the alcohol industry should have no role in formulating alcohol policies and I think that is probably right, because if you are putting people’s health first you have to protect from commercial and vested interests. But they obviously want to have their say; they are stakeholders and it is important to them. Some have run responsible drinking campaigns and all of that. So they have to have their say but this strategy should be about health not trade or enterprise, and that is just my personal opinion.

Q158 The Chairman: Could I ask for some clarification about this working party structure? You said it could be instead of the actual committee?

Glenis Willmott MEP: Sorry, it is the Committee on National Alcohol Policy and Action that I am talking about, which is made up of member state experts. It is useful for member states so that they can share ideas and best practice, but they are saying that its role could be strengthened. If it were a full working party under the council structures, I think it would be a stronger group.

Q159 Viscount Bridgeman: Are you aware of any ways in which the EU-funded research by other member states on alcohol-related harm has influenced policies made at the European or national level?

Glenis Willmott MEP: We have had a look at this and there is a project that is EU-funded, the AMPHORA project, Alcohol Measures for Public Health Research Alliance. It published some key findings that EU adults drink 27 grams of alcohol a day, which is more than twice the world’s average, which is weird really. I do not know why that is in Europe but it is. It has done some work on the fact that 138,000 EU citizens die prematurely from alcohol in one year. Again, that is amazing. It has done a lot of work that is really helpful and important. It talks about EU drinkers consuming more than 600 times the exposure level set by the food
safety authority. In many ways, we do get interesting and useful information to use in future work.

Q160 Viscount Bridgeman: Does it also differentiate between the different parts of the European Union?

Glenis Willmott MEP: I do not know that.

Viscount Bridgeman: I am very pleased to say that in Mr La Via’s country health is improving with the reduction in the consumption of alcohol, which I think is common with the Mediterranean region.

Giovanni La Via MEP: As you know, we have a big difference across Europe, with a higher level of consumption in some traditional producing countries and a lower level in different countries. I think it is going to change with a different level of consumption of some final products, with a high increase, especially among young people, of high-level alcohol products, and this is very important to know for improving the next generation’s health. We need to improve a new alcohol strategy with a specific measure for young people.

Viscount Bridgeman: That is very useful. The only rider I would add to that is that recent research in the UK has just come out with the fact that there is now binge drinking among middle-aged women at a higher social level, so maybe there is a need to be flexible on that point.

Giovanni La Via MEP: It is so, because we are going to see a different kind of consumption across the ages, with a specific target for consumption for young people, a different target for people of middle age and probably—and it is a real difference with the past—a high level of consumption by people of an older age. It is clear that we need to know well the evolution, and the new targets of consumption for different kinds of consumers appearing better in the European alcohol strategy will have a better result.

Glenis Willmott MEP: I think that is right. What has come to light is that we have all been focusing on young people binge drinking and it seems to be middle-aged professional women who are going home after a bad day and having a few glasses of wine every night, and we have not thought about that. I think that came as a bit of a surprise to everybody, do you not think?

Q161 Viscount Bridgeman: Yes. We have talked about labelling at length and the advantage of that is it is much easier to make modifications to printing on the labels that exist at the moment. There is also minimum unit pricing and I think we may just have talked about that, and the restrictions on availability, including licensing and age restrictions. Then of course there is always national taxation. Do you have any comments on the factors influencing these?

Giovanni La Via MEP: As you know, we have different experiences across Europe. For instance, the level of taxation is not the same in the different European countries and we have no clear result in the reduction of consumption when you have a higher level of taxation. Then we have to use pricing, taxation and other measures, and combine in our strategy all the instruments that we have in our portfolio. For this reason, information campaigns, taxation, labelling and other measures have to combine for the good result that we want to achieve.
Q162 Viscount Bridgeman: Forgive my ignorance on this, but can national taxation be incorporated at the European level?

Giovanni La Via MEP: As you know, this is not a simple position because you are coming from the United Kingdom that is opposing this position. Some pro-European countries have tried to start a common taxation policy but there is not a clear majority in the European Council on this point. Every time we start to discuss it we are going to see that there is not a majority and we will turn back, and then it is clear that now we have to continue with national taxation policies for the next years.

Viscount Bridgeman: We are well aware that we come from the highest taxed country of the lot.

Glenis Willmott MEP: I think the problem is that every time there is a discussion about harmonised taxation, all the British MEPs go, “Oh no”, because we know this is something that the UK will not even discuss so we try to keep away from that. We have talked about labelling. On minimum pricing, my only concern is that we should look at the evidence on all these things and on the effect that it has had, but we do not want the bigger profits to go to the supermarkets if we have minimum pricing. There should be some discussion about what happens to that extra profit if you have minimum pricing. It should be about tackling the issue of the cheapest drinks, in my view, because we know that people now drink at home before they go out and they drink the cheap alcohol, white cider or whatever it is. I think we have to look at it on the cheapest drinks, but I would also hope that people thought that is not just about more profits for supermarkets. Maybe we could use the profits for some other prevention measures or they could be ring-fenced in some way. I would just make that plea when you are thinking about it.

Q163 Viscount Bridgeman: Of course there is the question of marketing. Lord Tomlinson has referred to the industry’s involvement and that is quite closely linked, of course, with marketing. Has your input from other bodies included things like watershed television for young people?

Glenis Willmott MEP: All I can say is that it seems obvious to me that you have to protect children and young people from alcohol harm so there certainly should be some sort of legislation on watershed. I think that is absolutely right, but I do not have any more information on that, I am sorry.

Q164 Lord Tomlinson: I just wanted to assure you that those who come from the United Kingdom find it quite easy to be against some elements of tax harmonisation and still be very positive Europeans. There is not an exact correlation between support, for example, for things like Tobin taxes and the quality of your support for Europe.

I want to ask you a specific question because you referred to Italian wine. The reforms that have taken place inside the common agricultural policy have concentrated people’s minds on the production quality of wine rather than the quantity and therefore a lot of the worst quality wine has gone for distillation into industrial alcohol. How far has that had an impact on levels of consumption in, say, Italy?

Giovanni La Via MEP: First of all, I want to thank you for your question because in the past legislature I was a rapporteur for the reform of the CAP. I worked on this field and I can
clearly answer. It is clear that we have a big difference between member states in wine production. In the southern Europe region we can produce wine with 14 degrees and in the northern part of Europe we can reach seven or eight degrees, and then we have to enrich the wine with sugar. It is clear that the quality of production is going to increase year by year, especially in the southern countries of Europe. We have reached a very good quality and we are ready to reduce the quantity of wine that is going to be used for distillation. We know well that in the previous reform of the common organisation of the market in wine we stopped the possibility of using distillation for reducing the quantity of wine on the market. Then we had the crisis legislation for member states such as Spain, Italy, Greece and France. For the last three years we have not used this line of budget for the distillation, and then probably we have to move forward for having a better common organisation of the market in wine, changing something. For instance, if some northern countries could not use sugar for the enrichment of their wine, we can increase the level of consumption of concentrated must coming from the southern regions of Europe and arrive at a good quality production, reducing the level of excessive production across Europe and reducing the use of sugar. As you know, at this moment we are not good producers of sugar in Europe and we are going to import it from outside. To use our production in a better way inside the European 28 member states will probably be a common goal for the next reform, for the next five or 10-year programme in agriculture, but all the 28 member states in the European Parliament have to decide together how we can improve the new agricultural policy. It is not possible to continue to support with public money producers who are going to produce something that is not useful for our consumers. On this one, I think that there is a clear majority.

Q165 Viscount Bridgeman: I just have a supplementary. Going back to the marketing, the loi Evin from France is a very good template for advertising behaviour. Admittedly, it was directed mainly at tobacco but certainly included alcohol. This came in about 20 years ago. Has that come back in your output at all?

Glenis Willmott MEP: I do not know anything about that at all. No, you have beaten us entirely on that, I am afraid.

Viscount Bridgeman: Evin was the Minister concerned and it is known as the Loi Evin. I suggest it is worth looking at it because that produces quite a discipline on the market.

Giovanni La Via MEP: We have to study.

Q166 Lord Tomlinson: Is a common view emerging anywhere at all about harmonising blood alcohol levels among drivers? I think we and Malta share the distinction of being the two baddies in this area. Is there any view that it needs to be harmonised, that it should be harmonised?

Giovanni La Via MEP: As you know, this is a competence of the member states. Why? Because we are not going to discuss health but we are going to discuss security, and this is a competence of the member states. Probably we can try to improve the common regulation on this issue, but it is still a competence of the member states and we do not enter the competence of the member states.

Q167 Viscount Bridgeman: Can you tell us if there is a wide disparity in sanctions, on conviction, among the member states for drink driving?
Giovanni La Via MEP, Glenis Willmott MEP and Valentina Barbuto, European Parliament—Oral Evidence (QQ 153-168)

**Giovanni La Via MEP**: It is the same. We can only try to make a recommendation but not a regulation to member states to go forward, but we cannot oblige member states. This is a real problem that we have in front of us.

**Viscount Bridgeman**: The wide disparity does exist, presumably?

**Giovanni La Via MEP**: Yes, it is a wide disparity because every member state is going to take a different decision and then there is not a common goal.

**Q168 The Chairman**: Can I ask another very brief question, which is about the treaties? Do you think the treaties achieve the right balance between the power of the Union and the member states in health matters?

**Giovanni La Via MEP**: It is clear that it is not enough. We have to improve. There is only an article on this point but, as you know, the treaty is an agreement between the member states and if they want to they can always change the treaty, but sometimes they will not or sometimes, as you know, we need unanimity for having a new treaty. As you know, we always discuss our presence in Strasbourg, because next week we will go to the other Parliament that we have there. Is it useful to have two different Parliaments for the same Members in two different countries and to work three weeks in one place and one week in another? But that is the treaty and we cannot change the treaty.

**Lord Tomlinson**: And another Parliament in reserve in Luxembourg.

**Giovanni La Via MEP**: Yes, this is the third one. We do not use that one.

**Glenis Willmott MEP**: If I can add something there. I agree with everything you have said there, of course, but treaty change is difficult as well when you start talking about referenda. If there is a possible treaty change, that makes it slightly more complicated. In terms of health, I think there is more we could do. We do not want to take over national competences for running health services or anything like that, but where it brings added value then we should look at it. For example, I have done a lot of work on prevention. Should we have more prevention strategies that work across Europe? When you are talking about cervical cancer screening, in some of the newer member states that have joined they do not have the same level of minimum standards that we do in some of these areas. Maybe we could do more in that sort of area. As I said, it is a member state competence but maybe it should be reviewed to see where it brings added value, because that is what it is really about.

**Giovanni La Via MEP**: I want to add only one point. We started with the same views with six member states and we want to continue with 28 member states. With six member states it was quite easy to change the treaty and to find unanimity. With 28 member states it is more difficult and we are not going to change the rules among us and we continue without having the real possibility of changing what we want. Sometimes we can decide only on some points but not on others because there is not the possibility of changing the treaty on that point.

**Glenis Willmott MEP**: I think subsidiarity is important though and it should be only where it brings added value. If it is a member state competence and it does not bring anything to it to have things done at European level then there is no point in doing it at European level. It should be whatever makes sense. I think sometimes member states should look at this and it
may be that they can make some changes without treaty change—I do not know—on some of the issues that I have mentioned on prevention strategies and things like that.

Valentina Barbuto: I am Valentina Barbuto. I represent Mr Pedicini, who could not be here today. I did not want to intervene before because I have heard a lot of interesting points that have been already been made and I do not want to repeat myself on them. I just want to say that we support a new strategy and we would like the work to start from where it ended in 2012. We think that the five priorities are still valid as a general framework for action.

Just to add a couple of comments to what has already been said. We think that some areas of further work could be, for example, synergies with existing regulations and legislation. In particular, the Commission has recently started some quite relevant work on how to promote sport and €14.7 billion has been allocated to initiatives in the areas of education and training young people in sport under the new Erasmus+ programme for 2014-20. The sport-related issues were taken on board by the Italian presidency as a priority item. We think that there need to be positive synergies to promote sport among young people and this could also help to tackle the association between athletes and alcohol.

On the EU-funded research, there are funding streams available within the EU programmes and the new Horizon 2020 programme has allocated €1,200 million in the health, demographic change and wellbeing challenge. We would like to work to push the Commission to ensure that alcohol consumption and the related harms are taken into account as an important health issue. To conclude, in principle we are in favour of the three policies that you mentioned in your questions. We are also aware of the fact that, for example, the minimum unit pricing is a very controversial issue, so we are following the case of Scotland and we will be reconsidering our position after the legal process is completed with the ECJ.

The Chairman: Thank you very much indeed for that. I do not think we have any more questions. Thank you very much indeed for your time. It has been extremely useful to meet you and to get your engagement with these questions. Thank you very much.

Giovanni La Via MEP: Thank you for the possibility of this meeting because it is useful to have an exchange of views with a national Parliament. We hope to begin to increase this level of exchange to have better knowledge of the opinions coming from different member states and to make better regulation and legislation at the European level.

The Chairman: I very much hope that our report will help make some contribution.
Transcript to be found under Adrian Brown.
WEDNESDAY 26 NOVEMBER 2014

Members present

Baroness Prashar (Chairman)
Baroness Benjamin
Lord Blencathra
Viscount Bridgeman
Lord Faulkner of Worcester
Lord Judd
Lord Morris of Handsworth
Lord Sharkey
Lord Tomlinson
Lord Wasserman

Examination of Witnesses

Stephen Cummins, Policy Lead on Alcohol, Home Office, and Daniel Greaves, Head of Drugs and Alcohol Unit, Home Office

Q169  The Chairman: Good morning, Mr Greaves and Mr Cummins. We are really grateful to you for being with us this morning, and we do appreciate you giving us your time. Just by way of background, this session is open to the public, a webcast of the session goes out live and a video transmission, and is subsequently accessible via the parliamentary website. A verbatim transcript will be taken of the evidence and put on the parliamentary website. A few days after the session you will be sent a copy of the transcript to check it for accuracy. It would be helpful if you could advise us of any corrections as quickly as possible. If after this evidence session you wish to clarify anything or give us some supplementary points, you are welcome to submit those too. Before I start, would you like to introduce yourselves and say anything by way of introduction?

Daniel Greaves: Yes, I am Dan Greaves. I am head of the Drugs and Alcohol Unit at the Home Office. I am very grateful for this opportunity to feed into your important inquiry. As I trust our evidence will bring out, alcohol is a driver of crime and disorder, and the Home Office has been very active in tackling alcohol-related harm. That is a programme of work that I have led. In many ways, this inquiry is timely, as scoping work is under way around the future of the EU Alcohol Strategy. It is an opportunity for us to air some of our approaches and get feedback from the Committee.
Stephen Cummins: I am Stephen Cummins from the Alcohol team at the Home Office. I have policy responsibility at the department for the delivery of the alcohol strategy. My team also covers issues such as pricing, legislation and strategic engagement. I also sit on the officials group for the British-Irish Council on alcohol policy. I have been closely involved in supporting the Scottish Government in their legal case in defence of minimum pricing legislation in Scotland.

Q170 The Chairman: Thank you. Did the EU Alcohol Strategy from 2006 to 2012 have any effects on domestic law enforcement efforts with regard to alcohol-related crime?

Daniel Greaves: The EU Alcohol Strategy in this sense created a broad strategic framework and was really intended to support the development of coherent national strategies among member states. It was primarily addressed to the harmful effects of alcohol on public health, rather than directly seeking to reduce harm caused by alcohol-related crime. This very much reflected the area of competency within which the EU Alcohol Strategy was developed. For that reason—because the focus was much more on public health than on alcohol-related crime and law enforcement—the impact on domestic law enforcement approaches was limited, notwithstanding the strategy’s focus on drink-driving enforcement. That is not to say that we in the UK have been idle in tackling alcohol-related harms and working with law enforcement. It might help the Committee if I just describe some of our domestic activities to tackle alcohol-related crime.

The Chairman: That would be extremely helpful.

Daniel Greaves: I will bring this out more fully in my evidence, but nearly half of violent crime is related to alcohol. Roughly one in five people think that alcohol-related anti-social behaviour is a fairly or very big problem in their area. So, it has been a big focus for the Government’s Alcohol Strategy. At a national level we introduced police and crime commissioners in England and Wales, and 35 out of the 41 police and crime commissioners have made tackling alcohol-related crime a priority. We have strengthened the mandatory conditions on all alcohol licences to enable tougher action on irresponsible promotions in pubs and clubs. We have introduced a ban on the sale of alcohol below cost price and we have also challenged the industry to do more on a voluntary basis to tackle alcohol-related harm. But much of our action has been at a very local level. We have introduced new powers and strengthened existing powers around dealing with problem premises, such as doubling the fine for persistent underage sales. We introduced a late-night levy to allow councils to collect a contribution towards the cost of policing and clean up. We have worked in partnership with 20 local alcohol action areas. We have also strengthened new anti-social behaviour powers. So, there have been quite a wide range of actions both at a national and critically at a very local level, empowering communities and strengthening the tools for local authorities.

The Chairman: How do things work at a local level? You say you have done that nationally and locally. How do you influence local activity?

Daniel Greaves: Local authorities have a wide range of powers and duties in relation to alcohol, not the least of which is that they are local licensing authorities under the Licensing Act 2003. They have the ability to issue, revoke and review licences, and set up local licensing policies. They have quite wide-ranging powers. I guess one of the ways we influence local activity is by setting out the broad shape of the powers that exist. We have
done that in relation to the late-night levy for example; strengthening powers to deal with problem premises is another. The other is by issuing guidance and helping the sharing of good practice. Another is by challenging the industry to work in partnership with local authorities. The Government have brokered arrangements with the industry to support the 20 local alcohol action areas—rolling out best practice schemes such as Best Bar None, and community and alcohol partnerships—so we can influence this in a range of different ways.

**Stephen Cummins:** Just to add to that point, it is a changing landscape at local level. There have been a number of changes in recent years that we have been supportive of and contributing to. Dan has mentioned the introduction of police and crime commissioners. We have also had the shifting of responsibility for public health to local authorities. We have the creation of NHS England, and Public Health England as well. It is very much a new framework. Our role in central government has been to work with this new landscape to provide as much support as possible and encourage local solutions to tackle local problems caused by alcohol.

**Daniel Greaves:** Yes, and that has included in some respects direct engagement with the 20 local alcohol action areas to help them build the partnerships, the strategies and to lever in the support to enable them to be effective.

**The Chairman:** Do you want to ask a supplementary, Lord Tomlinson?

**Lord Tomlinson:** Yes. You did say that alcohol is responsible for, or related to, nearly half of violent crime. You then, when you were talking about the powers of local authorities, referred to their powers to revoke licences. Do you have any idea, or can you give us any idea, of the number of licences that have been revoked, and what sort of proportion of the total that is?

**Daniel Greaves:** I am sure we will have that information somewhere, but I am afraid I do not have that information to my fingertips.

**Lord Tomlinson:** Do you think you could supply it to us? I would be very interested to know.

**The Chairman:** It would be very helpful. Thank you for that.

**Baroness Benjamin:** You mentioned all the people that you work with on alcohol policy. Do you ever work with universities? Many universities promote alcohol as one of the big attractions for why potential students should come to them. So, do you ever work with universities?

**Stephen Cummins:** Yes, absolutely—on a number of levels. You have mentioned the student element. One of the things we have just launched is an initiative with the National Union of Students, where we are working with seven participating universities on a range of issues in terms of raising awareness of the harm caused by alcohol and doing really practical things within the student community to protect young people and mitigate some of the harms associated with alcohol. We also work with the academic community around building the evidence base for effective interventions on alcohol policy. Another example is alcohol pricing. The University of Sheffield, which I believe has given evidence to this Committee, has led the development of a model around alcohol pricing and minimum pricing. We work with other universities as well. Cardiff University has done some really interesting things around alcohol-related harms. So, the answer to your question is yes.
**Lord Wasserman:** What is the situation in London? You said 35 PCCs have identified alcohol. What about MOPAC in London?

**Stephen Cummins:** Interestingly, on MOPAC, the Mayor’s Office for Policing and Crime are leading the piloting of sobriety tags in four London boroughs. We are working really closely with MOPAC on that, alongside colleagues in the Ministry of Justice. It is a really interesting innovation. It relies on some quite exciting technology which has been developed in the United States. So, we are watching this with interest. We have a very close relationship with MOPAC, and we are really grateful for their leadership in taking this pilot forward.

**Lord Wasserman:** It was very difficult to persuade the Minister to introduce these sobriety tests. I am glad to see you take a positive line on them.

**Stephen Cummins:** Yes. We are very keen to monitor the pilot and look very closely at the evidence, both in terms of compliance and the impact on behaviour. We are watching very closely both in London and the pilots in Northamptonshire too.

**Q172 Lord Sharkey:** Could you say what role excess drinking and underage drinking play in the amount and extent of public disorder? Could you tell us what problems, and the scale of the problems, these issues present for law enforcement?

**Daniel Greaves:** There are three questions there, and I will take them in turn. In relation to the extent of public disorder, we know that around a quarter of adults reported drinking heavily. What I mean by that is more than six units for a woman or more than eight units for a man on their heaviest drinking day in the last week. It is this kind of excessive drinking—often termed binge drinking—that is most likely to be linked with offending behaviour. Alcohol does play a large part in the amount and extent of public disorder. We know from the Crime Survey for England and Wales that in about 49% of violent incidents the victim believed the perpetrator to be under the influence of alcohol. This is particularly the case where the violence is committed by a stranger. It rises to 70% in those cases. We know also the impact of alcohol on the wider community. I have already said that one-fifth of people perceive people being drunk and behaving antisocially as a very or fairly big problem in their area. We know that over a third (35%) of all penalty notices for disorder issued by the police are for drunk and disorderly in a public place. That equated to almost 25,500 notices in the year ending June 2014.

You also asked about underage drinking. It is worth noting there has been a marked decline in underage drinking in recent years. Over the last decade the proportion of 11- to 15-year-olds who have ever had an alcoholic drink reduced from 61% to 39%, and those who had drunk in the last week from 25% to 9%. That mirrors wider reductions in risky behaviours such as drug use, teenage pregnancies and youth offending. However, we do not underestimate the issue; we know that underage drinkers are more likely to offend than their non-drinking counterparts. We are very keen to use all the levers at our disposal, including partnership, working with the alcohol industry through Challenge 21 and Challenge 25, to continue that downward trend.

You also asked about problems for law enforcement, and public disorder does represent a particular challenge for law enforcement and requires quite significant resources in the night-time economy to deal with the consequences of excessive drinking. It is probably reflected by the fact that 35 of the 41 police and crime commissioners have made alcohol a strategic priority in their crime and policing plans. It is very difficult to estimate the amount
of time and resources the police spend on alcohol—because they do not record it in that
way—but there is anecdotal evidence, which is that a very significant proportion of arrests at
the weekend and quite a number of injuries to police officers are associated with alcohol-
related crime and disorder. Have I missed any key points?

Stephen Cummins: No. Just to add to that, in Durham they have done some interesting work
looking at this issue. This is just based on a local survey, but they estimate that on a weekend
over 80% of arrests are alcohol related. As Dan says, in terms of officers being injured, their
survey results were that 86% of officers surveyed had been injured when dealing with
someone that was drunk. That highlights the scale of alcohol-related disorder in the night-
time economy.

Lord Sharkey: A quick supplementary: you mentioned that underage drinking is in decline.
Do you have a view about why this is?

Daniel Greaves: There may be a range of factors. I am also responsible for drugs, and we
have looked at this in a drugs context and tried to understand why there is a long-term
downward trend. It is a downward trend that is present in a number of other countries, so it
is not related, I do not think, to the UK alone. It is also related to a wide range of risky
behaviours, whether it is alcohol consumption, drugs, teenage pregnancies or youth crime.
So, it is a wider trend of aversion to risky behaviours. I do not think we have an adequate
explanation for why that might be. There are, however, some factors within the UK that
make it a more hostile environment, if I can use that language, for underage drinkers. If we
contrast it with 10, 20, 25 years ago, it is much harder for a young person to come about
drink than it would have been previously. The penalties are stiffer; there is much greater
awareness about the harms associated with early exposure to drink and early drunkenness;
and there is much greater focus on standards and policies within retail outlets and pubs, and
much greater expectation. The expectation now is that if you look under 21 or 25, you will
be challenged. That has moderated the expectations that perhaps were not present when I
was 15 or 16; you will be challenged and ejected from a bar.

Q173 Viscount Bridgeman: In previous evidence we have heard that there has been quite a
considerable increase in middle-aged female binge drinking. Has that come into your
considerations in the present context?

Stephen Cummins: It has in terms of the overall consideration of the alcohol strategy,
because that takes a very broad view in reducing harmful levels of consumption. Obviously,
from a narrow Home Office perspective, we are particularly focused on crime and disorder
and the harm that impacts on the night-time economy, but we are also leading a cross-
Government strategy and working really closely with colleagues in the Department of Health
and elsewhere. Looking at harmful consumption across the broad range of age groups is an
important consideration for us.

Lord Blencathra: With regard to disorder, I remember reading Home Office studies in the
1990s—and I think these have been continued—showing that the amount of disorder is
dependent on if all the nightclubs are turned out at the same time, at two in the morning,
and there are junk food stalls in the street and people cannot get home. In that situation,
there is a much higher level of disorder. However, if you can dissipate when people are
leaving the nightclubs, irrespective of the amount of alcohol drunk, and they can get home
more quickly in taxis, you have much less disorder. Is that still valid?
Daniel Greaves: That is absolutely right. When we talk about alcohol-related crime, we are largely talking about violent crime and disorder, and we know that can be quite significantly affected by what are known as “situational factors”: the layout of a nightclub, whether it spills out to a marshalled taxi area, and whether people congregate around late night refreshment outlets. It is worth noting that the Licensing Act 2003 covers alcohol sales, but equally the sales of late-night refreshment. That is certainly something we have picked up from the local alcohol action areas work and partnership working with nightclubs. If there is an individual who is of concern, when they are ejected from a club they are brought to the attention of the police. There is good use of dispersal powers, good layout of the public realm, and thinking about the relationship with late-night refreshment and taxi marshalling and so forth. That all comes together and still remains very much at the centre of the thinking that has come out of the local alcohol action areas.

Q174 Baroness Benjamin: The advertising of alcopops for young children used to be quite wide on television and has now stopped, and also, through PSHE in schools, they are educating young people about alcohol. Are you involved in any of those policies?

Daniel Greaves: We work very closely with the Department of Health on supporting the PSHE curriculum, both on drugs and alcohol, but equally across the Home Office on issues like relationships, gangs and so forth. There is close partnership working on that. There is also partnership working with DCMS and the Advertising Standards Authority around regulating the exposure of young people to alcohol advertising. There is strong evidence that that is an important factor and one that we need to bear in mind.

You talked about alcopops. My sense in terms of the size and shape of the market is that alcopops are much less prevalent than they were perhaps 10 to 20 years ago.

Q175 Lord Tomlinson: We have talked around the incidence of violence and other things that the police have to deal with as a consequence of excessive drinking. Can you give us any idea what the cost is in cash terms and in police being away from work as a consequence of confronting violence? Can you give us an idea of the cost that alcohol consumption has, the effect it has on police resources, both in time and money?

Daniel Greaves: I can start to describe that. In terms of alcohol-related crime, we estimate that the cost to society in 2010/11 prices was some £11 billion.

Lord Tomlinson: Before you go too far into the cost to society, I am really specifically interested in the cost of forgone police services; because they are dealing with this they are not available elsewhere.

Daniel Greaves: I can tell you that the £11 billion is broken down into three components. The first is in the cost incurred in anticipation of crime, so security expenditure. The second is consequence of crime, such as property stolen, and emotional and physical impact. The third is in response to crime; that is, cost to the police and criminal justice system. I cannot give you a figure around opportunity cost, the value they would have created by doing other activities. That is not a number I am able to give you, but the £11 billion is made up of those three components.

Lord Tomlinson: What proportion is the third one, do you know? Presumably, you got the total of £11 billion by adding up three figures. It is the third one that I would like to know.
Daniel Greaves: I do not have that to my fingertips, but it is a relatively small proportion of that overall number, because the largest element is the emotional and physical cost of crimes like sexual assault and rape, to the individual. The quantifiable cost of those is very pronounced, so of that £11 billion my guess is that a small proportion of that would be attributable. However, the breakdown is not yet published and I am happy to look at this issue further.

Lord Tomlinson: I would be grateful if you could look at the cost in relation to the police, particularly as the police are under so much pressure in other areas, and if you could let us have that, I would be very grateful.

Daniel Greaves: One thing I should point out, though, is this is survey-based evidence. The police do not routinely collect data on the extent of alcohol-related crime through police-recorded crime, nor do they quantify the amount of time spent for each alcohol-related crime. Therefore, it is very difficult to empirically build those up; it is based much more on survey data. I understand you are taking evidence from Chief Constable Adrian Lee, the national policing lead for alcohol, and perhaps this is an issue you would care to pursue further with him. Improving the evidence base about the cost of alcohol-related crime to the police directly is a conversation we have had. Given constraints on budgets, it is quite an important issue.

The Chairman: Who does the surveys? Do you do the surveys or do the police?

Daniel Greaves: The surveys are independent surveys run ultimately by Government. The Crime Survey for England and Wales is run by the Office for National Statistics.

Q176 Lord Morris of Handsworth: We have had a lot of statistics in terms of the relationship between alcohol and crime. What I am not clear about is where the responsibility lies, whether it is the police service or, indeed, other agencies. From your point of view, as policymakers, advisers and whatever, could you tell us for what percentage of crime in the UK is alcohol recorded as a contributing factor?

Daniel Greaves: I said at the beginning that almost half of violent offences are believed to be alcohol-related. This is particularly prevalent in the incidence of stranger violence, where 69% of victims perceived the perpetrator to be under the influence of alcohol, and alcohol is present in around 24% of partner abuse incidents. We know that the concentration of violent incidents tends to be around what we sometimes call the night-time economy. There is a significant over-representation of incidents at the weekend as opposed to other days of the week and an over-representation of violent incidents happening in the evening as opposed to the morning and afternoon. We also know that alcohol can be a contributory factor in incidents of minor crime and antisocial behaviour. The Home Office did an evaluation of what was known as the Alcohol Arrest Referral Scheme, and of those arrested for an alcohol-related offence, 12% were arrested for acquisitive crime and 10% for criminal damage. It is not just violent crime where we know there is a particular relationship; it is also in relation to acquisitive crime, criminal damage and also wider antisocial behaviour.

Q177 Viscount Bridgeman: What proportion of road-traffic offences, injuries and deaths are caused by excess alcohol consumption? A further question is: to what extent might this be remedied by lowering the 80 mg limit, which I think now applies only to England, Wales and Malta, is that right, in the whole of the European Union?
Daniel Greaves: Yes. This is an area of policy where the Department for Transport has the lead, but to be helpful to the Committee we have consulted with colleagues at the Department for Transport and we will do our best to answer your questions. Colleagues have emphasised that drink-driving is a serious threat to road safety, and the law on drink-driving is enforced rigorously by the police, who have the power to carry out breath tests of any driver suspected of having drunk alcohol or committing a road-traffic offence, or one who has been involved in a road-traffic collision. The penalties for drink-driving are stiff, potentially six months in custody and a 12-month ban. The reason for that is because a significant proportion of road-traffic accidents are related to excess alcohol consumption. Department for Transport figures show that the overall total of drink-drive casualties of all severities in 2012 was some 9,930, and that is approximately 5% of all reported road casualties. The same figures show that 1,200 people were seriously injured in that same year and an estimated 230 people were killed in drink-drive incidents. That is quite a significant pattern of harm, but I should note that drink-drive deaths and serious injuries are 85% down on 1979, which suggests there has been a very significant culture change over time, which awareness and enforcement play a part in tackling.

I understand from colleagues at the Department for Transport that there are no plans to alter the drink-drive limit, as their emphasis is on strengthening enforcement and focusing on high-risk offenders. The DfT view is that improving enforcement is likely to have the most impact on the dangerous people who drink and drive, and will therefore be the most effective use of scarce resources rather than lowering the prescribed alcohol limit for driving. It is fair to say that although many other countries have a lower limit for drink-drive offences, they do not necessarily have a better road-safety record, and the reduction seen since 1979 is quite pronounced.

Viscount Bridgeman: I should mention that Dr Lars Møller of the WHO did make the point that there is a paradox between a rather better record for road deaths in this country with the higher limit than there is in other countries with a lower limit.

Stephen Cummins: The penalty point is worth emphasising. The disqualification for 12 months, for example, for somebody who has been convicted in a court of drinking in excess of the drink-drive limit is a significant deterrent. The combination of better enforcement and stiffer penalties does have an impact here in England and Wales.

Daniel Greaves: We should not pretend that law enforcement and the law are the only drivers of outcomes in this area. There has been a culture shift. There is an expectation now that it is antisocial and unacceptable to drink and drive, whereas perhaps that was less likely to be the case and to be challenged by peers in the 1970s, so culture change also has an important role to play.

Q178 Lord Faulkner of Worcester: I have a question on enforcement, and I should declare an interest as a former president of the Royal Society for the Prevention of Accidents, which was very disappointed with the last Government for not reducing the limit and, indeed, as far as I know, it is still their position that they would like the limit reduced. Can you tell us a bit about the point you made about penalties? Do you have, and perhaps you could supply the Committee with, details of what penalties are applied in other countries that have lower limits? Are we the only country that automatically takes away a driver’s licence for 12 months on conviction or is that something that is done elsewhere?
Daniel Greaves: That is slightly beyond my knowledge, but I am confident that colleagues at the Department for Transport will be able to help you address that question, so we will pick it up with them and come back to the Committee.

The Chairman: We can ask the question on that.

Lord Wasserman: I am not surprised that the Department for Transport is very keen on enforcement, because it is nothing to do with them. That is putting it on to the police, as it is the police’s job to do the enforcement. It is fine to say, “We do not want to reduce the limit because we hope that enforcement will be improved”, but who is going to pay for this extra enforcement when the police are already stretched dealing with other crimes? It is odd for them to say, “We think enforcement is the key”, when, as I say, it is not their responsibility.

Daniel Greaves: I think they are very mindful of the costs to the police and the efficiency arguments here and, for that reason, are looking to develop mobile evidential-breath-test equipment to reduce the costs on the police of dealing with drink-driving incidents and make much more of the process able to be done at the roadside. They are sensitive to those arguments about the costs imposed on the police.

Lord Wasserman: Thirty-five PCCs have made it a priority, but there are 41 PCCs, which means that some PCCs have not made it a priority and they probably are not enforcing the drink-drive limits to quite the extent. Adrian Lee will tell us more about this, but it is a very difficult one as long as policing is a local responsibility, for which I am very keen, but it does mean that we cannot simply assume that Government wanting to have more enforcement will lead to more enforcement, because they have no levers to pull to ensure that the police do enforce these regulations.

Daniel Greaves: The Home Secretary has been clear that she wants police forces to be accountable to their local areas and that is part of the rationale for directly elected police and crime commissioners. I should say that 35 of the 41 have made alcohol a strategic priority in their crime and policing plan. That does not mean that the other six have ignored it entirely. They have statutory duties and functions; there are significant harms, and I am sure it remains an important issue, but you can only have so many strategic priorities without having any priorities at all. I know in a number of areas in which I work, and I have worked very closely with Adrian Lee and also colleagues in Nottingham, the alcohol harms are recognised to be very significant and this is quite high up on the agenda, both in terms of the enforcement action and in their lobbying effort for us to do more at a national level.

Lord Tomlinson: Just to pursue this, Lord Wasserman asked a question and the converse of that question is also relevant here. The policing numbers have gone down, so how do you compare accurately the statistics of a few years ago, when policing numbers and, presumably, enforcement were much higher than the statistics that you quote today, when there are fewer police available for enforcement? Are you satisfied that there is a genuine change of behaviour, or could it just be that there are so many policemen in crucial hours manning our streets that they are not manning the roads and, therefore, you get a statistical illusion of improvement?

Daniel Greaves: This is a broader issue and Home Office Ministers have been clear that there is no simple relationship between police numbers and levels of crime.

Lord Tomlinson: Well, they would, wouldn’t they?
Daniel Greaves: It is difficult to provide a definitive answer in this context, but given the scale of that and the fact that that change has happened since 1979, there is a distinctive trend between 1979 and now. I do not remember the number I gave you, but I think it was an 85% reduction since 1979. Over a very long period when we have seen different patterns of investment and different police numbers, it would be difficult to argue that that was solely down to the absence of enforcement.

Q179 Baroness Benjamin: I have put this particular question to all our witnesses so far and I would like to hear your views on it. Do you think we need to rethink the way we promote the idea of “do not drink and drive”, because when you think about it you are telling people, “If you are driving, have less drink, but if you are not driving you can have as much drink as you like”? Do we have to rethink what we are saying when we are talking about “do not drink and drive”? What are we telling the public?

Stephen Cummins: It is multi-faceted and what Dan has described in terms of the downward trajectory is significant and has been attributable to multiple factors. We have spoken at length about strengthening enforcement, which is part of the response. I do think public-awareness campaigns—and I am sure we will get on to talking about this soon—do have an impact. There have been some quite significant results in terms of the effectiveness of some of these campaigns, and the “do not drink and drive” message is a part of that cultural shift that has occurred over a period of time and has shifted what is acceptable in terms of drinking alcohol. To answer your question, there is a part that they can play, but it is part of a multi-faceted response to this problem.

Daniel Greaves: It is a multi-faceted response that is not just about public-awareness campaigns. We may come on to this later on, but the evidence tends to show that if you are looking at reducing the risk of someone having a problematic relationship with drink, you are looking at a multi-component approach across a life course, not just awareness campaigns at a particular point in somebody’s life.

Q180 Lord Judd: What in the Home Office’s perception is the correlation between levels and patterns of alcohol consumption and domestic violence, particularly including child abuse, sexual offences? What other harm to third parties do you believe is covered by any such correlation?

Daniel Greaves: I will begin and perhaps Steve can follow. The Crime Survey for England and Wales for 2012-13 estimated that in around a quarter of partner-abuse incidents the offender was under the influence of alcohol. In relation to sexual offences, the Crime Survey for England and Wales in 2011-12 estimated that in 40% of serious sexual assaults the offender was under the influence of alcohol.

You asked about child abuse. We have limited quantified evidence linking alcohol to child abuse. However, we do have strong anecdotal evidence that both drugs and alcohol are a feature of child abuse, including child sexual exploitation. Parental problems, such as mental illness, alcohol, drug misuse, domestic violence and learning disability, and sometimes a combination of all of the above, are known to increase the likelihood of children experiencing emotional abuse and neglect. Our colleagues at the Department for Education estimate that 1.3 million children live with parents who are thought to misuse alcohol.

You talked about other third-party harms. In aggregate terms, we think that alcohol-related harm costs the UK £21 billion a year, and that includes £3.5 billion of cost to the NHS and
wider health harms, and just over £7 billion in terms of the cost to the economy resulting from lost productivity due to alcohol. We have focused on victims of crime and we have focused on the police service, but there is an impact on the wider economy in terms of productivity as well, which we should not lose sight of, and in particular in relation to workplace alcohol policies and workplace alcohol awareness.

**Lord Judd:** Is there a difficulty, do you know, in this sphere about the amount of unreported or uninvestigated abuse that takes place? How far are the statistics with which you are able to work really figures in which we can have great confidence?

**Stephen Cummins:** There is a broader issue here, as you rightly touch on, in terms of the under-reporting of domestic violence and partner-abuse incidents, and this is something that a huge amount of effort has gone into in recent years. What we see now is improved levels of recording and we are noticing that change in the Home Office with some of the data that we are seeing. Frankly, there is a lot more to do, and working with victims groups, which I know colleagues in the Home Office and Ministers are very keen to do, in terms of increasing levels of reporting is a priority for the department.

**Daniel Greaves:** There are perhaps two separate issues here. One is that a lot of the numbers I have quoted have been from the Crime Survey for England and Wales, which is self-reported data rather than police-recorded crime. As Steve has recognised, under-reporting of what can sometimes be called hidden crime is something that the Home Office, Her Majesty’s Inspector of Constabulary and police forces are aware of. If there are increases in the reporting of domestic violence, that is obviously of concern, but in some respects it can be a positive thing, because it means victims of that kind of abuse feel more confident that they will be heard sympathetically and dealt with in a professional manner by the statutory authorities. There is a complex relationship, and I agree that this is one that makes the statistics quite hard to interpret.

**Lord Judd:** It is not only under-reporting, though, is it? There is also the matter of how thoroughly it is investigated, and it does seem to me that there is quite a difference in the performance of police in different parts of the country. In some parts of the country the police seem to take these issues very seriously and in other parts there is still a bit of a macho culture functioning, which rather spoils the amount of evidence we can accumulate.

**Daniel Greaves:** I go back to my point that the bigger numbers I have been sharing with the Committee today have been from the Crime Survey for England and Wales, which is our primary mechanism for measuring crime patterns in the UK. I recognise there are issues around reporting and focus and all of those will impact on police-recorded crime, but most of the numbers I have been relying on principally have been self-report through the Crime Survey for England and Wales.

**Lord Faulkner of Worcester:** I would like to ask a supplementary first and then my own question. This is a very difficult area, but do you have any statistics about what proportion of victims have become victims as a result of taking alcohol themselves?

**Daniel Greaves:** That is a very complex question. There is evidence of a correlation between alcohol consumption and the likelihood of being a victim of violent crime, but it is often part of a wider mix of factors and it is difficult to disentangle the impact that alcohol has had and to quantify that.
Lord Faulkner of Worcester: You do not have statistics that would lead us to a conclusion on that.

Stephen Cummins: There are statistics available that we could provide to the Committee. Dan is absolutely right that there is not an established causality here between alcohol and being a victim of partner violence, and there are a number of factors that are associated with the fact that victims tend to drink more, which the evidence suggests. We would be very careful to say that there was a clear causality there, because I am not sure that you can infer that from the data.

Q181 Lord Faulkner of Worcester: I was quite careful in how I asked the question as well, for obvious reasons. My proper question is much easier and that is: should we be here at all and should we not be talking about an EU alcohol strategy, or is this something that should be left to the Home Office to sort out for us in the UK?

Daniel Greaves: It is fair to say that the previous EU Alcohol Strategy focused on alcohol-related health and other linked harms, and that largely reflected the competence under which that strategy was developed, which was around the EU’s ability to take action to complement national policies directed towards improving public health. It is important to recognise the limits of the EU’s competence in respect to alcohol-related crime. The EU’s competence in relation to criminal matters does not explicitly cover alcohol-related crime. Article 83(1) of the Treaty states that member states may adopt minimum standards concerning the definition of certain serious crimes, such as human trafficking, sexual exploitation, terrorism, illicit drug trafficking, money laundering and so forth. However, that would seem to apply to only a small subset of alcohol-related crime, arguably illicit alcohol, which is perhaps more appropriately dealt with by the EU’s Internal Security Strategy and multinational efforts to tackle organised crime.

I understand scoping is under way to inform whether or not there should be a new alcohol strategy and what its remit and focus should be, and we will seek views from Ministers as part of that process. We will consider a push to include alcohol-related crime in the strategy on a case-by-case basis, but if this was considered, Ministers would need to be assured that any such action respected the limits of the EU’s competence in this area and would need assurances that any EU measures observed the principle of subsidiarity, as set out in Article 5(3) of the Treaty. As a general rule, EU-level action would only be deemed appropriate if the objectives could not sufficiently be achieved by the member states acting individually or in concert, or if EU-wide action could add greater value.

Aside from illicit alcohol, it is fair to say that alcohol-related crime is not necessarily cross-border in its nature. There are not very new or fast-moving issues to be dealt with in this issue, as there are perhaps in drugs or other areas, and patterns of harm and the domestic responses around licensing regulations and criminal justice systems are very different by member state.

Therefore, we remain to be convinced there is a compelling case for further co-operation in this area, but this is something that Home Office Ministers would be consulted on and consider on a case-by-case basis.

Lord Judd: Going back to the original question, I do not want to put words in your mouth, but would you in the Home Office say that the evidence of your experience indicates that this is a major social issue that needs a lot more work done on it?
Daniel Greaves: The Home Secretary made clear in the Government’s Alcohol Strategy and the response to the consultation on it that the Government consider alcohol to be a very significant issue. It is one of the top three lifestyle issues associated with premature death; it is associated with £21 billion of costs, £11 billion of which is alcohol-related crime. Yes, it is a very significant issue and one that the Government, working in concert with local partners in the industry and health partners, have been very keen to have a comprehensive strategy to tackle. The question is not whether we need to continue to focus very heavily on alcohol as a social issue; that is a given. It is just a question of the added value of EU co-operation, of which we remain to be convinced.

Stephen Cummins: I agree with that and would add that we would agree with what colleagues in the Department of Health have said on this issue about whether or not there should be a new EU alcohol strategy. We would certainly say that there is merit in the development of the strategy within the framework that Dan has outlined and with due regard to competences and the principle of subsidiarity. There are a number of areas where EU legislation as it is currently constructed can potentially limit the options that are available for member states to tackle alcohol-related harms, and this is an area where further analysis and study would be useful. This includes, for example, the directives on alcohol taxation, and some of the definitions of alcohol beverages were defined at a European level. These are all really interesting issues that it is useful for the European Commission to be looking at, and we in the Home Office and colleagues in the Department of Health are very keen to look at that.

Q182 Baroness Benjamin: A very simple question: how should new EU alcohol policies differ from EU drug and tobacco policies?

Daniel Greaves: As a starting point, the approach to a particular problem needs to be guided by the balance of competences between the EU and member states and the nature of the policy in question. There should only be EU action where the principle of subsidiarity is met and where there is real added value. On the face of it, there are some similarities faced around tackling alcohol and tobacco issues: both products are sold legally and present health risks, and the tools for addressing the issues have some commonality, for example regulating packaging, advertising, taxation and pricing. However, even in that instance the challenges are not identical: there is a low-risk level of consumption of alcohol and there is no safe level of consumption of tobacco. Illicit drug markets, on the other hand, are quite different. Illicit drugs are, by their nature, prohibited, and the manufacture, import, supply and possession are subject to penalties across the union. The policy challenge, in a sense, is not to regulate illicit markets for a product with a recognised low risk level of consumption, but to prevent the use of and to tackle the supply of an illegal product. I have responsibility for the UK’s input into the EU Drugs Strategy and it may be helpful for me to describe that, if that is of any use to the Committee.

The Chairman: If you can do that briefly, that would be helpful.

Daniel Greaves: The strategy includes a mix of public health actions, prevention and treatment and work, and criminal measures under a justice and home affairs legal base. The EU Drugs Strategy provides the overarching framework for the period 2013 to 2020, and there is a series of action plans. Essentially, the objectives are to contribute to a measurable reduction in the demand for drugs and drug dependence; secondly, to contribute to a disruption of the illicit drugs market; and thirdly, to encourage co-ordination
in the analysis. In addition to technical co-operation on prevention, treatment and support of the European Monitoring Centre for Drugs and Drug Addiction, there is an existing mechanism in place to identify, risk assess and control drugs at an EU level. Since 2009, globally, nearly 400 so-called legal highs, new psychoactive substances, have emerged, and the EU plays a role in helping member states to understand the dynamics of that market and to respond to the changing market. For that reason, the read across between the drugs strategy and the alcohol strategy is limited to the prevention and treatment efforts, which do share some common elements, as I said before. There are common risk and protective factors around a whole range of risky behaviours. In relation to treatment, we are largely talking about the treatment of dependence, and there are some commonalities in medical and psychosocial interventions and, equally, in practical support around housing and unemployment, which help people to rebuild their lives. The commonality between the strategies is largely around the prevention and treatment element rather than the regulation of the market, which is quite a different challenge.

Q183 Lord Blencathra: Moving on to fraud, what are the potential effects on fraud of different rates of alcohol taxation across the EU? I do not just mean people going to Calais to pick up cheap booze. What effect could pricing policies, such as minimum unit pricing and below-cost sales bans have on the illicit alcohol trade?

Stephen Cummins: I will take this question if it is okay with the Committee. Turning to the first element of your question, on alcohol taxation, taxation policy of course is an area where HM Revenue and Customs have the lead responsibility. Colleagues there have advised that alcohol duty fraud is one of the largest tax crimes in the UK; HMRC’s published estimates suggest it costs taxpayers around £1.3 billion a year. They advise that the problem has grown somewhat since the introduction of the European single market in the early 1990s, and there is no doubt that the significant differences in excise duty rates between member states can help, to some extent, to incentivise that fraud. While criminals may use a number of different methods to bring goods to the market, duty differences are often so great that it is still profitable for them to pay the duty of lower taxing member states and then divert the alcohol to the UK market, which generally has higher levels of taxation. As an extreme example, a litre of wine in France incurs less than four euro cents excise duty and a similar litre of wine here in the UK incurs £2.73 excise duty. Other relevant factors, such as local purchasing power, exchange rates and proximity to borders can help to feed the levels of illicit activity.

Turning to the second part of the question, on minimum pricing and below-cost sales, it is fair to say that we considered the impact of minimum pricing and below cost sales on the illegal trade of alcohol very closely. On minimum pricing, we established that there was some risk that, if the minimum price was set at a significant level, this could lead to increased levels of smuggling, illicit production and bootlegging of alcohol. For the equivalent risk for the ban on below-cost sales, we assessed that as quite minimal, simply because fewer products are affected by the ban on below-cost sales as opposed to an introduction of a minimum unit price for alcohol.

Q184 Lord Judd: In the light of all the considerable experience at the disposal of the Home Office, would you argue that education programmes and awareness-raising campaigns are effective tools to reduce alcohol-related crime? Could you tell us a bit about your experience
of such campaigns: which have been particularly effective and where you think best practice seems to be established?

**Daniel Greaves:** There is limited evidence overall that education programmes and awareness-raising campaigns are by themselves effective in changing behaviour. However, a systematic review of the evidence has shown that they can have some effect in promoting awareness and changing attitudes. In part, that is around the difficulty of measuring behaviour change but, equally, in part, about the importance of thinking about a multi-component approach. Raising awareness and giving people facts alone is very rarely fully effective. You need to equip young people with what one might call skills around resilience: the ability to make positive choices, say no, and weigh up risks. The evidence tends to be that there is a common range of risk and protective factors across risky behaviours, not just around alcohol; you need to look at it in a rounded way across alcohol, drugs, crime and a range of issues. You need to look across the life course at building the resilience of an individual rather than just focusing on awareness campaigns. There is some evidence that awareness campaigns, when they focus on scare tactics, can be ineffective. There is a role for awareness campaigns to play, but largely as part of a multi-component programme rather than as standalone, and the evidence tends to suggest that scare tactics can be ineffective.

It is fair to say that this is an area where the evidence is developing rapidly. Both the UN and the EU have been developing the evidence base here and developing standards around prevention, and it may be worth speaking to experts on the UN prevention standards and the EU prevention standards to understand the evolving evidence base further.

**Lord Judd:** Again, I do not want to put words in your mouth, but would you suggest that more work should be done on the interrelationship between alcohol and drugs in this whole area? Does that not suggest that it is impossible to tackle this effectively without looking at the reasons behind drug-taking and alcohol consumption as distinct from just reacting to the consequences?

**Daniel Greaves:** Absolutely. You have to look at alcohol and drugs in a rounded way. In individual experience and in the policy response the two are inextricably linked. There are three strands to the UK's drug strategy: restricting supply, reducing demand and promoting recovery. In the demand reduction and prevention area and the treatment recovery area, there are real commonalities in the challenge, and we do need to think in a rounded way not just about alcohol prevention or drugs prevention but about equipping young people with the knowledge, the resilience, the experience when thinking about the range of environmental factors that influence their decisions, rather than taking a single alcohol or drugs approach and just saying, “Do not do this, do not do that”. We need to look at the issues in the round. That is what the literature tends to say, and I know that we are working quite closely in partnership with local areas through Public Health England, who it may be worth speaking to, to translate that evolving evidence base into local practice and equip local practitioners and schools with the skills, confidence and resources to play that approach out through local delivery.

**Q185 Baroness Benjamin:** Is any work being done to ask young people, especially, “Why do you want to drink and to take alcohol?” because some of them are blindly going down this road, and when you ask them why they are doing it, they say, “Because”. They do not have an answer. Are we looking into the reasons why?
Stephen Cummins: That is a very good question. There have been quite a lot of things that have been done. We touched earlier on the work that the National Union of Students has done in this area. In addition, it is worth making reference to some of the work that the independent charity Drinkaware has done in looking at the behaviour of young people on a so-called drunken night out and looking at some of the risk factors there, and understanding what drives the excess consumption of alcohol and then looking at interventions and strategies to help mitigate some of those risks. We are applying some of that learning to one of our local alcohol action areas and some of the work we are doing in Nottingham. There have been quite a lot of studies into this area.

Daniel Greaves: We have also done that in relation to drugs. We ran a targeted digital campaign over the last two summers around new psychoactive substances, so-called legal highs, looking to disentangle why people take these drugs and what the effective messages might be. Through that audience insight work we established that the message “you do not know what you are taking” is quite powerful and “do not put your friends at risk” is another powerful message. That was drawn out of the insights about why an individual was taking something. In relation to so-called legal highs, people confused a substance not being in controlled with it being safe, and the evidence suggests that these are harmful substances of which you cannot predict the composition. Your question is absolutely the right one. You do need to think very carefully about the audience, which will be segmented, before you construct any kind of communications message.

The Chairman: Mr Greaves and Mr Cummins, thank you very much indeed for your very comprehensive answers. We are very grateful to you for your time this morning, and I would be very grateful also if you could send us the supplementary evidence that we have asked for and any statistics that you think would help.

Lord Blencathra: Could we add to that, Lord Chairman, a paper on the question I asked? Could we have two pages at most showing the examples where disorder is reduced and you control the situational factors?

Daniel Greaves: We will do our best.

The Chairman: Thank you very much indeed.
Home Office—Supplementary Written Evidence

Supplementary material
The Committee made a request of the Home Office to provide some additional material as written evidence. This included the following:

a) Statistics on the total number of alcohol licences that have been revoked.
b) Comparison of the penalties for drink driving applied in other EU Member States.
c) Statistics relating to the alcohol consumption of victims of crime, including victims of domestic abuse.
d) Local good practice of where situational factors are controlled to reduce alcohol-related crime and disorder.

I have included this material as a set of annexes to this letter which I hope will be helpful to the Committee.

The Committee also asked for an estimate of the police cost of alcohol-related crime.

To coincide with the publication of the UK Alcohol Strategy in 2012 the Home Office estimated that alcohol-related crime costs society around £11.4 billion per year, based on 2010 prices and 2010/11 crime levels. This was calculated using a methodology based on unit costs associated with crime types. We subsequently extracted the police cost from the £11.4 billion estimate, which we calculated as £0.7 billion. This was based on surveys of how police divide their resources between different offences and the number of alcohol specific offences involving arrests.

The remaining £10.7 billion consisted of other costs of crime, such as physical and emotional costs to victims, the value of lost output and costs to the Criminal Justice System. We can calculate the value of these other elements if that would be of further use to the Committee.
Annex A

Licensing statistics

The Home Office provides annual statistics on premises licences, club premises certificates, personal licences, 24-hour alcohol licences and late night refreshment licences.

The latest figures for the year ending 31 March 2014 were published online on 11 December 2014 and are available to view at: https://www.gov.uk/government/collections/alcohol-and-late-night-refreshment-licensing-england-and-wales-statistics

The tables below are taken from the latest licensing figures.

Table A1: Number of premises licences, club premises certificates and personal licences, England and Wales, 31 March 2014

<table>
<thead>
<tr>
<th>Numbers</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Premises licences</td>
<td>204,282</td>
</tr>
<tr>
<td>Club premises certificates</td>
<td>15,358</td>
</tr>
<tr>
<td>Personal licences</td>
<td>570,044</td>
</tr>
</tbody>
</table>

Table A2: Number of licences surrendered, lapsed, revoked, forfeited, suspended or withdrawn by licence type, England and Wales, 2013/14

<table>
<thead>
<tr>
<th>Numbers</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Surrendered Lapsed Suspended by a court Suspended by a licensing authority Withdrawn</td>
</tr>
<tr>
<td>Premises licences</td>
<td>5,166 621 11 4,027 42</td>
</tr>
<tr>
<td>Club premises certificates</td>
<td>242 29 168 25</td>
</tr>
<tr>
<td>Personal licences</td>
<td>257 6 2 14</td>
</tr>
</tbody>
</table>
Penalties for drink driving applied in EU Member States

There is no information collected centrally within government that provides details of the penalties for drink driving applied in other EU Member States.

In order to assist the Committee the Home Office has compiled the following table based on comparative information that is available online. However, this information has not been officially produced or verified by any government department.

**Table B1: Comparison of selected member state drink driving limits and penalties**

<table>
<thead>
<tr>
<th>Country</th>
<th>Limit</th>
<th>Punishment</th>
<th>Further details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>49mg</td>
<td>50mg - 79mg = fine 80mg + = more severe fine / potential driving ban</td>
<td>1mg for drivers who have held a licence for less than 2 years / drivers of vehicles over 7.5 tonnes</td>
</tr>
<tr>
<td>Belgium</td>
<td>50mg</td>
<td>Not known</td>
<td>Fines and driving bans increase as the alcohol concentration in the blood increases</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>50mg</td>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td>Czech Republic</td>
<td>zero</td>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td>Croatia</td>
<td>50mg</td>
<td>Not known</td>
<td>Zero tolerance policy for all drivers less than 24 years old.</td>
</tr>
<tr>
<td>Cyprus</td>
<td>49mg</td>
<td>Not known</td>
<td>Particularly high number of random police checks</td>
</tr>
<tr>
<td>Denmark</td>
<td>50mg</td>
<td>Imprisonment if over 0.20%, fine: one month’s pay after taxes</td>
<td>Zero if not driving safely</td>
</tr>
<tr>
<td>Estonia</td>
<td>20mg</td>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>50mg</td>
<td>Fine or jail up to 6 months plus license suspension from 1 month to 5 years</td>
<td>Penalties vary by level of intoxication</td>
</tr>
<tr>
<td>France</td>
<td>50mg</td>
<td>€135 fine &amp; 6 points</td>
<td>Penalties can be suspended for 3 years. For aggravated cases suspension for 3 years, €4500 fine, &amp; up to 2 years imprisonment.</td>
</tr>
<tr>
<td></td>
<td>20mg</td>
<td>bus drivers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>80mg - aggravated / criminal offence</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>Zero for beginners (less than 2 years experience/under)</td>
<td>50mg = €500 fine and 1 month license suspension</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Blood Alcohol Limit</td>
<td>Penalty Details</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Gibraltar</td>
<td>50mg</td>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td>Greece</td>
<td>50mg</td>
<td>Not known</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Zero tolerance for drivers who passed their test less than two years ago.</td>
<td></td>
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<td></td>
<td></td>
<td>Routine breath testing without a probable cause is permitted and practiced by</td>
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<tr>
<td></td>
<td></td>
<td>the traffic police, especially on weekends and major holidays.</td>
<td></td>
</tr>
<tr>
<td>Hungary</td>
<td>Zero</td>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td>50mg</td>
<td>2-year ban &amp; €1500 fine</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>20mg for learner drivers/ newly qualified drivers/ professional drivers/ those</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>who do not have their license on them when stopped.</td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>50mg to 80mg</td>
<td>500-2000 fine, 3–6 months license suspension</td>
<td></td>
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<tr>
<td></td>
<td>80mg to 150mg</td>
<td>€800-3200 fine, 6–12 months license suspension, up to 6 months imprisonment</td>
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<tr>
<td></td>
<td>150+</td>
<td>€1500-6000 fine, 1–2 years license suspension, 6 to 12 months imprisonment,</td>
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<tr>
<td></td>
<td></td>
<td>vehicle seizure and confiscation</td>
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<tr>
<td></td>
<td></td>
<td>Zero for drivers with less than 3 years experience and professional drivers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(bus, trucks etc...). License is always revoked in case of: professional drivers,</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>second offence committed within two years or in case of an accident.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine breath testing without a probable cause is permitted and practiced</td>
<td></td>
</tr>
<tr>
<td>Latvia</td>
<td>20mg for less than</td>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 years of experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50mg for more than</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 years of experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lithuania</td>
<td>20mg for less than</td>
<td>Not known</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Country</td>
<td>BAC Limits</td>
<td>Penalties</td>
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<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Luxembourg</td>
<td>20mg less than 2 years of experience &amp; professional drivers 50mg more than 2 years of experience</td>
<td>€145 fine and 2 points on the driving license 80mg earns you a citation 120mg means loss of license</td>
<td></td>
</tr>
<tr>
<td>Malta</td>
<td>80mg</td>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>20mg less than 5 years of experience 50mg more than 5 years of experience</td>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td>Poland</td>
<td>20mg 50mg</td>
<td>Banned for up to 6 months – 3 years &amp; prison up to 1 month  Banned for 1 – 10 years &amp; prison for up to 2 years</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td>50mg</td>
<td>Levels between 50mg and 80mg = fine &amp; loss of licence for at least a month Penalties increase for readings over 80mg</td>
<td></td>
</tr>
<tr>
<td>Romania</td>
<td>Zero</td>
<td>License is suspended for a maximum period of 90 days. Can be reduced to 30 days Any amount of alcohol in the blood will lead to a drink-driving charge</td>
<td></td>
</tr>
</tbody>
</table>
if the driver takes driving lessons for at least 7 days, passes a test and obtains an authorisation

<table>
<thead>
<tr>
<th>Country</th>
<th>BAC Limit</th>
<th>Severe Penalties</th>
<th>Random Breath Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scandinavia (Norway and Sweden)</td>
<td>20mg</td>
<td>Severe penalties - including prison</td>
<td>Random breath tests are common in both countries</td>
</tr>
<tr>
<td>Slovakia</td>
<td>Zero</td>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td>Slovenia</td>
<td>Zero 3 years or less experience &amp; professional drivers, 50mg for all others</td>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>50mg - less than 2 years experience 30mg - vehicles over 3.5 tones/passenger vehicles with more than 9 seats</td>
<td>€500 fine Over 120mg - up to 6 months imprisonment &amp; license suspended for up to 4 years</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>20mg</td>
<td>Up to 6 months imprisonment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10mg</td>
<td>Maximum 2 year imprisonment</td>
<td></td>
</tr>
</tbody>
</table>

Annex C

Alcohol consumption of victims of crime
The Committee asked for further statistics relating to the impact of the consumption of alcohol by victims of crime, including victims of domestic abuse.

Although there are clear links between alcohol and violent crime, proving causal linkage is hard. Whether it directly causes violence or not, alcohol helps to create environments in which it’s more common, ranging in scale from the UK night-time economy to an individual household. It is important to remember that there are many potential drivers of violence, which often interplay so defining causal factors is difficult.

Information from the Crime Survey for England and Wales (CSEW) on whether victims of crime were under the influence of alcohol at the time of an incident is not routinely published. Information is published for two specific crime types; partner abuse and serious sexual assault. This information comes from a separate self-completion module in the CSEW. The 2012/13 CSEW estimates that in around a quarter (24%) of partner abuse incidents, the offender was under the influence of alcohol.

The 2011/12 CSEW also estimated that in 40% of serious sexual assaults, the offender was under the influence of alcohol. However, as with domestic abuse, there is no explicit causal link between alcohol and sexual offences. All sexual violence is unacceptable, whether or not alcohol is a feature.

Table C1 shows the proportion of incidents of serious sexual assault in which alcohol and drugs were a contributing factor (2011/12 CSEW). This contains both victim and offender alcohol figures. These figures are from the self completion part of the CSEW. Figures for this are published by the ONS each February.

The detailed questions on partner abuse and serious sexual assault are rotated each year, and figures on serious sexual assault for 2013/14 are due to be published in February 2015.

Table C1: Influence of alcohol and drugs in incidents of serious sexual assault experienced by adults aged 16 to 59 since the age of 16, by sex, 2011/12 CSEW

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Offender under the influence of alcohol</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>..</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>No</td>
<td>..</td>
<td>49</td>
<td>49</td>
</tr>
<tr>
<td>Don’t know/can’t remember</td>
<td>..</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td><strong>Offender under the influence of drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>..</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>No</td>
<td>..</td>
<td>69</td>
<td>69</td>
</tr>
<tr>
<td>Don’t know/can’t remember</td>
<td>..</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td><strong>Offender drugged victim</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>..</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>
Victim use of alcohol or drugs

Victim under the influence of alcohol  
..  33  32

Victim under the influence of drugs they had chosen to take  
..  3  3

Victim under the influence of alcohol or drugs they had chosen to take or that the offender had drugged them  
..  35  35

Unweighted base$^3$  
40  830  870

Source: Crime Survey for England and Wales, Office for National Statistics

1. If the victim had experienced more than one serious sexual assault, question was asked of the most recent incident.
2. Figures are not published for CSEW estimates based on less than 50 respondents.
3. Unweighted base refers to question on whether offender was under the influence of alcohol.
.. Denotes 'not available'.

Although it is true that people who drink more often are more likely to be a victim of domestic abuse, this doesn’t mean if you drink you become a victim or that the victim is to blame. It is really important to clarify that, whilst there is a link between alcohol consumption, illicit drug-taking and partner abuse victimisation, there is no evidence of a causal link and a victim’s consumption may affect, or be affected by their experience of partner abuse.

Table C2 shows the proportion of partner abuse incidents where alcohol was a contributing factor, including figures for both offender and victim consumption.
Correlations between alcohol and domestic abuse are difficult and should be considered in context.

Table C2: Influence of alcohol and drugs in incidents of partner abuse experienced in the last year$^{1,2}$, by sex, 2012/13 CSEW

<table>
<thead>
<tr>
<th>England and Wales</th>
<th>Adults aged 16 to 59</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
</tr>
<tr>
<td></td>
<td>Percentages</td>
</tr>
<tr>
<td>Offender under the influence of alcohol</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18</td>
</tr>
<tr>
<td>No</td>
<td>66</td>
</tr>
<tr>
<td>Don't know/don't want to answer</td>
<td>16</td>
</tr>
<tr>
<td>Offender under the influence of drugs</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>85</td>
</tr>
<tr>
<td>Don't know/don't want to answer</td>
<td>10</td>
</tr>
<tr>
<td>Victim was under the influence of alcohol</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td>No</td>
<td>74</td>
</tr>
</tbody>
</table>
Table C3: Proportion of adults aged 16 to 59 who were victims of partner abuse in the last year\textsuperscript{1,2}, by alcohol consumption, drug taking and sex, 2012/13 CSEW

<table>
<thead>
<tr>
<th>Frequency of alcohol consumption during the last month</th>
<th>Men</th>
<th>Women</th>
<th>All</th>
<th>Unweighted base</th>
<th>Men</th>
<th>Women</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a drink in the last month</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>420</td>
<td>782</td>
<td>1,202</td>
<td></td>
</tr>
<tr>
<td>Less than a day a week</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>1,149</td>
<td>1,966</td>
<td>3,115</td>
<td></td>
</tr>
<tr>
<td>1-2 days a week</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>1,495</td>
<td>1,544</td>
<td>3,039</td>
<td></td>
</tr>
<tr>
<td>3 or more days a week</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>1,248</td>
<td>963</td>
<td>2,211</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency of feeling very drunk in the last 12 months</th>
<th>Men</th>
<th>Women</th>
<th>All</th>
<th>Unweighted base</th>
<th>Men</th>
<th>Women</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1,304</td>
<td>1,880</td>
<td>3,184</td>
<td></td>
</tr>
<tr>
<td>Less than once every couple of months</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>1,070</td>
<td>1,378</td>
<td>2,448</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{1. Source: Crime Survey for England and Wales, Office for National Statistics}
\textsuperscript{2. If the victim had experienced more than one partner abuse, question was asked of the most recent incident.}
\textsuperscript{3. Unweighted base refers to question on whether offender was under the influence of alcohol. Other bases will be similar.}
The Committee asked for examples of where local situational factors are controlled to reduce alcohol-related crime and disorder.

### Have taken any CSEW drug in the last 12 months

<table>
<thead>
<tr>
<th>Frequency</th>
<th>No</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Once every couple of months</td>
<td>2</td>
<td>7</td>
<td>4</td>
<td>565</td>
<td>544</td>
</tr>
<tr>
<td>Once a month</td>
<td>5</td>
<td>9</td>
<td>7</td>
<td>431</td>
<td>355</td>
</tr>
<tr>
<td>Two or three times a month</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>320</td>
<td>199</td>
</tr>
<tr>
<td>Once a week or more</td>
<td>7</td>
<td>17</td>
<td>11</td>
<td>104</td>
<td>112</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3,828</td>
<td>4,993</td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>19</td>
<td>11</td>
<td>444</td>
<td>234</td>
</tr>
</tbody>
</table>

1. Source: Crime Survey for England and Wales, Office for National Statistics
2. If the victim had experienced more than one partner abuse, question was asked of the most recent

### Annex D

**Local good practice**
The Committee asked for examples of where local situational factors are controlled to reduce alcohol-related crime and disorder.
Partnership schemes

Best Bar None is an award scheme which aims to drive up management standards in pubs, bars and clubs. It works to reduce alcohol-related crime and disorder in a town centre by building a positive relationship between the licensed trade, police and local authorities. Any licensed premises can apply to join its local scheme, but accreditation is only granted after a thorough assessment to ensure that minimum standards are met. Over 60 Best Bar None schemes now operate in towns and cities across the UK.

Community Alcohol Partnerships bring together local retailers & licensees, trading standards, police, health services, education providers and other local stakeholders to tackle the problem of underage drinking and associated anti-social behaviour. By providing advice, guidance and resources, CAP support communities in developing their own capability to deliver a coordinated, localised response to underage alcohol misuse. To date, 86 CAPs have been set up across the United Kingdom.

Pubwatch is a long-established national initiative, run by licensees and supported by the police. The scheme brings licensees together, enabling them to take collective action to ban troublemakers, provide an early warning system and develop good working relations between licensees, the police and local authorities. Pubwatch schemes can be found in most UK towns and cities.

Street Pastors is an inter-denominational Church response to urban problems, engaging with people on the streets to care, listen and dialogue. Street Pastor teams patrol the streets, visiting pubs and nightclubs and building good relationships with these premises, the doormen, the police, and taxi marshals among others. Street Pastors provide a range of assistance to those who become vulnerable or distressed in the night time economy. There are now some 12,000 trained volunteers in around 270 teams around the UK.

Taxi Marshals help to disperse people from the town centre quickly and safely. They are effective in controlling taxi queues, improving the safety of vulnerable persons, preventing with disorder and anti-social behaviour, and reducing illegal pick ups by hire cars. They play an important role in reducing crime and disorder by acting as extra eyes and ears for the police and the licensing authority. Many taxi marshals have radio contact with CCTV control rooms in order to facilitate that.

Case studies

Success in reducing crime and disorder in Swansea
On a busy Saturday night, Swansea city centre sees around 20,000 visitors. Swansea is unusual in that its night time economy is highly concentrated around a single street. There are 33 licensed premises on Wind Street itself, with a further 26 in adjoining streets. In 2010 crime mapping revealed that Wind Street had the second highest number of incidents reported to the police of any street in England and Wales. Prior to 2014 the approach to policing the city centre was quite reactive. The police tended to congregate at one end of Wind Street and intervene only when trouble broke out.
In February 2014 Chief Inspector Jason Davies introduced a different approach. This comprised:

- Officers being deployed into designated zones identified as being hot spots by the analysis of data.
- Officers being visible in the middle of the street and ensuring early engagement with any signs of drunkenness and disorder.
- Supervision of zoning system by a Sergeant, who also coordinates prisoner transport, evidence collation and meal breaks to ensure officers remain on the street and not in the station.
- The systematic capture of intervention data and feeding it into an analytical process.
- Using this analysis and a licensing traffic light system to conduct premises licensing visits at the key times and dates, setting standards with designated premises supervisors as routine.
- Using the analytical process to engage with licensees at regular meetings to raise awareness at problem venues and work together to reduce the issues in question in the first instance with a view to review only when this engagement fails.

Comparisons of levels of crime and anti-social behaviour in the night-time city centre in the first quarter of 2014/15 with the same quarter in the two previous years show significant success in reducing incidents of anti-social behaviour, thefts and crime overall.

**Action to tackle the use of licensed premises by organised crime groups**

Licensed premises can provide an apparently legitimate front for organised crime groups (OCG) to operate behind. Within such premises markets can be developed for drug supply, counterfeit or stolen goods and provide a convenient business through which money can be laundered. Targeted action, often by a partnership of police, licensing authorities, trading standards and environmental health departments, against breaches of licensing conditions or the Licensing Act can cause significant disruption to OCGs. As well as pursuing any licensing and criminal offences there is considerable scope for financial investigation enquiries and recoveries using Proceeds of Crime Act 2002 powers.

In **Sussex** for example, an OCG was involved in the management of a rural public house and distributing controlled drugs from the premises. The full involvement of licensing officers in planning a strike resulted in a successful operation that secured the arrest and prosecution of OCG members, capture of evidence and the closure of the pub within 24 hours of the raid through an expedited review application to the licensing committee.

In **Durham**, licensing officers pro-actively monitor new license applications, in particular those for premises that have previously closed through insufficient trade or new building applications and are not connected to a reputable chain. This has successfully identified OCG’s seeking to establish themselves in new areas and/or with new businesses.

In **Northamptonshire**, a focus on OCGs involved in the running of licensed premises has proved to be successful in applying for the revocation of premises licenses and reducing crime. In one example, a venue was owned by OCG members who were involved in the importation of drugs and the licensed premises enabled them to launder money through its
accounting books. Following a successful criminal investigation and trial, a successful application was made to revoke the premises license based mainly on the criminal running of the venue, supplemented with evidence of violence that had occurred there. Subsequently, the premises has been acquired by a new operator, it has been rebranded and now operates successfully as a safe venue within the night time economy.
Institute for Alcohol Studies—Written Evidence

About the Institute of Alcohol Studies (IAS)

The Institute of Alcohol Studies (IAS) welcomes the opportunity to contribute to the House of Lords inquiry into the future of the EU Alcohol Strategy and to respond to the call for evidence.

The core aim of the Institute is to serve the public interest on public policy issues linked to alcohol, by advocating for the use of scientific evidence in policy-making to reduce alcohol-related harm. The IAS is a company limited by guarantee, No 05661538 and registered charity, No 1112671. For more information visit www.ias.org.uk.

IAS has a long history of involvement in alcohol policy, research and advocacy at the European level. In 1990, IAS worked alongside the French organisation ANPAA to establish Eurocare, the European Alcohol Policy Alliance, to enable alcohol issues to be addressed at the EU level, and to make the case for an EU alcohol strategy on alcohol. Throughout this time, IAS was involved in a range of EU activities and projects, perhaps the most notable of which was being commissioned by the EC to undertake a major review of the alcohol issue to serve as the evidence-base for the EU alcohol strategy. Today the IAS has a place on the Eurocare Board and the European Alcohol and Health Forum (EAHF).

Response to call for evidence

1. Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

IAS is a strong supporter of effective alcohol policy in Europe and has been calling for a renewed EU Alcohol Strategy since 2010, when the previous Strategy was approaching its expiration date. IAS sees the failure to establish a renewed Strategy in 2012 as a significant setback for achieving progress on reducing alcohol harm in Europe. IAS has, alongside partner NGOs, expressed concerns about the limitations of the interim EU Alcohol Action Plan, which seeks to address a much narrower element of alcohol harm, covering young people and heavy episodic (binge) drinking, and has made repeated calls for a new comprehensive strategy that would take a whole population based approach and thus include policies that would impact all Europeans affected by alcohol problems, including adults of working age and those affected by third party harms (e.g. victims of drink drive accidents and domestic abuse).

We believe the next EU Strategy should be based on the evidence-based framework for effective alcohol policies outlined in the World Health Organisation (WHO) Global Strategy to reduce harmful use of alcohol (2010) and, more specifically, the WHO European Action Plan to reduce the harmful use of alcohol 2012-2020 (2011). Both of these strategies have received unanimous endorsement by all EU Member States and are based on the best available scientific evidence of policy effectiveness. The ten policy areas for action outlined in these two strategies are:

21. Leadership, awareness and commitment
22. Health services’ response
23. Community action
24. Drink-driving policies and countermeasures
25. **Availability of alcohol***
26. **Marketing of alcoholic beverages***
27. **Pricing policies***
28. Reducing the negative consequences of drinking and alcohol intoxication
29. Reducing the public health impact of illicit alcohol and informally produced alcohol
30. Monitoring and surveillance

*denotes a “best buy” policy: The WHO has identified, in line with the international evidence, the three “best buy” policy interventions that are most cost-effective in reducing harmful consumption of alcohol are controls on price, availability and promotion of alcoholic beverages.

IAS acknowledges that the responsibility for delivering public health policy lies primarily with individual member states. Each country in the EU has different requirements and cultural backgrounds and there is no one-size-fits-all strategy that can be applied. The EU Alcohol Strategy should therefore seek to support and complement comprehensive national alcohol strategies by focusing on policy areas where the EU mandate can add value, for example in relation to trade and cross border issues. It should also provide Member States with the freedom to implement national policies that prioritise the health and wellbeing of their citizens. An EU Alcohol Strategy could therefore address the following policy areas:

**Price**
- Acknowledgement and acceptance of the evidence to support price controls in order to reduce the affordability of alcohol as one of the most cost effective interventions to tackle alcohol harm
- Enabling and encouraging Member States to regulate domestic alcohol prices through taxation, minimum unit pricing and other fiscal measures where appropriate
- Reviewing the EU directive on alcohol taxation to allow Member States to implement pricing policies that incentivize the production and consumption of lower strength alcoholic beverages (especially for wine products)

**Marketing**
- Review the EU Audio Visual Media Services Directive to establish a framework for regulating exposure of children to alcohol marketing activities in digital media. This would apply across the EU and therefore prevent cross-border discrepancies that can undermine national policies in Member States
- Enabling and encouraging Member States to adopt statutory and co-regulatory frameworks for marketing and advertising, and discouraging self-regulatory frameworks that have been shown to fail to protect children from exposure to alcohol marketing

**Availability**
- An EU directive could establish a common minimum purchase age for alcohol, set at 18 years
- The EU Services Directive should be reviewed to enable licensing authorities to fully recover the costs associated with enforcing licensing regulations through license fees
Labelling
- Establish an EU-wide requirement for all alcoholic beverages to list their ingredients, allergen and calorie information, in line with EU current regulations on the Provision of Food Information to Consumers
- Establish an EU-wide requirement for all alcoholic beverages to carry independent health information for consumers, for example in relation to drinking during pregnancy, drink driving and risk of dependency, liver disease and cancer

Drink Driving
- A harmonised Blood Alcohol Content legal limit across the EU would prevent cross-border discrepancies for drink driving incidents, as would a harmonised penalty system

Workplace policies
- Encourage a uniform approach to alcohol policies in the workplace across the EU, combining legislation, alcohol-free workplaces, and interventions aimed at those employees whose drinking patterns have an impact on performance at work

Monitoring and Surveillance
- Greater resources could be dedicated to data collection throughout the EU relating to alcohol consumption and related harms, including third party harms such as drink driving accidents, alcohol-related assaults, injuries, domestic abuse and sexual assaults. Better data on the impacts of alcohol will enable policymakers to identify policy needs and monitor and evaluate policy effectiveness.
- Common measurement standards could be agreed across the EU in order to monitor and evaluate alcohol harm and interventions to reduce harm and help to prevent cross-border discrepancies. For example, a common unit of alcohol or standard drink would harmonise consumption trend data across the region and also allow for common EU consumer information such as low risk drinking guidelines and health information on labels (see above)

A primary aim of an EU Alcohol Strategy must be to ensure that a Health in All Policies approach is taken with decisions at the EU level, and that the health and wellbeing of EU citizens is prioritized over trade and economic operator interests. An important objective within this aim must be to address the health inequalities, both within and between Member States, which are exacerbated by harmful alcohol use.

2. Are the EU’s alcohol policies underpinned by a sound scientific base?

There are many elements of the previous EU Alcohol Strategy that were underpinned by a strong evidence base of effectiveness. The comprehensive framework of policies outlined acknowledged the breadth of scope required in order to reduce alcohol harm across the EU population. Similarly, funding streams were established to advance the work of alcohol researchers and develop the evidence base for effective policies, through projects such as AMPHORA and ALICE RAP. Funding was also allocated to NGOs in order to build capacity amongst civil society actors, thus following an evidence-based approach of good governance in policymaking.
However, the previous EU Alcohol Strategy could have been more ambitious in its objectives to be more in line with evidence of effectiveness, and its expiration in 2012 presents a real threat that EU alcohol policies are not currently being prioritised according to the scientific evidence of the burden of disease in the region. The EU is the heaviest drinking region in the world and a significant proportion of alcohol harm is experienced by adults of working age through chronic health conditions including liver cirrhosis, cancer, stroke, heart disease and also mental illness and dependency (WHO EU Alcohol Action Plan, 2011). The focus of the current EU Alcohol Action Plan is on young people and binge drinking, and whilst the latter will capture the adult population to some extent, the Plan does not include recommendations for interventions aimed at reducing health problems caused by regular heavy consumption amongst middle-aged adults, who have the absolute highest rates of disability and premature death due to alcohol. For example, the recommendations for alcohol workplace policies refer only to those targeting young people, and lower blood alcohol content levels are recommended for young drivers and professional drivers of public transport services for children. Therefore it could be argued that the current EU alcohol policy is not underpinned by the scientific evidence relating to the health needs of all EU citizens, or the most cost-effective approach to tackling alcohol harm.

Within the narrow scope of the EU Action Plan on Youth and Heavy Episodic Drinking, there are several recommended policies that are based on good scientific evidence of effectiveness. These include supporting the implementation of fiscal and pricing policies to discourage heavy episodic drinking, promoting and ensuring the implementation of screening, early identification and brief advice in relevant subgroups and settings, use of effective enforcement measures to reduce availability of alcohol to underage people, use of legislation and co-regulation to reduce the exposure of young people to alcohol advertising and the establishment and enforcement of lower blood alcohol content levels for young and professional drivers. There are also several recommendations for improved and harmonised data collection, monitoring and surveillance of alcohol harm and interventions, which will help to improve the evidence base for effective EU policies in the future.

The Science Group of the EU Alcohol and Health Forum was established in 2008 to provide scientific guidance to the Forum. Since its inception the Group has produced two reports, relating to adolescent exposure to alcohol marketing and alcohol policies in the workplace. However, as outlined below, the function and role of the Science Group could be improved upon in order to ensure that EU alcohol policies are underpinned by an up to date evidence base of effectiveness moving forward, and that the evidence advising such policies is independently verified and free from commercial vested interests.

3. Are the EU’s alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?

The absence of a current EU Alcohol Strategy means that there is no comprehensive policy framework in existence at the EU level that can be compared to the WHO Global Alcohol Strategy or WHO EU Alcohol Action Plan. The interim EU Action Plan on Youth Drinking and Heavy Episodic Drinking has a narrower scope, however, as stated previously, there are operational objectives within this that adhere to WHO recommendations based on the best
available scientific evidence. These include:

- Encourage health related information including alcohol related risks on alcoholic beverages to help consumers make informed choices. Also, ensure that containers of alcoholic products carry a warning message determined by public health bodies describing the harmful effects of drinking during conception and pregnancy
- Support and implement fiscal and pricing policies to discourage heavy episodic drinking
- Promote and ensure the implementation of Screening, Early Identification and Brief Intervention in all relevant subgroups and settings
- Promote, ensure and enforce adequate level of controls in on- and off-premises relating to underage sales
- Use existing legislation and co-regulation to reduce young people’s exposure to alcohol advertising
- Reduce alcohol related traffic accidents by establishing lower BAC levels (for young drivers and profession drivers for public transport services for children)
- Make data on alcohol related harm available as a basis for policy making

Policies outlined in the previous EU Alcohol Strategy that were in alignment with WHO frameworks, but are absent from the Action Plan on Young People and Binge Drinking include:

- Recommendations for a drink driving legal blood alcohol content (BAC) limit of 0.5mg or less for all adults, combined with the enforcement of frequent and systematic random breath testing, supported by education and awareness campaigns involving all stakeholders
- Setting a minimum purchase age of 18 years for all alcoholic beverages, including beer and wine

A key omission from the EU alcohol policies at present is a set of specific, measurable and timely targets or indicators, outlining the EU ambitions for reducing alcohol harm. This is in contrast to current WHO strategies that include the following goals:

- To achieve a 10% relative reduction in the harmful use of alcohol, as appropriate in the national context, by 2025 (WHO Global Action Plan for Prevention and Control of Non Communicable Diseases 2013-2020 – baseline data from 2010)
- Offer brief advice programmes to 30% of the population at risk of hazardous or harmful alcohol consumption; or offering early identification and brief advice to 60% of the population at risk (WHO European Alcohol Action Plan)
- To achieve a 25% global reduction in premature mortality from non-communicable diseases (NCDs) by 2025 (World Health Assembly Political Declaration, May 2012)

IAS believes that a new EU Alcohol Strategy should compliment existing WHO strategies by including targets and indicators that have been endorsed by Member States.

42 It is noted that the UK and Malta are the only EU countries with a BAC of 0.8mg/ml, higher than the recommended minimum of 0.5mg/ml
4. Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

IAS believes that the mechanisms created in the previous EU Alcohol Strategy still have an important role to play in working to reduce alcohol harm in Europe, however the roles of the Committee on National Alcohol Policy and Action (CNAPA) and the EU Alcohol and Health Forum (EAHF) need to revised to reflect the requirements of a new, more ambitious strategy that puts Health in All Policies at the heart of it focus.

As CNAPA is the body representing Member States, it is essential that its role be strengthened to reflect its position as the driving force for the design and implementation of a new EU Alcohol Strategy. It could be argued that to date CNAPA’s view has not been awarded sufficient attention, with several calls for a renewed EU Strategy since 2010 failing to result in action from the European Commission. CNAPA has recently been tasked with drafting a scoping paper, outlining the principals required for a new EU Alcohol Strategy. This will be presented to the new Commissioner following their appointment. It is essential that the views and priorities of CNAPA are given active consideration in developing and implementing European alcohol policy.

Conversely, the EUAHF has been awarded greater priority in the EU alcohol policy process that its remit requires. Despite the EUAHF having no official role in policy development, views of forum members were sought throughout the development of the EU Alcohol Action Plan, and objections from economic operators to scientific reports produced on behalf of the Forum have been upheld. IAS is a member of the Forum and sees value in maintaining a mechanism whereby NGOs and public health bodies can discuss with the European Commission how economic operators can contribute to actions that will reduce alcohol harm. However, we believe that the role and function of the Forum should be guided by the WHO guidance, which states alcohol industry activities should be restricted to their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages and that they should have no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests. We therefore believe the EUAHF should become a more focussed body, with an agreed workplan that is aligned to a set of core objectives laid down by CNAPA. Economic operators can commit to take action that will achieve measurable objectives, in line with such a workplan. NGOs and public health bodies can support this process by ensuring that commitments are based on evidence of effectiveness and are subject to robust monitoring and evaluation processes, and that there is transparency in all Forum activities.

The function of the Science Group of the EUAHF would be better placed if it reported directly to CNAPA. This would enable policy discussions on the evidence to support interventions to reduce alcohol harm to be free from commercial conflicts of interest. It is not appropriate that economic operators with pecuniary interests in policy areas such as price and marketing should be involved in the presentation of scientific evidence to policy makers. The Science Group of the EUAHF should therefore be re-established as an
independent expert group, free from membership from economic operators.

5. Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?

The previous strategy established funding streams for alcohol research, including the Alice Rap and AMPHORA projects, however the absence of an EU Alcohol Strategy presents the threat that research grants will not be made available to investigate alcohol harm.

Whilst there are funding streams available within EU programmes for alcohol research, there is an urgent need for better data on alcohol in Europe and coordination of alcohol research, both of which should be addressed in a new EU Alcohol Strategy. The European Commission’s evaluation of the Alcohol Strategy to 2012 highlighted that less than 3% of the total budget of the Health Programme for 2008-2013 and less than 1% of the budget for health under the Seventh Research Programme were allocated to alcohol. This is not sufficient given the harm cause by alcohol.

The European Commission’s Committee on Alcohol Data Collection, Indicators and Definitions outlines three key indicators for monitoring changes in alcohol consumption and alcohol-related harm. These indicators measure:

- Volume of consumption (total recorded and unrecorded per capita consumption of pure alcohol in litres by adults (15 years and older), with sub-indicators for beer, wine, and spirits);
- Harmful consumption pattern (intake of at least 60 g of alcohol on a single occasion at least once per month during the previous 12 months); and
- Health harm (years of life lost – YLL) attributable to alcohol, with sub-indicators for alcohol-attributable YLL from chronic disease and injury).

The WHO European Alcohol Action Plan recommends that regular reports on alcohol are prepared covering the following five topics:

- Drinking among adults, including trends in alcohol consumption, types of alcohol consumed, socioeconomic variables, demographic characteristics, drinking and pregnancy, adults’ drinking behaviour and knowledge of alcohol, and geographical patterns of alcohol consumption;
- Underage drinking, including trends in alcohol consumption, types of alcohol consumed, socioeconomic variables and drinking among different ethnic groups, associations with other substance use, and drinking behaviour and knowledge of alcohol;
- Drinking-related ill health, including hazardous, harmful and dependent drinking, consultations about drinking with health professionals, alcohol-related hospital admissions and alcohol-related mortality;
- Availability and affordability of alcohol;
- Costs to society, including expenditure on alcohol-related harm, alcohol-related crime and alcohol-related traffic accidents; and
- Policy responses, including all the policy outcomes of [the WHO] Action Plan relevant to a country related to leadership, awareness and commitment, health services’ response, community and workplace action, drink–driving, availability, marketing, pricing, reducing
intoxication, and reducing the impact of illicit and informally produced alcohol.

At present several Member States collect relevant data on alcohol harm and consumption, however there are many countries where sufficient data is not routinely available. We recommend that an EU Alcohol Strategy includes funding mechanisms for data collection for the above indicators, so that alcohol harm and policy progress can be monitored and evaluated across the EU.

6. Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

Tensions exist between the promotion of free trade (under Article 34 of the EU Treaty) and the conditions upon which Member States can restrict free trade, including the protection of public health (outlined in Article 36), through fiscal measures for alcohol within the EU. Current EU regulations have the ability to undermine Member States’ efforts to implement pricing policies designed to protect public health. The abolition of the duty paid allowance system effectively undermined countries with higher taxation rates for alcohol, and Scotland’s plans to introduce minimum unit pricing for alcohol could potentially be thwarted by a legal decision made in the European Court of Justice.

In 2012, the legal challenge to Scotland’s plans to introduce minimum unit pricing, launched by the Scotch Whisky Association and Spirits Europe, generated an unfavourable and ill-informed opinion from the European Commission. This did not correctly differentiate between the roles of minimum unit pricing and taxation, and recommended that taxation alone could achieve the same objective of reducing consumption of cheap, strong alcohol amongst harmful drinkers. However, the EU Directive on alcohol taxation actually prohibits the implementation of a taxation system for all beverages based on their alcoholic strength. Indeed, this is one of the many reasons why the Scottish Government turned to minimum unit pricing as a policy solution to the problems caused by cheap, strong drink in Scotland. Minimum pricing and taxation are complimentary policies and are not mutually exclusive.

Questions have been referred to the European Court of Justice (CJEU) for clarification by the Scottish Courts in the legal challenge. If the CJEU responds unfavourably against minimum pricing, which has been ruled by Scottish Court of Session as a proportionate response to a public health need, this will raise a key issue regarding the role of the European Courts in re-assessing evidence considered by elected legislatures within Member States. This would raise questions about subsidiarity and the margin of appreciation between Member States and the EU and could potentially have adverse consequences for wider public health policies than alcohol.

Institute of Alcohol Studies

16 September 2014
Institute of Alcohol Studies, Alcohol Focus Scotland and Professor Nick Sheron, University of Southampton—Oral Evidence (QQ 33-51)

Institute of Alcohol Studies, Alcohol Focus Scotland and Professor Nick Sheron, University of Southampton—Oral Evidence (QQ 33-51)

Transcript to be found under Alcohol Focus Scotland.
Lundbeck Ltd—Written Evidence

Lundbeck Ltd—Written Evidence
Lundbeck—Written Evidence (EAS0011)

Lundbeck is an ethical research-based pharmaceutical company specialising in brain disorders, such as depression and anxiety, bipolar disorder, schizophrenia, Alzheimer’s disease, Parkinson’s disease and alcohol dependence.

1. Should there be another EU Alcohol strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next strategy be, with reference to the previous strategy and evaluations thereof?

A new EU Alcohol Strategy is essential to protect the EU’s economic and public health and should strive for reducing alcohol harmful consumption, which is key to the EU’s growth.

A revision of the EU Alcohol Strategy would respect the subsidiarity principle and is in line with the Treaty on the Functioning of the EU (Article 168.5))43. Member states, including the UK, have repeatedly called upon the European Commission to renew the EU Alcohol Strategy (e.g. Council Conclusions44, CNAPA meetings45), with limited impact in Brussels to date.

The assessment of the EU Alcohol Strategy concluded on the effectiveness and relevance of EU to support member states and the value of a platform where national experts can exchange best practices.

A key priority area outlined in this assessment report was for the need to reduce the negative impact of alcohol in the workplace. Research indicates that many alcohol-dependent people are employed and estimates from the International Labour Organisation suggest that globally, 3-5% of the average workforce are alcohol-dependent, and up to 25% drink heavily enough to be at risk of dependence48.

Employees who are alcohol-dependent in the workplace are therefore at increased risk of putting their colleagues in harm (1/4 workplace accidents are linked to alcohol)49 as well as negatively impacting upon the economic health of their companies (it is estimated that up to

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49 Alcohol related accidents, Drinkaware.co.uk, updated in June 2014 available at: http://www.drinkaware.co.uk/check-the-facts/effects-on-your-safety/alcohol-related-accidents/
€74 Bn annual productivity losses in the EU are due to alcohol dependent workers\(^\text{50}\). The European Workplace and Alcohol project (EWA) therefore recommends\(^\text{51}\):

1. That a business culture is created that promotes an alcohol-free environment where internal policies and prevention health campaigns are implemented and include alcohol brief interventions and access to support systems
2. Support is provided to HR and managers to cope with employees who may have alcohol-related problems.

In addition to the workplace, at a minimum, a new EU Alcohol Strategy should be brought in line with the World Health Organisation (WHO) commitments made by the 28 EU member states under the WHO Global Alcohol Strategy\(^\text{52}\) which establishes 10 priority areas reflecting an integrated approach to alcohol policy from prevention, to early diagnosis, screening and treatment, as outlined below:

1. leadership, awareness and commitment  
2. health services’ response  
3. community action  
4. drink-driving policies  
5. availability of alcohol  
6. marketing of alcoholic beverages  
7. pricing policies  
8. reducing the negative consequences of drinking and alcohol intoxication  
9. reducing the public health impact of illicit alcohol and informally produced alcohol  
10. monitoring and surveillance

In addition, a new EU Alcohol Strategy should support member states to reach their WHO target on alcohol which stipulates a 10% reduction in the harmful use of alcohol by 2025\(^\text{53}\). This ambition is supported by data from the 2012 DALYs (disability-adjusted life years), which demonstrate that currently, 139 million DALYs or 5.1% of the global burden of disease and injury, were still attributable to alcohol consumption\(^\text{54}\).

A new EU Alcohol Strategy should also be built on the new independent evidence produced by EU research programmes and the leading key opinion researchers and epidemiologists in this area. Significantly, this shows that in Europe 71% of the net-mortality and 60% of the costs related to alcohol are due to dependence\(^\text{55}\) and therefore the value of earlier prevention interventions within the healthcare sector and beyond has the potential to save the lives of thousands\(^\text{56}\). Still, despite the share of the burden of alcohol dependence in costs to society and links to other expensive chronic conditions, less than 15% of people with


\(^{51}\) EWA Policy Recommendations, 2014:  
http://eurocare.org/library/ewa/library/ewa_policy_recommendations_english

\(^{52}\) WHO, Global strategy to reduce harmful use of alcohol, 2010:  
http://www.who.int/entity/substance_abuse/alcstratenglishfinal.pdf?ua=1


\(^{54}\) WHO, Global status report on alcohol and health, 2014:  
http://apps.who.int/iris/bitstream/10665/112736/1/9789240692763_eng.pdf?ua=1

\(^{55}\) In the context of diagnosed alcohol dependence as defined by DSM-IV.

\(^{56}\) Rehm et al., ‘Interventions for alcohol dependence in Europe: a missed opportunity to improve public health’, Centre for addiction and Mental Health, May 2012,  
alcohol dependence are diagnosed and less than 10% are actually treated\(^57\). These figures reflect the prevailing failure of early interventions within the healthcare setting, including in primary care to address alcohol related problems.

EU-researchers have identified the reasons behind the low diagnosis and screening figures as (1) lack of training/education and limited experience to engage in this area pro-actively\(^58\); (2) lack of time and effective national incentive systems that allows them to engage in a cost-effective manner\(^59\); (3) low preference to initiate alcohol preventive talks with patients\(^60\).

Researchers\(^61\) and the WHO\(^62\) therefore recommend measures to support member states to address AUDs in primary healthcare services and to support the monitoring in the progress in the areas below, which could be taken into consideration in a new EU Alcohol Strategy:

1. Inclusion of harmful alcohol use screening as a risk factor (e.g. AUDIT-C) in chronic disease management in primary care pathways, e-health checks and routine protocols.

2. Adopt and/or update professional and/or national clinical practice guidelines for primary care and for the early detection, brief interventions and treatment of AUDs (e.g. WHO identifies the NICE AUDs Guidelines as Best Practice). Currently only 60% of the WHO-Euro region has guidelines in place\(^63\). More than having guidelines in place, there is a need to fund a monitoring system on their implementation.

3. Support appropriate training for PHPs and revise the medical curricula to bring them up to speed on the value of Brief Interventions, screening methods for AUDs in routine screening and in relation with other chronic conditions (e.g. hypertension), treatment options and appropriate referral systems when needed.

4. Mechanisms to encourage PHCPs to screen and detect AUDs, e.g. create disease management programmes, create and improve incentive structure systems for the early detection of harmful use of alcohol (NB: OECD\(^64\) identifies UK’s QOF system as a best practice).

In terms of process, a new EU Alcohol Strategy needs to have SMART\(^65\) objectives to ensure an adequate monitoring of the progress made in the different member states and within each priority area. This requires that targets and indicators are established (e.g. reduce the prevalence of AUDs by 15% by 2025; increase screening of AUDs by 15% by 2025) and that the EU and national research-scientific communities are properly funded alongside


\(^{59}\) AMPHORA, op. cit.

\(^{60}\) Brotons C et al, Attitudes toward preventive services and lifestyle: the views of primary care patients in Europe. The EUROPREVIEW patient study, Family Practice 2012; 29:i168-i176


\(^{64}\) OECD Making Mental Health Count, 8 July 2014

\(^{65}\) SMART: Specific, Measurable, Assignable, Realistic, Time-related
international organisations which can lead the monitoring (e.g. WHO’s policy timeline and monitoring report on the EU Alcohol Strategy) and produce unbiased evidence (e.g. OECD).

2. Are the EU’s Alcohol policies underpinned by a sound scientific base?

The EU Alcohol Strategy was adopted in 2006 and reflected the priorities of the time, which still remain relevant. As mentioned above however, from the initial five priorities identified, efforts in the workplace setting should be reinforced. In addition, in the last 10 years, a wealth of new unbiased evidence has come to the fore regarding the links between heavy drinking and episodic drinking and poor health, the burden of alcohol dependence and the cost-effectiveness of policy interventions to reduce alcohol-related harm. All of these should be taken into account when revisiting the EU Alcohol Strategy. In particular we would like to highlight the findings and recommendations of AMPHORA\textsuperscript{66}, ALICE-RAP\textsuperscript{67}, EWA\textsuperscript{68}, INEBRIA\textsuperscript{69} and ODHIN\textsuperscript{70}.

3. Are the EU’s Alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example under the World Health Organisations (WHO)?

Lundbeck supports further cooperation between the EU and international organisations and would like to encourage further alignment with existing international frameworks to address alcohol-related harm. This would entail a renewal of the EU Alcohol Strategy so as to:

1. Include measures on the 10 WHO priority areas (as mentioned above).
2. Confirm the WHO target of a 10% relative reduction in the harmful use of alcohol for the reduction of 25% of NCDs\textsuperscript{71}, which the 28 EU member states have committed to.
3. Support and coordinate with the WHO a systematic measurement of the progress made in the 10 priority areas and the 10% target.

4. Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practices between Member States, industry, civil society organisations and EU institutions, for example, the EU and Alcohol Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

As a member of the EAHF, Lundbeck welcomes the creation of the EAHF and CNAPA as relevant platforms to implement and support the Alcohol Strategy. Moreover, Lundbeck believes in the value of bringing likeminded healthcare stakeholders (private and public) to reduce alcohol related harm. As such, Lundbeck has contributed to the Conclusions of the Roundtable on Alcohol Related Harm, which promote an integrated approach from prevention, early interventions in the healthcare sector including early diagnosis, screening, access to treatment and the establishment of adequate services\textsuperscript{72}.

\textsuperscript{66} AMPHORA – Alcohol Public Health Research Alliance, \url{http://www.amphoraproject.net/}
\textsuperscript{67} ALICE-RAP - Addiction and Lifestyles in Contemporary Europe-Reframing Addictions Project, \url{http://www.alicerap.eu/}
\textsuperscript{68} EWA – European Workplace and Alcohol, \url{http://www.eurocare.org/ewa} \
\textsuperscript{69} INEBRIA – International Network on Brief Interventions for Alcohol & Other Drugs, \url{http://www.inebria.net/Du14/html/en/Du14/index.html}
\textsuperscript{70} ODHIN – Optimizing Delivery of Healthcare Interventions, \url{http://www.odhinproject.eu/}
\textsuperscript{71} WHO, Global Monitoring Framework for NCDs, global target 2, \url{http://www.who.int/nmh/ncd-tools/target2/en/}
\textsuperscript{72} ELPA et al., Conclusions of the Roundtable on Alcohol Related Harm, 2013, \url{http://www.elpa-info.org/tl_files/elpa_downloads/2013%20content/Conclusions%20of%20the%20EU%20Roundtable%20on%20Integr} \textsuperscript{ated%20Approach%20to%20Alcohol%20Re...pdf
Concerning CNAPA, Lundbeck welcomes CNAPA’s commitment to advocate for ambitious and holistic alcohol policies. Lundbeck would like to reiterate the Commission’s implementation report on the fact that CNAPA would benefit from more political visibility. For example, beyond the exchange of best practices, CNAPA could open a structured dialogue with the forthcoming EU Trio Presidencies and with the EP Health Coordinators to present CNAPA’s recommendations on how to take EU policy action on alcohol to the next level.

In addition, it may be useful to have a structured and timely dialogue on (1) the timelines and processes for applying to EU funding for member states to improve national healthcare systems; (2) with other EU departments to provide recommendations on EU’s health priorities and ensure “alcohol/health in all policies”.

EAHF and CNAPA should remain separate and independent platforms, however, to improve coordination, it could be beneficial to ensure the presence of representatives from the EU Trio Presidencies and CNAPA members at the EAHF meetings – who could report back to CNAPA members on points of relevance.

Taken into account recent defections from the EAHF by healthcare organisations there is room for improvement so that EAHF becomes more engaged with the range of health and evidence based literature published in peer-review journals.

For example, in line with other healthcare stakeholders, Lundbeck would encourage the EU to strengthen and provide the necessary resources for the EAHF’s Science Group to fulfill its full potential. We believe that the Science Group can play an important role in (1) setting the scene in each EAHF session on the health consequences of harmful use of alcohol and on new evidence published of interest to the EAHF; (2) identifying research gaps and priorities for EU funding based on discussions with the healthcare members of the EAHF.

To make EAHF’s membership less bureaucratic and burdensome, Lundbeck would suggest:

- Provide practical guidance on how to monitor specific types of commitments (e.g. Google analytics to assess online campaigns, feedback questionnaires and media clippings to assess events, etc)
- Open EAHF up to individual membership alongside “umbrella organisations” membership to improve the accountability of the commitments made

5. Is the EU funding allocated to alcohol-related research and harm-reduction programmes sufficient to achieve the stated aims?

The EU has played an essential role in ensuring that EU funding is allocated to the research community and to international institutions to monitor and model the effects of alcohol and policies (see examples given above).

Despite the results and recommendations of these research projects, Brussels seems reluctant to take them on board and renew the EU Alcohol Strategy to reflect them. In addition, more funding is needed to (1) ensure that sound communication and media

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programmes are put in place (beyond an outreach to the EU media, results have to be presented to European and National Parliaments, the Council and Trio of Presidencies); (2) to monitor the implementation of the recommendations; (3) and to ensure the sustainability of the research in the long-term.

The Joint Action on Alcohol Related Harm also provides important funding to advance alcohol policy.

However, when compared to other risk factors or chronic conditions, alcohol remains significantly underfunded in the EU. The total EU budget for the 38 specified alcohol projects from 2004-2014 amounted to EUR 15,779,994.57. Compared to the area of nutrition and physical activity in the same time span, the total EU budget for the 37 projects amounted to EUR 23,460,186.59, a negative difference for alcohol of almost EUR 8 million.

More efforts could also be made to ensure that countries affected by austerity measures are not penalised for investing in cost-effective healthcare solutions that help reducing alcohol-related direct and indirect costs and fostering productivity (e.g. some treatment programmes for addiction people have been cut in the South of Europe).

Also, due to the complexity of alcohol-related problems and how alcohol affects the human body, more research is needed on:

1. the link between alcohol dependence and co-morbidities (hypertension, stroke, cancer, diabetes, liver and gastro-diseases, depression) and the value of reduction of alcohol consumption to reduce co-morbidities and alcohol related costs (indirect and direct costs)
2. the effectiveness of early interventions, early screening and adequate treatment and counselling services for reducing AUDs, which represent the bulk of alcohol-related costs, mortality and disability
3. budgets allocated to health systems to screen AUDs in PHC and incentives systems to diagnose and manage AUDs in comparison to tobacco
4. how alcohol affects the brain; the link between receptors in the brain (e.g. kappa) and addiction

The WHO has also recommended for standardised coding and data collection systems in order to improve the ability to benchmark across the EU.

6. Do EU policies on taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes

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of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

The WHO states that pricing policies are one of the elements in an overall alcohol policy and should be developed alongside other policy measures identified as the 10 priority areas, including improving healthcare services delivery (early detection, brief interventions, screening and treatment).

Additionally, the All Party Parliamentary Group (APPG) on Alcohol in the UK Parliament on 11 August published their manifesto on how to make alcohol misuse a public priority. The aim of the manifesto is to serve as a foundation for the future government’s Alcohol Strategy and to promote public health and minimise alcohol-related harm in the UK.\(^80\)

19 September 2014

Professor Theresa Marteau, Director, Behaviour and Health Research Unit, University of Cambridge; Chris Baker, Consultant; John Duffy, Statistics and Policy Consultant; and RAND Europe—Oral Evidence (QQ 63-73)

Transcript to be found under Chris Baker.
Transcript to be found under Department of Business, Innovation and Skills.
Portman Group—Written Evidence

1. The Portman Group is the responsibility body for UK drinks producers. We regulate the promotion and packaging of alcoholic drinks sold or marketed in the UK; challenge and encourage the industry to market its products responsibly; and lead on best practice in alcohol corporate social responsibility.


EXECUTIVE SUMMARY

3. There is no requirement for an overhaul of the existing EU alcohol strategy. However an evolved and strengthened strategy should take into account the lessons and successes of partnership working between the UK Government and the UK drinks industry that has demonstrated effectiveness at tackling alcohol harms.

4. Recent EC funded research\(^82\) suggests that within the EU there exists wide variation in national consumption patterns and harms. Furthermore this research examined the influence of demographics and culture on alcohol policy effectiveness finding that these factors can have a strong impact on both drinking styles and alcohol control policy effectiveness.

5. Within the UK, the vast majority of adults enjoy alcohol responsibly and government statistics clearly show significant declining trends in harmful consumption, alcohol-related crime and drinking among young people over the past decade\(^83\). The UK industry has worked in partnership with the UK Government to support these trends through voluntary action.

6. However recent Government data\(^84\) demonstrates how national trends conceal local areas with disproportionate harms.

7. A local approach, based on partnership working between local authorities, police, industry, and community groups, has shown effectiveness in the UK when it comes to tackling these locally-specific alcohol harms.

8. An evolving EU strategy should recognise the importance of local data and evidence and facilitate best practise sharing at the national, regional and local levels.

CONTEXT: ALCOHOL TRENDS

The UK in Europe

\(^81\) Department of Health Public Health Responsibility Deal - https://responsibilitydeal.dh.gov.uk/
\(^82\) European Commission Alcohol Public Health Research Alliance (AMPHORA) - http://www.amphoraproject.net/
\(^84\) PHE Longer lives map – liver disease, http://longerlives.phe.org.uk/
9. The UK consumes less alcohol than 15 European countries including France, Austria, Germany, Portugal, Ireland and Denmark and is below the average for European OECD members\textsuperscript{85}

**UK National Trends**

10. Government statistics show patterns of harmful alcohol consumption are in decline. Per capita consumption has fallen 19% in the last 10 years\textsuperscript{86} and binge drinking has fallen by nearly 25% since 2005\textsuperscript{87}

a. 70% of adults drink within NHS lower risk guidelines on their heaviest drinking day; this has increased every year since new measurements were recorded in 2005\textsuperscript{88,89}

b. Drinking among 11-15s has fallen to the lowest recorded level (i.e. since 1988) and hospital admissions for under 18s due to alcohol-related conditions have fallen in recent years\textsuperscript{90}

c. Alcohol-related violent crime has nearly halved since 1995\textsuperscript{91}

d. Drink driving fatalities have halved since 2004\textsuperscript{92}

11. While the national picture improves, local data shows areas which continue to suffer disproportionate harms.\textsuperscript{94} For example, the North East of England suffers a rate of alcohol-related admissions two-thirds higher than that in the South East\textsuperscript{95}

**SPECIFIC QUESTIONS FOR RESPONSE**

*Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?*

12. The UK Government’s alcohol strategy\textsuperscript{96} recognises the UK drinks industry’s role and responsibility in tackling alcohol harms and places an emphasis on partnership working with industry in order to deliver its public policy objectives in this area.

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\textsuperscript{85} OECD Health at a Glance: Europe 2012 - \url{http://dx.doi.org/10.1787/9789264183896-en} also see \url{http://portmangroup.org.uk/docs/default-source/sponsorship-booklet/trends-in-alcohol---a-compilation-of-data-from-across-the-uk-1-2.pdf?sfvrsn=0}

\textsuperscript{86} British Beer and Pub Association Statistical Handbook 2014

\textsuperscript{87} Office for National Statistics Opinions and Lifestyle Survey 2012

\textsuperscript{88} Office for National Statistics Drinking: adults behaviour and knowledge in 2009, and Opinions and Lifestyle Survey 2012

\textsuperscript{89} Office for National Statistics Opinions and Lifestyle Survey 2012

\textsuperscript{90} Public Health England Local Alcohol Profiles England and Health and Social Care Information Centre Smoking, drinking and drug use among young people in England

\textsuperscript{91} Office for National Statistics Crime Survey for England and Wales

\textsuperscript{92} Department for Transport

\textsuperscript{93} Office for National Statistics Drinking: adults behaviour and knowledge in 2009

\textsuperscript{94} Public Health England Local Alcohol Profiles England

\textsuperscript{95} Health and Social Care Information Centre Statistics on Alcohol 2014

\textsuperscript{96} Home Office The government’s alcohol strategy - \url{https://www.gov.uk/government/publications/alcohol-strategy}
13. Through the Government’s Public Health Responsibility Deal\textsuperscript{97} Alcohol Network (RDAN), the UK drinks industry is fulfilling a range of voluntary pledges designed to improve public health.

14. The UK Government has recognised the need for locally-targeted action to tackle alcohol-related harms and has introduced 20 Local Alcohol Action Areas (LAAAs)\textsuperscript{98} which are also supported by the drinks industry via a range of industry-led local partnership schemes.

15. Given the UK’s improving national trends around alcohol (see above) and the ongoing partnership working between the UK Government, local authorities, the UK drinks industry and the third sector, an evolved EU alcohol strategy should look to incorporate a stronger focus on:

   a. **Better partnership working between governments and the alcohol industry at national level** to work together to improve public health and develop better alcohol awareness, education and information;

   b. **Strengthening local and regional partnerships between authorities, frontline service providers and the alcohol industry to tackle alcohol harms on a locality-specific basis.** An EU strategy should also acknowledge and support the effectiveness of locally-targeted solutions to alcohol harm.

16. In the UK, the effectiveness of partnership working is evidenced by the success of the Government’s Public Health Responsibility Deal Alcohol Network (RDAN). Through the RDAN framework the alcohol industry has publicly committed to voluntary pledges designed to improve public health and develop better education and targeted local support to tackle alcohol harms. These pledges are designed to further the positive trends around alcohol in the UK.

17. Under RDAN the UK drinks industry have voluntarily pledged to:

   - Improve health information on alcohol labels on 80% of products on shelves, by December 2013;
   - Increase awareness of alcohol units in the on-trade;
   - Increase awareness of alcohol units, calories & other information in the off-trade;
   - Tackle under-age alcohol sales;
   - Continue support for Drinkaware (the alcohol education charity);
   - Strengthen the rules on advertising & marketing of alcohol (including introducing a new alcohol sponsorship Code of Practice);
   - Support community actions to tackle alcohol harms (including targeted local action to support the Government’s LAAAs programme);
   - Take 1 billion units out of the UK market by 2015 through alcohol unit reduction (including responsible can packaging); and

\textsuperscript{97} Department of Health Public Health Responsibility Deal - [https://responsibilitydeal.dh.gov.uk/](https://responsibilitydeal.dh.gov.uk/)

Support lifeskills education and alcohol education in schools

18. A full list of Responsibility Deal pledges, including the details of and signatories to each pledge is available.\(^{99}\)

19. The evolving partnership framework of RDAN allows for further pledges to be made by industry, beyond those commitments made at the outset. For example, in July 2014, a new set of pledges\(^{100}\) under the RDAN was announced. These included voluntary commitments by:

- Producers calling time on super-strength products in large cans
- Retailers committing to the responsible display and promotion of alcohol in shops and supermarkets; and
- Pubs and bars ensuring they stock house wines below 12.5% ABV and promote lower-alcohol products to customers

Whilst most RDAN pledges are currently under delivery, notable targets have been reached in certain pledges, including:

- **Labelling.** At a government-industry summit in July 2014, Public Health Minister Jane Ellison MP confirmed the industry had achieved its aim by delivering 79.3% against its target of ensuring 80% of all products on shelves would include clear unit content, NHS guidelines and a warning about drinking when pregnant on their labels, by December 2013.\(^{101}\)

- **Unit reduction.** In April 2014, the Department of Health confirmed the industry is on-track to deliver on its pledge to remove 1 billion units of alcohol from the UK market by 2015. 253 million units had been removed through direct industry action in the first year of the pledge.\(^{102}\)

In the UK, the focus on partnership has proved effective in helping to improve public health and in tackling alcohol harms in those local areas most in need of support. A one-size-fits-all approach cannot adequately address the different requirements of individual member states and an EU strategy should recognise that local/regional policies based on a partnership approach have a proven track record in the UK, and are based on a constructive relationship between industry and government at national level.

Partnership working has secured positive contributions from the alcohol industry and delivered funding and expertise to local service providers at no cost to the taxpayer.

**Are the EU’s alcohol policies underpinned by a sound scientific base?**

20. The EU’s alcohol policies should incorporate and support evidence gathered at the local level. A key development in the UK since the initiation of the last EU Alcohol

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\(^{101}\) A full report will be published by the Department of Health in due course.

Strategy in 2007 has been the improvement and expansion of data collection and monitoring, particularly at the local level.

21. The Local Alcohol Profiles England (LAPE) project\textsuperscript{103} developed by Public Health England has allowed detailed examination of trends in health harms, crime and anti-social behaviour that demonstrates the effectiveness of local partnership working and highlights areas in which problems may be concentrated.

22. The Government’s Local Alcohol Action Areas (LAAAs) initiative\textsuperscript{104} used this local level data to identify areas with specific problems that required additional support from the Home Office and industry schemes to address particular issues.

23. One of the five priority themes of the previous EU alcohol strategy was to “develop and maintain a common evidence base at EU level.”\textsuperscript{105} As part of this endeavour the European Commission provided funding for the Alcohol Public Health Research Alliance (AMPHORA) project which examined policy interventions across 12 European countries and assessed their effectiveness in the context of broader socio-demographic changes. Results were recently published in the journal *Substance Use & Misuse*.\textsuperscript{106}

24. One of the key findings of this research was that ‘unplanned’ contextual factors such as social, cultural, economic, religious and demographic changes account for more variation in alcohol consumption than ‘planned’ policy interventions: “By and large in the 12 European countries altogether the policies explain approximately 30%, while the unplanned variables explain about 80% of the total consumption variability.”\textsuperscript{107} Similarly in relation to liver mortality and transport accident deaths, unplanned changes accounted for more variation than planned interventions in most countries.\textsuperscript{108}

25. The implications of this research are that context is important to alcohol policy effectiveness and that the transferability of interventions between countries with different socio-demographic features and drinking cultures may be limited. These findings support the importance of locally gathered evidence of policy effectiveness and the need to interpret the scientific base within the cultural context.

26. A sound scientific base for policy recommendations at the EU level should seek to incorporate local data and experience and provide tools and guidance for local authorities to feedback into the broader strategy.

\textsuperscript{103} Public Health England *Local Alcohol Profile England* - http://www.lape.org.uk/


\textsuperscript{105} European Commission *An EU strategy to support Member States in reducing alcohol related harm*

\textsuperscript{106} Substance Use & Misuse, Volume 49, Number 12 (October 2014). *Drinking Patterns in 12 European Countries: Unplanned Contextual Factors and Planned Alcohol Control Policy Measures* http://informahealthcare.com/toc/sum/current

\textsuperscript{107} AMPHORA, *Report of an analysis of European alcohol-related cultural, social and policy interactions and their impact on alcohol consumption and alcohol-related harm*, p. 396

\textsuperscript{108} Ibid, p. 397-8

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Declaration of Interest
We are a not-for-profit organisation funded by eleven member companies\(^\text{109}\) who represent every sector of drinks production and collectively account for more than half the UK alcohol market.

Confidentiality
There are no confidentiality issues and we confirm full public disclosure.

19 September 2014

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\(^{109}\) Current member companies: AB InBev; Bacardi Brown-Forman Brands; Beverage Brands; Carlsberg; Diageo; Heineken; Jägermeister; Molson Coors; Pernod Ricard; SAB Miller and Treasury Wine Estates
Transcript to be found under Advertising Association.
OVERVIEW

1. As agreed at the oral evidence session on Wednesday 3 December 2014, we are pleased to provide our supplementary evidence containing the detail requested by the committee including:

   - An overview of the number and location of industry-led local alcohol partnership schemes;
   - An overview of the progress of monitoring and evaluation of the Responsibility Deal Alcohol Network pledges;
   - An overview of where there is incomplete or limited official data available in the UK or at EU level when looking at alcohol trends.

LOCAL ALCOHOL PARTNERSHIPS BY LOCAL AUTHORITY

2. As requested by the Committee, our supplementary evidence includes a spreadsheet of all local alcohol partnerships schemes operating in the UK, by local authority. (Annex 1).

3. Local alcohol partnership schemes are industry-led and funded and include: Community Alcohol Partnerships, Best Bar None, Purple Flag and Pubwatch. Street Pastors also operate as part of many local partnerships but are not funded by the drinks industry. Business Improvement Districts are not covered in the information provided, although they are an important part of many local partnerships.

4. We have ensured the information is as up-to-date as possible, and is correct as of 2013. However, partnership schemes have been increasing in number and changing in size and scope, therefore additional schemes may be currently operating that are not included in this list.

5. More information about local alcohol partnerships (including key case studies) can be found here: http://www.portmangroup.org.uk/responsibility-programmes/landing_page/local-partnerships

EVALUATION OF RESPONSIBILITY DEAL ALCOHOL NETWORK (RDAN)

6. As part of the Government’s Responsibility Deal Alcohol Network (RDAN) the UK drinks industry has made a series of voluntary commitments to help improve public health and tackle alcohol-related harms. Overall these form part of the industry’s commitment to promoting responsible drinking across communities (Annex 2).

7. Full details of all the pledges can be found here: https://responsibilitydeal.dh.gov.uk/pledges/

8. Examples below set out the monitoring and evaluation of key pledges, including the completed labelling pledge and the ongoing unit reduction pledge. A number of pledges are still under delivery. A full evaluation of RDAN will be carried out by the London School of Hygiene and Tropical Medicine in 2015.

9. Alcohol Labelling Pledge - completed
   
   a. In March 2011, the drinks industry committed to ensuring 80% of products on shelf would be labeled with clear unit content, the Chief Medical Officers’ lower risk drinking guidelines and a warning about drinking when pregnant by 2013.

   b. The full details of the pledge can be found here: https://responsibilitydeal.dh.gov.uk/pledges/pledge/?pl=1
c. In November 2014 the final evaluation report confirmed that the drinks industry met its target by achieving 79.3% compliance with the pledge elements as measured by products on shelf (Stock Keeping Units SKUs).


e. The final evaluation report was carried out by Campden BRI and examined a sample of over 500 products on sale in the UK from a range of national, regional and independent supermarkets and off-licences. Campden BRI was appointed as an independent contractor by the Department of Health.

f. The report also highlights the significant increase in health information on labels delivered by the pledge:

- Unit information has increased 46% since 2008
- 75% of products now show the CMO’s daily guidelines, up from 6% in 2008.
- 91% of products now carry an alcohol & pregnancy warning, up from 18% in 2008

10. Alcohol Unit Reduction Pledge - ongoing

a. In March 2011, the drinks industry voluntarily committed to help ‘foster a culture of responsible drinking which will help people drink within guidelines’ by removing 1 billion units of alcohol sold annually from the market by December 2015.

b. The full details of the pledge can be found here:
https://responsibilitydeal.dh.gov.uk/pledges/pledge/?pl=22

c. This pledge will be primarily achieved by reducing the strength of well-known brands and growing the market for innovative new product ranges of low and lower alcohol drinks.

d. In April 2014 the first monitoring report on the unit reduction pledge was published by the Department of Health. The report showed that the industry was on track to deliver the pledge and had already removed 253 million units of alcohol from the market in the first 9 months of the pledge.

e. The full report can be found here: https://www.gov.uk/government/publications/responsibility-deal-pledge-on-alcohol-unit-reduction-1st-report

f. The Department of Health is scheduled to publish the second monitoring report on the progress of the unit reduction pledge in due course.

EVIDENCE GAPS AT UK AND EU LEVEL

11. The UK Government collects and publishes robust and wide ranging data related to many alcohol specific and alcohol-related issues. The Portman Group uses only official data when looking at alcohol trends in the UK (Annex 3 (a) (b) & (c))

12. Recently, however, some UK datasets have been discontinued. This will result in the inability to robustly monitor the effectiveness of policy and voluntary pledges to educate the public and change behaviour. Such datasets include:

a. Health and Social Care Information Centre (HSCIC), Knowledge and Attitudes to Alcohol – measures knowledge of units and safe drinking guidelines. The figures were collected from 1997 to 2009, when it was discontinued. This information is vital to monitoring public understanding of alcohol units and of the guidelines set by the Chief Medical Officer.
b. Office of National Statistics (ONS), General Lifestyle Survey, Harmful Drinking - between 2005 and 2010 data was collected on the proportion of men and women exceeding 50 and 35 units respectively as a measure of harmful drinking in the population. The data showed a 33% decline in harmful drinking for men and a 40% decline for women, however the discontinuation of this dataset means we do not know whether this proportion has continued to decline.

13. At EU level, there is a lack of robust data available that allows suitable comparison across member countries and therefore limits best practice sharing.
   a. Drink Driving: There is a lack of directly comparable trends in alcohol-related transport mortality. Although most member states do provide estimates the WHO warns that “estimates vary widely from country to country on the percentage of road traffic deaths attributable to alcohol... The information available is, however, incomplete, with only 85% of countries providing data (WHO Regional Office for Europe, 2009), and its reliability will be influenced by the completeness and practice of BAC testing in the event of a road crash.”

b. Drinking Patterns: WHO draws attention to sporadic national survey results for estimates of rates of heavy episodic drinking (binge-drinking) within member states. Comparability is undermined by the wide variation in how heavy drinking is measured, for instance Malta uses 48g of alcohol on one occasion, Finland uses 70g, Czech Republic uses 80g; Hungary uses intoxication as a proxy, Poland measures yearly alcohol intake. The differing methodologies mean that making comparisons between member states is difficult. Knowledge of drinking patterns allows policymakers to target harmful consumption practices, and therefore comparable estimates would allow best practice sharing regarding policies aimed at reducing risky drinking behaviours.

c. Underage Drinking: Although the European School Survey Project on Alcohol and Other Drugs (ESPAD) attempts to collect comparable data related to underage alcohol consumption this project has limited data for EU member states. There is no data for Germany or Austria, the Netherlands has information for just one of the five periods measured, Denmark and Switzerland also demonstrate data gaps and the UK is singled out as a country of “limited comparability”. Further work is needed to build a database that can provide thorough and meaningful comparisons of underage consumption across the EU.

d. Alcohol-related crime: The Crime Survey for England and Wales provides clear statistics showing a 47% decline in violent crimes in which the offender is perceived by the victim to be under the influence of alcohol since 1995. However the Portman Group is not aware of any EU level data collection or monitoring that would allow comparisons or trends in alcohol-related violence and crime to be analysed.

Declaration of Interest
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Confidentiality
There are no confidentiality issues and we confirm full public disclosure.

110 Alcohol in the European Union Consumption, harm and policy approaches, WHO Regional Office for Europe (2012)
111 Ibid – see Annex 3
112 The 2011 ESPAD Report: Substance Use Among Students in 36 European Countries (2011)
113 Crime Survey for England and Wales, see table 3.11
114 Current member companies: AB InBev; Bacardi Brown-Forman Brands; Beverage Brands; Carlsberg; Diageo; Heineken; Mast Jägermeister UK; Molson Coors; Pernod Ricard; SAB Miller and Treasury Wine Estates
Transcript to be found under Chris Baker.
SAB Miller PLC—Written Evidence

Introduction

SABMiller supports the points raised in the submission that the Committee has received from our trade association, the British Beer and Pub Association (BBPA).

Our submission below answers questions 1 and 3 of the Committee’s inquiry, is complementary to the BBPA’s submission and offers the Committee some additional context on the EU Alcohol Strategy and its practical application through the EU’s Alcohol and Health Forum, of which SABMiller is a founding member.

It also offers some perspectives on the UK government’s Public Health Responsibility Deal (PHRD) and the Scottish Government’s Alcohol Industry Partnership (SGAIP), both of which are excellent examples of industry partnerships focused on dealing with alcohol-related harm.

SABMiller is headquartered in London, with operations in more than 75 markets around the world. Since moving our primary listing from Johannesburg to London in 1999, SABMiller has risen from being a FTSE 30 company to a FTSE 10 company with a market capitalisation of £53 billion. We employ 740 people in the UK, supplying some of our premium brands such as Peroni Nastro Azzurro and Pilsner Urquell to UK consumers.

1. Should there be another EU Alcohol Strategy? If so bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next strategy be, with reference to the previous strategy and evaluations thereof?

1.1 SABMiller believes that the EU Alcohol Strategy has been an effective framework for meaningful action to address alcohol related harm. At the strategy’s heart is an inclusive multi-stakeholder approach which has encouraged targeted actions which respect local cultural differences.

1.2 The EU’s Alcohol Strategy and its Alcohol and Health Forum (the “Forum”) were positively evaluated in an independent report prepared for the European Commission by the COWI Consortium,\(^\text{115}\) which found that it had been successful in stimulating concrete stakeholder-driven action to address alcohol-related harm. The report also concluded that continuing this approach would ‘maintain and strengthen ...the momentum of stakeholder action’.

1.3 The COWI report also highlighted the value of an EU strategy which has helped Member States to define ‘an EU-wide approach to address common issues, including a shared evidence base, and an EU-wide baseline and benchmarks for further action’\(^\text{116}\).


\(^{116}\) COWI report, 2012, p.3
1.4 We agree with the assessment of the COWI report that an already successful EU Alcohol Strategy can be further refined and focused; for example by expanding the sectors involved in the Forum and by focusing its work on fewer well-defined action areas that are more clearly aligned with the EU Alcohol Strategy.

1.5 The success of the current EU Alcohol Strategy is based on its:

- recognition that the majority of adults drink responsibly;
- focus on tackling alcohol-related harm; and
- emphasis on a multi-sectoral partnership approach to addressing alcohol related harm.

1.6 The partnership approach to alcohol policy is one in which private sector businesses, government and civil society work together to identify and deliver locally tailored solutions to complex societal problems based on the national context and culture.

1.7 Tackling alcohol-related harm at a European level requires a policy approach that promotes the following:

1. multi-stakeholder dialogue;
2. targeted local initiatives – i.e. avoiding one-size-fits all solutions; and
3. evidence-based interventions.

The EU’s Alcohol and Health Forum, of which SABMiller is a founding member, is a perfect example of such a policy approach and should be central to any future EU strategy.

1.8 Since 2007, through the Forum, SABMiller has delivered 30 separate commitments in a number of our European markets. These commitments have resulted in strengthening of our marketing policies, increased staff training, the development of consumer information programmes and, importantly, integrated responsible drinking messages into our advertising and packaging. Responsible drinking messages help to remind consumers to respect the legal drinking age, not to drink and drive and to abstain from drinking when pregnant or breast feeding. This has been a challenging process but has ensured that our efforts to tackle irresponsible drinking are ambitious, measurable and stand up to scrutiny.

1.9 Our compliance with our latest set of commitments, for which we achieved full and, in one case, ‘near-full’ compliance, is set out in our public report\textsuperscript{117}. KPMG Sustainability\textsuperscript{118} reviewed our assessment of compliance with each of the commitments, which were:

- Ensure that 100% of our labels and packaging carry an appropriate Responsible Drinking Message (RDM).
- Ensure that all our commercial communications meet the guidelines of our Policy on Commercial Communications on RDM placement and content.

\textsuperscript{118} KPMG Sustainability is part of KPMG, a global network of professional services firms providing audit, tax and advisory services.
SAB Miller PLC—Written Evidence

- Place a Pregnancy RDM on at least one brand or brand variant or on a packaging type per market.
- Implement at least one communication campaign or awareness raising initiative on pregnancy per country in scope.
- Achieve 30% spontaneous awareness among surveyed consumers for any SABMiller RDM.
- Achieve 10% spontaneous awareness among surveyed consumers for the pregnancy RDM.
- Move to an adult audience threshold of 75/25 for all media placements across radio, websites, print and TV.
- Ensure that 100% of all SABMiller owned digital commercial communication platforms are secured by an age check.

UK examples of the partnership approach to dealing with alcohol-related harm

1.10 SABMiller operates in over 70 markets world-wide and, in our experience, the UK provides some examples of best-practice in government and industry partnerships. We believe that the Public Health Responsibility Deal (PHRD) and the Scottish Government Alcohol Industry Partnership (SGAIP) demonstrate effective and practical ways of government and private sector businesses working together to tackle alcohol-related harm.

1.11 The PHRD has proved an effective framework for government and private sector business collaboration. It has encouraged and led the retailers and producers of beer, wine and spirits to work together with government to identify visionary solutions to alcohol-related harms. This has resulted in the following outcomes to date, all of which are supported by SABMiller:

1. 252 million units of alcohol removed from circulation through product innovation by the end of 2012 and industry on target to remove 1 billion by the end of 2015. In this regard, SABMiller’s local UK subsidiary, MillerBrands has committed not to introduce any canned product that contains more than 4 units of alcohol into its portfolio.
2. 80% of alcohol products on the shelf having health information included
3. Information on alcohol units rolled out in the on and off-trade
4. £5 million annual industry support for DrinkAware
5. Support for Challenge 21, Challenge 25 and the Proof of Age Standards scheme to tackle underage drinking and selling
6. Industry support for a range of schemes including Pubwatch, Best Bar None and Community Alcohol Partnerships which have made a significant contribution to addressing alcohol-related issues at a local community level.

1.12 In addition, SABMiller has pledged to fund responsible retail training for 10,000 people employed by small and medium-sized licensed businesses in the UK by 2016. Ofqual-accredited, this training placements will provide recipients with a portable qualification in responsible alcohol retailing.
1.13 In collaboration with the Home Office, SABMiller and the BII have agreed that all training between 2014 and 2016 will be offered in the twenty areas designated by the Home Office as ‘Local Alcohol Action Areas.’

1.14 The programme, run by the British Institute of Innkeeping (BII), has been designed to train staff in the Licensing Act 2003 and provide them with a thorough understanding of the tightly-regulated legal framework in which they operate. It is also aims to give them the confidence to deal with an aggrieved customer who is unhappy at being refused alcohol because they are either drunk or underage.

1.15 In Scotland, the forum for collaborative, targeted action to address the complex issues around alcohol misuse is the Scottish Government Alcohol Industry Partnership (SGAIP)\(^\text{119}\). Created in 2007, the SGAIP provides an open forum for information exchange and debate between the beer, wine and spirits producers and retailers and the Scottish government. It is part of a long term collaborative approach to fostering a culture which recognises that responsible, moderate consumption of alcohol can be part of a healthy society.

### 3 Are the EU’s alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?

3.1 The EU’s alcohol policies are, in our view, in line with the WHO’s Global Strategy to Reduce the Harmful use of Alcohol (GAS). This document provides Member States with a broad framework of recommendations that can be tailored to national circumstances, which is complementary to the EU’s partnership approach to tackling irresponsible drinking described in the response to question one above. Member States should use this framework to develop their own comprehensive and multi-sectoral national policies and programmes which respect local circumstances and cultural approaches to alcohol.

3.2 It is important to note that the GAS does not promote one policy intervention over another. Unfortunately some stakeholders tend to promote some interventions such as regulating availability of alcohol, restricting or banning advertising and using tax increases to curb the sale of alcohol in isolation, on the basis of their cost-effectiveness.

3.3 However, the GAS is described by the WHO as ‘a portfolio of policy options and measures that could be considered for implementation and adjusted as appropriate at the national level’\(^\text{120}\). Placing emphasis on only three policy options without taking account of national context and circumstances while measuring cost-effectiveness rather than effectiveness generally, clearly runs contrary to this approach. In fact the GAS states this explicitly when it says ‘Not all policy options and interventions will be applicable or relevant for all Member States and some may be beyond available resources. As such, the measures should be implemented at the discretion of each Member State depending on national, religious and cultural context, national public health priorities, and available resources, and in accordance with constitutional principles and international legal obligations’\(^\text{121}\).

\(\text{\textsuperscript{119} }\)http://www.scotland.gov.uk/Topics/Health/Services/Alcohol/Partnership

\(\text{\textsuperscript{120} }\)Global Strategy to Reduce Harmful Use of Alcohol (GAS), World Health Organisation, 2010, page 10

\(\text{\textsuperscript{121} }\)GAS, WHO, 2010, p.10-11
3.4 Promotion of restrictions on availability, tax increases on the sale of alcohol and advertising bans is not based on sound evidence and countries may risk unintended consequences by applying them. For example:

- Excessive taxes and restrictions on availability often displace consumption towards informal and illicit markets rather than reduce harmful use, this is particularly the case in low and middle income countries with a large unrecorded alcohol sector.

- Advertising bans were in fact specifically rejected by the World Health Assembly that endorsed the GAS. The evidence for advertising bans is extremely weak. Econometric and cross-sectional studies have failed to show a clear causal relationship between marketing expenditure and any indicator of harmful drinking. Where an association has been reported in a handful of longitudinal studies, it is very weak in real terms and does not make a compelling case that advertising causes harmful drinking. Many of those countries that have applied severe restrictions on advertising have continued to record problematic drinking patterns.

3.5 The EU approach and the WHO are aligned in that they both encourage Member States to tailor their actions to national circumstances, which we believe is the only way to develop effective policy to tackle irresponsible drinking. Efforts to promote certain policy measures above all others undermines that approach and should be avoided.

19 September 2014

Transcript to be found under British Beer & Pub Association
About SHAAP

SHAAP was set up in 2006 by the Scottish Medical Royal Colleges and Faculties through SIGA, the Scottish Intercollegiate Group on Alcohol. Clinicians had become increasingly concerned at the escalation in alcohol-related health damage in Scotland - both in its acute effects seen in admissions to accident and emergency departments and in chronic conditions such as liver disease and brain damage. As a partnership, it is governed by an Executive Committee made up of members of the Royal Colleges, including the Royal College of Nursing.

SHAAP provides the authoritative medical and clinical voice on the need to reduce the impact of alcohol related harm on the health and wellbeing of people in Scotland and the evidence-based approaches to achieve this.

SHAAP works in partnership with a range of organisations in Scotland and beyond. Key partners include Alcohol Focus Scotland, the British Medical Association (BMA), the Scottish Alcohol Research Network (SARN), the Alcohol Health Alliance, the Institute of Alcohol Studies, Eurocare and the European Public Health Alliance (EPHA). SHAAP has a place on the Eurocare Board and the European Alcohol and Health Forum (EAHF). Since 2013, we have allocated significant staff time for partnership work based at the Eurocare office in Brussels. We have consulted widely with our partners in preparing this response.

Response to call for evidence

1. Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

Yes. SHAAP is a strong supporter of effective alcohol policy in Europe and sees the failure to establish a renewed Strategy in 2012 as a significant setback for achieving progress on reducing alcohol harm in Europe. SHAAP has, alongside partner NGOs, expressed concerns about the limitations of the interim EU Alcohol Action Plan, which seeks to address a much narrower element of alcohol harm, covering young people and heavy episodic (binge) drinking, and has made repeated calls for a new comprehensive strategy that would take a whole population based approach and thus include policies that would impact all Europeans affected by alcohol problems, including adults of working age and those affected by third party harms (e.g. victims of drink drive accidents).

We believe the next EU Strategy should be based on the evidence-based framework for effective alcohol policies outlined in the World Health Organisation (WHO) Global Strategy to reduce harmful use of alcohol (2010) and, more specifically, the WHO European Action Plan to reduce the harmful use of alcohol 2012-2020 (2011). Both of these strategies have received unanimous endorsement by all EU Member States are based on the best available scientific evidence of policy effectiveness. The ten policy areas for action outlined in these two strategies are:
31. Leadership, awareness and commitment
32. Health services’ response
33. Community action
34. Drink-driving policies and countermeasures
35. Availability of alcohol\textsuperscript{122}
36. Marketing of alcoholic beverages\textsuperscript{123}
37. Pricing policies\textsuperscript{124}
38. Reducing the negative consequences of drinking and alcohol intoxication
39. Reducing the public health impact of illicit alcohol and informally produced alcohol
40. Monitoring and surveillance

SHAAP acknowledges that the responsibility for delivering public health policy appropriately lies primarily with individual member states. Each country in the EU has different requirements and there is no one-size-fits-all strategy that can be applied. SHAAP supports Eurocare’s recommendations that a new EU Alcohol Strategy should aim to support and complement comprehensive national alcohol strategies by focusing on policy areas where the EU mandate can add value, for example in relation to trade and cross border issues. It should also provide Member States with the freedom to implement national policies that prioritise the health and wellbeing of their citizens.

A primary aim of an EU Alcohol Strategy must also be to ensure that a Health in All Policies approach is taken with decisions at the EU level, and that the health and wellbeing of EU citizens is prioritized over trade and economic operator interests.

2. Are the EU’s alcohol policies underpinned by a sound scientific base?

No. The expiration of the EU Alcohol Strategy in 2012 presents a real threat that EU alcohol policies are not currently being prioritised according to the scientific evidence of the burden of disease in the region. The focus of the draft EU Alcohol Action Plan is on young people and binge drinking, and whilst the latter will capture the adult population to some extent, the Plan does not include recommendations for interventions aimed at reducing chronic disease rates caused by regular heavy consumption amongst adults. The recommendations for alcohol workplace policies refer only to those targeting young people. There is also no inclusion of drink driving recommendations. Therefore it could be argued that the current EU alcohol policy is not underpinned by the scientific evidence relating to the health needs of EU citizens, or the most cost-effective approach to tackling alcohol harm.

There are many elements of the previous EU Alcohol Strategy that were underpinned by a strong evidence base of effectiveness. The comprehensive framework of policies outlined acknowledged the breadth of scope required in order to reduce alcohol harm across the EU population. Similarly, funding streams were established to advance the work of alcohol researchers and develop the evidence base for effective policies, through projects such as

\textsuperscript{122} denotes a “best buy” policy: The WHO has identified, in line with the international evidence, the three “best buy” policy interventions that are most cost-effective in reducing harmful consumption of alcohol are controls on price, availability and promotion of alcoholic beverages.

\textsuperscript{123} Ibid.

\textsuperscript{124} Ibid.
AMPHORA and ALICE RAP. Funding was also allocated to NGOs in order to build capacity amongst civil society actors, thus following an evidence-based approach of good governance in policymaking.

However, the absence of an EU Alcohol Strategy presents a risk that funding for future research into alcohol policy, including data collection, monitoring and surveillance, will no longer be made available to maintain an evidence base for effective interventions.

3. Are the EU's alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?

No. The absence of a current EU Alcohol Strategy means that there is no comprehensive policy framework in existence at the EU level that can be compared to the WHO Global Alcohol Strategy or WHO EU Alcohol Action Plan.

4. Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

Some changes are needed. It is important to acknowledge that public health/NGO stakeholders, on the one side, and economic operators on the other side, have some important competing interests. Economic operators prioritise making a profit from alcohol sales while public health/NGO bodies prioritise preventing alcohol health and social harms. This means that NGOs often support actions to reduce alcohol availability and consumption, which place them in direct opposition to industry interests.

SHAAP has been an active member of EAHF since 2012. We appreciate the opportunities that the EAHF has given to enable NGOs concerned about public health to come together at regular intervals to exchange ideas and plan together. We have also welcomed the opportunities to hear about the activities of the Commission and economic operators.

As a member of Eurocare, SHAAP has taken a leading role in preparing a commentary on the EAHF’s functions and recommendations for improvements. We have also joined a sub-group of the EAHF which is examining governance arrangements for the group. However, we are concerned that the emphasis to date in discussions has been on monitoring voluntary and self-selected commitments made by members, rather than looking at broader ethical/governance issues.

However, although the EAHF is not supposed to influence the development of alcohol policy, our experience is that discussions do veer into policy-related areas. We made the following recommendations in early 2014:

- The Commission and member states should be guided by the World Health Organisation’s guidance that the alcohol industry’s activities should be restricted to their core roles as developers, producers, distributors, marketers and sellers of
alcoholic beverages and that they should have no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests.

- The Commission should put in place a workplan for the EAHF, to be drawn up in consultation with members, and with ambitious, yet achievable and measurable outputs. This should be aligned with relevant EU strategies and action plans, including, though not limited to, alcohol-specific strategies and action plans. All commitments should be aligned with the EAHF’s workplan, with ambitious, yet achievable and measurable outputs.

- A standing sub-group of the EAHF should meet to review arrangements for monitoring appropriateness of commitments in relation to the EAHF workplan, the evidence base and their delivery.

- New working arrangements should be established so that NGOs can meet independently with Commission officials to make recommendations on policy. However, as laid out in the EAHF’s Charter, a multi-stakeholder voluntary framework cannot encompass all fields of action around alcohol. It is reasonable that economic operators should also engage outside with Commission officials outside its auspices on relevant trade-related matters. The health-related policy discussions that the Commission would have with NGOs could inform these separate discussions by enabling the Commission to bring an ethical dimension, with a focus on health harms.

- Regular, themed meetings should take place, based on Commission officials’ identification of relevant issues which arise from discussions at the Forum.

- As originally envisaged, an annual ‘open forum’ should be convened to consult with and share perspectives with external stakeholders. Informed by these discussions, EAHF functioning and priorities should be reviewed and realigned if necessary.

- The Commission should review the functions and operations of the Science Group, in consultation with its Chair and the EAHF chairs’ recommendations.

5. Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?

No. Without an EU Alcohol Strategy, there are no stated aims.

There is a need for better data on alcohol in Europe and coordination of alcohol research, both of which should be addressed in a new EU Alcohol Strategy.

The European Commission’s evaluation of the Alcohol Strategy to 2012 highlighted that less than 3% of the total budget of the Health Programme for 2008-2013 and less than 1% of the budget for health under the Seventh Research Programme were allocated to alcohol. This is not sufficient given the harm cause by alcohol.

It is our view that the European Commission and Member States should regularly obtain comparable information on alcohol consumption, on drinking patterns, on the social and health effects of alcohol; and information on the impact of alcohol policy measures and of alcohol consumption on productivity and economic development. The European Commission
should monitor and follow the developments in Member States to see if targets are reached and to provide guidance if this is not the case.

There is a strong need for better coordination of European and National alcohol research, which would avoid unnecessary costs. Coordination should include a dialogue between European Commission, Member States and experts to discuss and agree on the most pressing research challenges in this field and recommend them for inclusion in Horizon 2020 and/or other transnational research programs.

6. Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

There are clear tensions. The EU has the capacity to undermine national efforts by Member States to reduce affordability of alcohol – which is a key determinant in rates of harm - through fiscal measures. The abolition of the duty paid allowance system effectively undermined countries with higher taxation rates for alcohol.

Our further comments relate specifically to the issue of Minimum Unit Pricing (MUP). SHAAP has campaigned for many years to promote this policy, the legislation for which was passed into law in Scotland in 2012 but has not yet been implemented, due to legal challenges by global alcohol producers. In 2012, the legal challenge generated an unfavourable and ill-informed opinion from the European Commission in 2012.

The case has been referred to the ECJ, who we hope will uphold the findings of the first judicial review of the legislation in the Court of Session in January 2013. At that time, the Court recognised the overwhelming evidence supporting the legitimate aims of Minimum Unit Pricing (MUP) to reduce alcohol consumption, with a particular focus on reducing consumption by hazardous and harmful drinkers. Judge Doherty in his ruling concluded that MUP was justified under Article 36 (protection of health and life of humans) and proportionate.

4 September 2014
Scottish Health Action on Alcohol Problems and Eurocare—Oral Evidence (QQ 99-116)

Transcript to be found under Eurocare.
The Scottish Licensed Trade Association, Scotch Whisky Association, British Beer & Pub Association and Wine and Spirits Trade Association—Oral Evidence (QQ 169-199)

Transcript to be found under British Beer & Pub Association.
I. Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

1. We believe the 2006 EU strategy to support Member States to reduce alcohol-related harm and its delivery mechanisms (European Alcohol and Health Forum and Committee on National Alcohol Policy and Action – CNPA) have fostered positive change, both in terms of policy and actions. The Strategy has offered a stimulus to action and has pushed stakeholders towards meaningful action to reduce alcohol-related harm.

2. The EU Strategy to support member states in reducing alcohol related harm was independently evaluated by COWI-Milieu\(^{125}\), who concluded that the approach had delivered results and that the priority areas remain relevant.

3. As highlighted in the COWI-Milieu independent evaluation report, the principles, including the multi-stakeholder partnership approach and the choice of areas for actions

remain relevant and the evaluation calls for greater cooperation and understanding between the different actors to lead to more and better progress.

4. spiritsEUROPE agrees there is merit in extending and strengthening the current EU Strategy, rather than seeking to change the current approach by developing a new one.

5. The European Union has a continuing role to play in helping Member States implement more effective alcohol policies to reduce harm. The components of such policies should be based on a multi-faceted approach with targeted interventions at local level that encourage people to adopt a responsible attitude towards alcohol consumption, combined with the appropriate level of legislation and enforcement.

6. An effective strategy to reduce alcohol-related harm should:
   • FOCUS on the real issue: harm is the target, not consumption per se;
   • WORK with all relevant stakeholders in partnership, not in silos;
   • INSIST on a robust evidence-base to underpin effective policies and actions.

II. Are the EU’s alcohol policies underpinned by a sound scientific base?

7. We agree with all those who call for policy making to be based on robust science and research. Effective evidence-based policy making depends – at least in part – on good evidence. The key is how that robustness is measured.

8. The European Commission should keep promoting an evidence-based approach to design policies but must also ensure the reliability and the quality of studies and research financed from its own budget.

9. spiritsEUROPE has concerns about the way research on alcohol-related harm is funded, conducted and presented by DG SANCO, believing much of the ‘evidence’ generated provides misleading signals to policy-makers.

10. Good research is ‘good’ no matter who funds it. It is grounded in solid principles, generates reputable, credible and reproducible findings that derive from sound scientific methods, and uses reasonable and fair assumptions and verifiable, correct data inputs.

11. There is a need for an open, constructive debate involving all interested stakeholders to discuss how we can ensure that research used by policy-makers is
   a. relevant
   b. neutral and objective
   c. fair and transparent
   d. robust, and
   e. based on appropriate engagement with all relevant stakeholders.

III. Are the EU’s alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?
12. The WHO strategy on the harmful use of alcohol provides a menu of options to Member States to apply policies best suited to the national context and addressing alcohol-related harm. This is in line with the current EU Strategy even though it precedes the WHO strategy. Similarly, both strategies recognise the role stakeholders play in helping reduce harm.

13. As stated by the WHO, it is important to understand that “alcohol-related harm is determined (…), by three related dimensions of drinking (irrespective of the choice of beverages): the volume of alcohol consumed, the pattern of drinking and, on rare occasions, also the quality of alcohol consumed.” Alcohol-related harm is largely related to high risk drinking behaviours and there is clearly a cultural complexity to alcohol consumption in Europe.

14. In order to address the point of consistency, spiritsEUROPE also believes that the Commission should have a coordinating role in ensuring the coherence of messages from Member States, ensuring that there is no gap between the policies and orientations chosen in various international fora - given the autonomy Members States have in setting their respective national alcohol policies.

IV. Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

15. spiritsEUROPE believes that the European Alcohol and Health Forum is an indispensable element for the inclusive delivery of any effective EU strategy to tackle alcohol related harm. Yet the current governance of the Forum could be improved to ensure it reaches its full potential.

16. spiritsEUROPE has been an active member of the European Alcohol and Health Forum since its inception in 2006. The current spiritsEUROPE Roadmap 2010-2015 covers spirits producers’ ongoing commitments running in 23 Member States. It is based on 3 pillars:
   - responsible commercial communications
   - responsible drinking
   - engaging more stakeholders on harm reduction

www.responsibledrinking.eu is the umbrella brand representing this commitment to reduce the level of alcohol related- harm.

17. Our sector’s long term commitment is reflected in the 317 prevention initiatives put in place since the Forum was created. Many of these initiatives are run in the individual countries by local producers in partnership with relevant stakeholders at national level. Detailed annual implementation reports are shared with the European Commission, to assess progress made. The reports are also available on the spiritsEUROPE website.126

18. Better collaboration between members of the European Alcohol and Health Forum and other bodies responsible for delivering the EU strategy, such as the CNAPA group, is essential to reach the shared objective of reducing harmful consumption of alcohol in Europe. Sharing good practices is vital. More information, communication, and interaction between the Forum members and CNAPA would be welcomed: there is no indication as to the level of awareness of CNAPA members about the discussions, conclusions and, even more broadly, the commitments made in the EAHF over the past seven years.

19. The current policy debate at European level is too polarized and inefficient. All stakeholders who have a role to play in tackling alcohol misuse should work together, at least in areas where there is agreement. Immovable ideological positions do not help to change consumption patterns.

20. By way of example, to tackle underage drinking, we believe multiple partners, working together, could achieve far more than all working separately. We suggest a kind of ‘matrix of responsibility’ should be developed targeting particular alcohol harms (see spirits: committed to reducing alcohol harm). Similar European matrices should be developed for drink-drive, binge drinking, etc.

21. The European Commission should bring all stakeholders together to work towards agreed, measurable targets. The current system, whereby industry, NGOs, Member States and others all work on their own specific initiatives is wasteful of effort.

V. Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?

22. Rather than the quantity of research, the quality of research and projects undertaken should be the priority of policy makers.

23. The need for sound, robust research is well recognised within the European Commission. Prof. Anne Glover was appointed as the first ever Chief Scientific Advisor in early 2012, and the Science and Technology Advisory Council was created in early 2013. These are positive developments, and must be maintained beyond the end of the mandate of President Barroso.

24. Apart from the funds available through the Horizon 2020 research programme, many individual DGs also disburse monies for research projects related to their specific areas. DG SANCO is one such Directorate General, and via the consumer, health and food executive agency (CHAFEA) has funded a number of studies and projects related to alcohol.

25. We have noted that the funds available have been repeatedly allocated to the same entities, even though the quality of the reports produced was consistently questioned.

Of nearly €15 million awarded in research contracts between 2009 and 2012 across ten projects, RAND Europe were awarded three projects, the Dutch Institute for Alcohol Policy (STAP (NL)) gained three, and the same researchers – and research topics - crop up time and again.

26. For more information, see our position paper: The body of evidence – policy making and research129

VI. Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

27. We believe that the existing Treaty and jurisprudence provides an appropriate framework within which to balance many different policy objectives, while allowing Member States policy space to protect public health.

28. spiritsEUROPE and its members are opposed to minimum unit pricing (MUP) for alcoholic drinks for a number of reasons:
   a. Price measures are ineffective in reducing consumption by hazardous and harmful drinkers. The consensus of international studies is that the price responsiveness of heavy drinkers is close to zero.130
   b. According to modelling by the School of Health and Related Research, University of Sheffield131, hazardous and harmful drinkers do not mainly drink alcohol which is cheap relative to its strength (and most such drinkers are relatively well-off anyway);
   c. Accordingly, we see no convincing evidence that MUP as a policy will reduce alcohol-related harm132 because it has not been shown that it will reduce the number of hazardous and harmful drinkers133;
   d. In addition, EU jurisprudence seems clear; for over 30 years minimum pricing schemes have invariably been ruled illegal by the CJEU as they breach internal market rules.

29. In June 2012, the Scottish Government notified this measure under the EU’s ‘TRIS’ procedure which allows the European Commission and EU Member States the chance to scrutinise technical regulations. In September, the Commission’s ‘Detailed Opinion’ warned the Scottish Government to refrain from introducing the measure on the grounds that it breached EU law governing free movement of goods, and noted that it might otherwise raise infraction proceedings against the UK, the member state. Five

133 Model-Based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland using the Sheffield alcohol policy model (v2): Second update based on newly available data. January 2012
Member States, namely France, Spain, Portugal, Italy and Bulgaria also filed ‘Detailed Opinions’ objecting to the MUP scheme.

30. We will not bore the Committee by reviewing in depth spiritsEUROPE’s and other plaintiff’s argumentation on this complex set of issues. In brief, we raised concerns over the legality of the scheme, arguing that MUP constitutes a quantitative restriction prohibited by Article 34 of the Treaty on the Functioning of the European Union (“TFEU”). When the Scottish Government proceeded anyway, we [together with the Scotch Whisky Association (SWA) and Comité Européen des Entreprises Vins (CEEV)] brought a judicial review case against the Scottish MUP legislation. In April 2014, the Inner House of the Court of Session in Edinburgh decided to make a preliminary reference\(^{134}\) to the CJEU (Case C-333/14) setting out six questions\(^{135}\) on which clarification is sought. The determination from the CJEU could take up to 18 months.

31. There are two directives which approximate rules in relation to \textbf{excise tax} in the EU. Directive 92/83/EEC (the structures directive) and 92/84/EEC (the minimum rates directive).

32. Directive 92/83/EEC introduced harmonised excise tax structures in the EU for alcoholic beverages. For spirit drinks, Member States are required (nominally) to apply a single rate of excise tax, levied per hectolitre of pure alcohol (hlpa), on all products. However, excise duty levied by Member States on other alcoholic beverages is largely fixed by reference to the number of hectolitres of finished product rather than alcohol content.

33. Directive 92/84 introduced minimum rates of excise tax for all categories of alcoholic beverage effective from 01/01/1993 which are still in force today, i.e. spirits €550 per hlpa (except those countries whose rates are €1,000 per hlpa or more, in which case they cannot fall below this level); intermediate products €45 per hl of finished product (equivalent to, at an assumed strength of 18% vol., €250 per hlpa); wine zero rate; beer €1.87 per degree of alcohol per hl (i.e. €187 per hlpa) or €0.748 per hl per degree Plato of finished product.

34. As an industry we are not against appropriate levels of taxation. All alcohol beverages can compete with each other, and the excise tax system should not distort that competition.

35. Tax is a blunt, ineffective instrument to address alcohol misuse. As heavy drinkers are the least price responsive, taxes have very little influence on alcohol misuse. Yet, high taxes carry unintended consequences, such as increased incentives for informal and unregulated markets to thrive.

\textbf{Conclusion}

\(^{134}\) The Court’s Opinion is to be found at \url{http://www.scotcourts.gov.uk/search-judgments/judgment?id=482a86a6-8980-69d2-b500-f0000d74aa7}

\(^{135}\) \url{http://curia.europa.eu/juris/document/document.jsf?text=&docid=157554&pageIndex=0&doclang=EN&mode=lst&dir=&occ=first&part=1&cid=116721}
36. Spirit drinks, rooted in the culture and history of European regions, are enjoyed responsibly by the vast majority of consumers, in convivial, social settings. For centuries, they have formed a cornerstone of celebrations, family gatherings, events and meals. However, it is also clear that a minority of consumers misuse alcohol, which can lead to significant harm to themselves, their families and society at large. As producers of spirit drinks, we take our role in society seriously—we make great efforts to reduce alcohol-related harm without punishing moderate, responsible consumers.

37. Through the European Alcohol and Health Forum, the spirits sector has committed to a five-year programme of actions, ranging from information campaigns to server training initiatives to the adoption of pan-sectoral marketing guidelines. Our network of national associations and companies fund and organise multiple campaigns to help reduce alcohol-related harm.

38. Our sector has previously stated its willingness to work with all others stakeholders at EU level as it does at the national level—from the public and private sector as well as the NGO community. We reiterate that offer with renewed urgency. We firmly believe that only by working in partnership will it be possible to seriously reduce binge drinking, underage drinking, drinking during pregnancy, drinking and driving and so on. Currently, the fight against alcohol harm is too fragmented, and lacks coordination. These are issues of execution, not strategy. Until fragmentation and suspicion are addressed, no EU Strategy will be as successful as it should be.

39. That effort is also hindered by an increasingly polemic, polarized debate: simplistic solutions are touted as the only possible way to solve what is an exceptionally complex, varied set of challenges. Collectively, we need more constructive discussion about the real problems, their causes and the remedies we might all apply towards reducing harm. Those remedies need to be based on sound science & robust evidence: we have good examples of initiatives that can reduce alcohol misuse.

40. European spirits producers are actively engaged in changing behaviours and attitudes toward alcohol consumption. We focus on harmful consumption and target groups which are at risk rather than addressing consumption in the general population.

41. For more than 10 years, spiritsEUROPE has also helped to fund and sustain prevention initiatives in several European countries, and plays an active role in promoting the exchange of good practices between industry-funded organisations engaged in prevention activities across Europe and worldwide. All the initiatives include measurement and evaluation processes to quantify the progress made and adjust the strategy as necessary. Details of all the campaigns are publicly available on www.drinksinitiatives.eu

10 October 2014
SpiritsEUROPE and Brewers of Europe—Oral Evidence (QQ 117-139)

The transcript to be found under Brewers of Europe.
A renewed European Union Alcohol Strategy should identify a clear set of priorities for the region in addressing alcohol-related harms and in implementing evidence-based policy options to achieve reductions in mortality, morbidity and other social harms. We therefore support the development of a second European Alcohol Strategy which (in comparison to the current strategy):

- Recognises more broadly the range of alcohol-related harms to both individuals and the wider community;
- Focuses on effective policy options for which there is a sound scientific evidence base;
- Adopts clear guiding principles with aims and objectives tied to well-evidenced policy interventions;
- Explicitly addresses the incompatibility of public health and alcohol industry objectives by restricting industry representation in strategy development and subsequent actions;
- Provides increased funding for alcohol-related research and harm reduction programs and improved processes for translating findings into policy independent of interference from commercial actors;
- Addresses inconsistencies in the legislation governing alcohol excise duties, which are key mechanisms for reducing alcohol-related harm.

Question 1: Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

1. The EU Alcohol Strategy played a role in developing the evidence base for strategies to reduce alcohol-related harm in Europe and harmonising alcohol policies across EU member states. As such, we believe that another EU alcohol strategy would be of significant value.

2. The strategy had a broad scope structured around five priority themes, with differential rates of success and progress achieved across these. The themes continue to address pressing issues of alcohol-related harm in the EU; however, their scope is relatively narrow and excludes important aspects of the challenges to which they relate. In framing alcohol-related harms for the next strategy, consideration should be given to the following:
a. Explicit recognition should be made of alcohol’s harm to those other than the drinker, rather than the current narrower focus on young people, children and the unborn child. Harm to others includes all those who are negatively influenced by the alcohol consumption of someone else, such as children, partners, colleagues, neighbours, victims of crime and society at large which bears the public cost of alcohol-related harm.

b. Separating the health consequences of alcohol consumption from consequences for the workplace. The strategy recognises the importance of preventing alcohol-related harm among adults, primarily through aiming to reduce negative health and wellbeing consequences. However, this sits uncomfortably under a theme also addressing the negative impact of alcohol on the workplace. The health consequences of harmful alcohol consumption, including workplace accidents, should be prioritised in their own and this health focus should be separated from problems such as absenteeism, unemployment and resulting effects on colleagues, businesses and the economy. These might more usefully be included as harms to others.

3. The theme ‘develop and maintain a common evidence base at EU level’ has presented challenges and limited progress was made under the last strategy. It is important to separate generating evidence of ‘what works’ in reducing alcohol-related harm, from generating datasets to enable future analyses and evaluation of interventions. A substantial body of evidence exists detailing effective alcohol policy interventions and recommended actions for reducing alcohol-related harm.136 This evidence is sufficient to provide the EU with a basis for facilitating and advising on policy action by member states. Ensuring the translation of evidence into policy, with adequate funding provided for robust and independent evaluations, should be a major focus of any new EU Alcohol Strategy.

4. Given these considerations, we propose that any new EU Alcohol Strategy should aim to:

   a. Prevent alcohol-related harm to drinkers, including acute harms from heavy episodic drinking and chronic harms from long-term alcohol use;
   
   b. Prevent alcohol’s harm to those other than the drinker, including to children, family, friends, local communities, and wider society;
   
   c. Reduce injuries and death from alcohol-related road accidents;
   
   d. Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption on oneself and on other people, and provide information on the risks associated with particular consumption patterns;
   
   e. Promote and facilitate the translation into policy of existing and emerging evidence on effective interventions to achieve the above aims.

**Question 2: Are the EU’s alcohol policies underpinned by a sound scientific base?**

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5. EU alcohol policy is primarily focused on two activities 1) supporting member states (and other relevant organisations) to implement evidence-based policies and 2) establishing the European Alcohol and Health Forum (EAHF) to support, provide input for and monitor the implementation of the EU strategy.

6. In relation to the former; the EU’s ability to enact legislation directly reducing alcohol-related harm is limited as powers relating to interventions with the strongest supporting evidence are retained by member states (e.g. adjusting BAC limits, excise duties and retail licensing systems). However, the EU can play an important role by assessing whether member states’ alcohol policies are likely to achieve (a) their stated aims and (b) the aims of the EU Alcohol Strategy. This may take the form of an independent scientific advisory group which scores all major alcohol policy initiatives (e.g. national alcohol strategies) against the existing evidence base, applying scientific judgement where appropriate. Such a group would also have the potential to perform an advisory role in ensuring intervention evaluations are robust and evidence from such evaluations is effectively communicated to policy makers at all levels.

7. The establishment of the EAHF is a key mechanism by which the EU Alcohol Strategy recognises the importance of working with stakeholders to reduce alcohol-related harm. Analyses of the use of such forums to protect public health have indicated that significant industry membership is associated with reduced effectiveness. Therefore, we are concerned that stakeholder action following the EU Alcohol Strategy has largely been translated as industry action, with alcohol producers and retailers strongly represented on EAHF (http://ec.europa.eu/health/alcohol/docs/forum_members_en.pdf). Whilst economic actors have a role to play in tackling alcohol-related harm, they also have major conflicts of interest (e.g. a substantial majority of alcohol sold is consumed by those drinking above guideline levels for low-risk drinking). Permitting the alcohol industry to have such a dominant voice in implementing the EU Alcohol Strategy and influencing future policy development is not an effective way to safeguard public health.

8. A more appropriate committee structure may be two or more separate committees with equal access to policy makers. Those committees should have clear and binding terms of reference. One committee would focus on trade and, where appropriate, implementation (e.g. for interventions impacting directly on retail or production). Alcohol industry membership would be confined to this committee where their expertise would be utilised and legitimate interests addressed. A second committee would focus on impacts on health and well-being, with membership predominantly drawn from the public health and scientific communities. To avoid actual or perceived conflicts of interest, the second committee should be demonstrably and wholly independent from the alcohol industry, meaning membership would not be offered to alcohol producers and retailers, trade organisation, corporate social responsibility bodies or any actor or organisation with financial links to any of these bodies.


Question 3: Are the EU’s alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?

9. The current EU Alcohol Strategy adopts a markedly different approach to the WHO. The World Health Organisation’s 2010 Global strategy to reduce the harmful use of alcohol articulates broad strategic aims and objectives, before identifying ten national ‘target areas’ (each with several associated policy options and interventions) and four global ‘key roles’ (each with several associated support strategies). The provision of these overarching aims with subsidiary target areas/roles and options/actions contributes to the coherence of the strategy. The organisation of the document around policy domains (e.g. pricing, alcohol availability) also makes it action-oriented. In contrast, the overall direction or purpose of the EU strategy lacks clarity. Five priority themes (some quite narrow) and relevant good practices are identified, and the focus is on specific harms, such as to young people. However, the absence of ‘big picture’ aims encompassing the totality of alcohol-related harms risks limiting the reach of the strategy and failure to consider the potential impact of interventions on multiple harms. Development of any future EU Alcohol Strategy should involve identification of clear high-level aims with related objectives tied to specific evidence-based policy interventions.

10. The orientation of the WHO strategy is explicit, through the inclusion of guiding principles for policy development and implementation. For example, while it is acknowledged that there are potentially conflicting public health and socioeconomic imperatives when determining alcohol policies (particularly in developing countries); the guiding principles state that “Public health should be given proper deference in relation to competing interests”. The current EU strategy does not specifically identify its founding principles. Acknowledging that the text of the current EU strategy indicates support for public health measures, we would nonetheless endorse inclusion of a “guiding principles” section in any future iteration, including a more strongly worded public health orientation. Such principles would help ensure consistency of the strategy through all levels, from the statement of overarching aims and objectives, through to implementation.

11. Both the EU and WHO alcohol strategies acknowledge national governments’ primary responsibility for alcohol policy, but argue international organisations have an important role in supporting and leveraging change. The WHO document is strengthened by a clear delineation between the policies national governments might develop and implement and the supporting role of the WHO. Four areas in which the WHO Secretariat is equipped to provide support are identified and specific actions are listed under each of these. For a future EU Strategy, the EU Commission’s role in reducing alcohol-related harms may be clarified and resulting actions better defined by categorising the actions in support of member states which are to be taken (e.g. coordination, capacity building, and knowledge dissemination).

Question 4: Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still active?

appropriate?

12. We limit our comments here to reiterating our concern regarding the role of industry representatives on the EAHF. As other public health experts have argued in relation the WHO Global Strategy on Alcohol, the alcohol industry has no particular claim to expertise in the evaluation and interpretation of evidence on the effectiveness of public health interventions. It also has substantial conflicts of interest in many policy areas. Indeed, in relation to tobacco, the efforts of industry to undermine public health interventions have been recognised, and they are now specifically excluded as stakeholders in the WHO Framework Convention on Tobacco Control, “an evidence-based treaty that reaffirms the right of all people to the highest standard of health”. Similarly, including industry actors in setting an alcohol policy agenda may compromise the public health aims of that agenda.

13. We stress the importance of separating the alcohol industry’s legitimate role as a stakeholder with expertise in alcohol production and retail and some aspects of policy implementation from the process of evaluating, synthesising and interpreting evidence of good practice where it has no legitimate role. Commitments proposed or promoted as a result of a future alcohol strategy should be evidence-based or, where they are novel, should be rigorously and independently evaluated with commitment from alcohol retailers and producers to facilitate this by making relevant data available for analysis.

**Question 5: Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?** (Funding for alcohol-related research under the EU’s seventh research programme (FP7) from 2007 to mid-2012 was 49 million euro, which represented less than one percent of the FP7 Programme’s budget for health)

14. Alcohol accounts for one third of the total global burden of disease. Allocating less than one percent of health research funding to addressing this does not appear proportionate. The aims of the EU Alcohol Strategy encompass a broad range of problems both medical and social and, we argue above, are currently too narrowly drawn. A significant increase in research funding to a level appropriate to both the scale and breadth of the problem is required.

15. However, allocation of funding does not address all problems. The FP7 programme adopted an overly bureaucratic approach to administrative oversight of projects which imposes counterproductive project management burdens on researchers. These hinder both on-going work and also future endeavours by discouraging scientists from further applications for EU research funding. These problems are compounded by the failure of the Commission to engage sufficiently with research findings and the process of translating of evidence into policy. Senior researchers have encountered inappropriate involvement of the alcohol industry in the research process, particularly around the lack of promotion and utilisation of research findings which are contrary to industry interests. Engagement with the research community to address these problems is vital if the EU

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Alcohol Strategy and research programmes aiming to inform future strategies are not to be undermined.

**Question 6. Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?**

16. The current alcohol taxation policies of the EU create inconsistencies in the excise duties levied across different types of alcoholic beverages. Specifying that wine and ciders must be taxed by product volume while permitting beer and spirits to be taxed by ethanol content prevents excise duty being levied in a way which reflects the public health risk associated with products. Under the current system, a 750ml bottle of wine must attract the same level of duty irrespective of whether it contains 90ml of ethanol or 120ml ethanol, despite the public health risk being greater in the latter case. In terms of duty levied per UK unit of alcohol, a 500ml can of normal strength cider would attract substantially more duty per unit than a 3L bottle of high strength cider (8p per unit vs. 5p per unit at current UK duty levels). For those motivated to purchase the maximum ethanol for the minimum price, such duty structures create perverse incentives to purchase beverages with higher alcohol contents in greater quantities. Consideration should be given to reforming alcohol duty structures to permit taxation which consistently reflects the alcohol content of products and the public health risk which this entails.

17. The CJEU is yet to rule on Scotland’s current proposals to introduce minimum unit pricing for alcohol (MUP) and the central considerations are (a) whether the potential public health benefit is proportionate given the infringement on the single market and (b) whether that public health benefit could be achieved via existing powers.

18. The University of Sheffield has produced and consistently updated estimates of the public health benefit associated with different levels of MUP in Scotland and in the other countries of the UK. These estimates are derived from a synthesis model incorporating the best available evidence on the likely effects of the policy. The methodology and analyses have been subject to repeated independent peer review and scientific scrutiny and are published in the world’s leading medical journals.

19. The University of Sheffield has concluded that MUP would provide a substantial public health benefit which, for a 45p MUP implemented in England in 2014/5, was estimated to be a reduction in alcohol-related deaths of 860 per year, in hospital admissions of 29,900 per year and reductions in direct costs to the NHS of £561m over ten years.

142 Sheffield Alcohol Research Group. Sheffield Alcohol Policy Model. 2014
20. Analyses are on-going to establish the alcohol duty increases which would be required to deliver similar public health benefits. Preliminary results indicate politically challenging levels of duty increases would be required.

18 September 2014
Wine and Spirits Trade Association—Written Evidence

The WSTA is the UK organisation for the wine and spirit industry representing over 340 companies producing, importing, transporting and selling wines and spirits. We campaign to promote the industry’s interests with governments at home and abroad. We work with our members to promote the responsible production, marketing and sale of alcohol.

Question 1
Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be with reference to the previous strategy and evaluations thereof?

1. We believe there is merit in renewing and strengthening the current strategy rather than developing a completely new one. The evaluation of the current strategy prepared by COWI\textsuperscript{144} on behalf of the Commission was positive and confirmed that the priority themes remain relevant for Member States and stakeholders. We support these findings.

2. The WSTA and its members are fully committed to promoting responsible drinking and to reducing alcohol-related harm in the UK. The WSTA supports fully the UK Government’s view that the best way to tackle anti-social behaviour caused by alcohol misuse is to do so at local level backed up by promoting the responsible retail and consumption of alcohol. The WSTA is at the forefront of the Government’s Public Health Responsibility Deal to tackle alcohol misuse. Government, businesses and NGOs have come together to improve public health through a series of voluntary commitments. The WSTA is playing a leading role in shaping the alcohol industry’s participation in the Deal. This approach is having positive results. Alcohol consumption has been falling in the UK since 2004:

- Per capita alcohol consumption in the UK has fallen 19% over the last 10 years and is now lower than it was in 1979 and lower than the European average.\textsuperscript{145}
- Young people's consumption has fallen fastest of all - with rates of binge-drinking among 16-24 year old men declining by 31% between 2005 and 2012, while for women of the same age the drop was 37%.\textsuperscript{146}
- The proportion of 11-15 year olds having ever tried alcohol has fallen to the lowest level since the national survey began in 1988 and has fallen from 61% to 43% since 2000.\textsuperscript{147}

3. As the WHO Report - Alcohol in the EU: Consumption, harm and policy approaches – acknowledges, there is considerable variation in alcohol consumption and consumption behaviour across the EU. It is clear therefore that a one size fits all approach is not the best way to address the issue of alcohol related harm across EU member states; a point reinforced in the WHO report which states:

"A consistent and coordinated relationship between local and national initiatives should be sought, and caution should be exercised in transferring specific community programmes developed in one culture or setting to another. They may work well in

\textsuperscript{144} Assessment of the added value of the EU strategy to support Member States in reducing alcohol related harm
\textsuperscript{145} BBPA analysis of HMRC customs clearances, 2014
\textsuperscript{146} Drinking habits amongst adults, ONS, 2012
\textsuperscript{147} Smoking, drinking and drug use among young people in England, HSCIC, 2013
one context and culture and less well in others where, in any case, they may have a
degree of success from different perspectives, such as raising awareness to bring
about popular acceptance of certain policies or changes in consumption."

4. In light of the experience in the UK, the WHO’s comments and of the limited public health
provisions of the Treaty on the Functioning of the EU, the WSTA questions whether
developing a new EU Strategy is the most appropriate means of tackling alcohol-related
harm.

- Given Member States’ competence on public health, we believe that the role of the
EU should be focussed on identifying and sharing best practice on initiatives to reduce
alcohol misuse. For example, the UK’s Community Alcohol Partnerships organisation,
which currently supports local partnership working to address issues such as under-age
sales and alcohol related crime, is sharing their knowledge and experience of tackling
local disorder with industry, local service providers and politicians in Poland.
- Rather than involving itself in discussing and/or promoting specific policy proposals,
the EU should continue to work on facilitating Member States’ efforts to reduce harm.
- An example of this would be the Joint Action work currently being conducted by the
European Commission to look at the feasibility of establishing a common unit of
alcohol across the EU28. This would provide increased clarity for consumers about the
amount of alcohol they consume, and would allow at-scale educational and awareness
campaigns across the EU28.

5. The UK alcohol industry has considerable experience of successfully delivering voluntary
commitments (e.g providing health information on at least 80% of alcohol product labels and
taking out one billion units from the market) and has invested in a number of initiatives
which support the promotion of responsible drinking and seek to tackle alcohol related
crime and anti-social behaviour e.g. Community Alcohol Partnerships, Challenge 25, The
Portman Group, Drinkaware, Best Bar None and Pub watch (details annexed).

6. There are important principles in the current strategy that we are concerned could be lost
if a new strategy were to be developed from scratch. For example:
- Recognition of the importance of a broad range of stakeholders working to tackle
alcohol-related harm; i.e. treating all stakeholders equally and promoting dialogue and
cooperation. There has been a clear campaign by some public health activists to try to
exclude industry from contributing to policy formation relating to alcohol, which is
ultimately counterproductive as it is in the industry’s interest to ensure consumers
enjoy alcoholic products in moderation
- The presumption against a ‘one-size fits all’ approach and recognition that drinking
patterns and cultures vary across the EU;
- The importance of implementing structures, such as the Alcohol and Health Forum,
which foster multi-stakeholder participation and recognise the value of a
voluntary/self-regulatory approach.
- A focus on alcohol misuse and related harm, and not on overall consumption, the
overwhelming majority of which is conducted responsibly.
- The need to base the Strategy on sound, objective scientific data, derived from a
wide range of sources.

148 Alcohol in the EU: Consumption, harm and policy approaches, Andréasson, 2010
• The principle that all categories of alcohol should be treated equitably.
• Giving suitable priority to the EU’s growth and jobs agenda – it is important that nothing in a future Strategy should lead to regulation or action which would impact on the recovery from the European recession.
• Respecting the principles of proportionality and subsidiarity - ultimately, implementing the most appropriate solutions to alcohol misuse remains a national responsibility. Updated Strategy should continue to recognise that “there are different cultural habits related to alcohol consumption in various Members States” – also highlighted in WHO Global Strategy.

Overall we believe that a renewed EU Alcohol Strategy should deliver added value and should not be a replacement for Member States’ national strategies.

**Question 2**

*Are the EU’s alcohol policies underpinned by a sound scientific base?*

1. We believe good research is conducted by experts in the particular field of research, rather than by advocates with a pre-existing policy viewpoint. Researchers/authors should be required to disclose their associations not only with business, but also with any policy advocacy groups (for example, temperance groups, health lobbies, etc).

2. The quality of the research in a number of projects funded by the European Commission has been poor and this has been challenged by the European body representing national trade associations and the alcohol industry.

3. Policies should be adopted based on the most accurate evidence in order to better target the problem. They should also recognise the differences between Member States and allow Member States flexibility to adopt those policies which are best suited to them. For instance it is not true to state that alcohol harm is a growing problem across the whole of the EU and that this is directly linked to consumption levels. As outlined above Alcohol consumption has actually been falling in the UK since 2004 with per capita alcohol consumption in the UK has fallen 19% over the last 10 years and is now lower than it was in 1979 and lower than the European average.149

**Question 3**

*Are the EU’s alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?*

1. The priority themes and aims of the current EU Alcohol Strategy address the target areas of the Global Alcohol Strategy and the European action plan to reduce the harmful use of alcohol 2012 – 2020.

2. While some degree of alignment between EU and other frameworks is desirable, the EU Strategy should first and foremost serve the 28 Member States. Its added value is to reflect the consensus within the EU as to the key priorities to address and the policy options

149 BBPA analysis of HMRC customs clearances, 2014
available, keeping in mind the WHO warning that “not all policy options and interventions will be applicable or relevant for all Member States”.

3. Separately from the Alcohol Strategy, the Commission and CNAPA (The Committee on National Alcohol Policy and Action) are working to finalise a two year Action Plan that will focus on young people and binge drinking—EU Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking). Although we have had several discussions with the Department of Health about this document, we still have concerns that it goes beyond the framework of the WHO Global Alcohol Strategy.

4. The Action Plan, as with the EU Strategy, adopts the multi-stakeholder approach, sets out a portfolio of options for Member States to consider and recognises self-regulatory actions have a part to play in reducing the harmful use of alcohol. We welcome this. However, in places the text still appears to focus on consumption per se rather than harmful use. It also talks about “young people” without adequately defining these as those below the minimum purchase age and in this respect far exceeds the WHO Global Alcohol Strategy by suggesting that those over the legal purchase age should not be exposed to marketing.

Question 4

Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between member States, industry, civil society organisations and EU institutions, for example the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA) still appropriate?

1. The COWI report recognised the value of the EAHF: “The EAHF appears to have succeeded in mobilising a broad range of stakeholders to address alcohol related harm and in stepping up actions. Actions under the EAHF have also likely contributed to engaging cooperation among stakeholders at national and local levels. One important strand of work aimed to support further development of industry self-regulatory systems for the marketing of alcoholic beverages. This has been carried out through commitments by EAHF members, through exchange of information in a dedicated Task Force and through reports on the state of play and progress made. Initiatives for further development of self-regulation have built on the effective self-regulation model of the 2006 Advertising Round Table in health and consumer policy areas. The results from the evaluation indicate that the EAHF process has motivated stakeholders to step up action in this area and has thereby contributed to the development and convergence of the alcohol advertising self-regulatory systems across the EU”.

2. The Forum could however be improved and a starting point for this would be implementation of the recommendations from the COWI report referred to above. In addition we would make a number of suggestions:
   - Participation in the Forum should be conditional on abiding by the principles on which the Forum is based i.e. multi-stakeholder dialogue;
   - Members of the Forum should commit to actions in line with the principles and the operational objectives of the EU Strategy. They should have active commitments in order to participate in the Forum plenary meetings;
   - There should be a recognition that not all members will agree on the best way to tackle alcohol-related harm. Effort should be put into identifying common areas of interest to foster more synergy and partnership working. The operation of the plenary
meetings should be reviewed to support this, with a clear understanding by all of how the agenda for each meeting is arrived at;

• A shared focus on what is trying to be achieved and on improving and clarifying methods to measure impact of commitments;
• A recognition and emphasis on the role of the Forum in contributing towards delivery of the European Alcohol Strategy and Alcohol Action Plan;
• The allocation of Public Health Programme funding to Forum members partially or in totality to fund their commitments and/or designed to inform the policy debate should be made based on a sound methodology in line with international or European professional diligence standards applicable, for example, to market research;
• There is currently little or no interaction between the Forum and CNAPA; some Member States do attend the Forum meeting but attendance is low and variable. It would be useful to have formal exchanges between the two bodies. Forum commitments should be on the agenda of each CNAPA meeting, and reciprocally, CNAPA members should present Member States’ national developments at Forum meetings.

Question 5
Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?

1. Yes. Since public health remains a Member State competence, the level of funding at EU level should be proportionate to the EU’s level of competence. There should be more comprehensive reviews of EU funded research to determine its value. As we have indicated in answer to Question 2, we have concerns about the way research into alcohol related harm is funded, conducted and presented and much of the “evidence” generated provides misleading signals to policy-makers. The same researchers seem to get funded time and again.

2. Additional areas where funding might usefully be directed are:
   • towards alcohol related research into cultural differences between Member States;
   • the importance and impact on harm of the illegal alcohol market.

3. Besides the quantity of research, we believe quality is even more important. We argue that the following principles of good research should apply to all funding:
   • Resources should be directed towards priority areas identified by the Strategy;
   • All stakeholders should be involved in transparently identifying the priority areas;
   • Funds granted by the EU should be subject to the highest levels of scrutiny and accountability, and adhere to the strictest methodological standards;
   • Data sources should be transparent and accessible;
   • There should be broad geographical coverage if results are extrapolated to inform EU policy.

Question 6
Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (ECJ) balance successfully the aims of the single market with the wishes of
The individual EU Member States to promote public health within their borders, for example through minimum pricing.

1. Yes

- The respective competence of the European Union and the individual Member States is defined by the Treaty on the Functioning of the European Union. This reflects the consensus negotiated by European Governments, who voluntarily agreed to transfer certain competences to the EU.
- The free movement of goods is a basic, founding principle of the Union. It is embodied by the Single Market, which benefit all European citizens and businesses and which is paramount to ensuring economic growth. The Treaty prohibits ‘quantitative restrictions and all measures having equivalent effect’ between Member States. Article 36 TFEU provides for derogations to the internal market freedoms that are justified on certain specific grounds, for example health.
- On the basis of the derogation in Article 36, some have argued that Member States have the right to introduce specific pricing measures on alcohol to protect public health, such as Minimum Unit Pricing (MUP). It is worth noting that the Treaty sets clear limits to the derogation and the European Court of Justice has further clarified that Article 36 does not apply if the health outcome can be achieved with measures which are less restrictive of intra-EU trade and that the measures have to be supported by data and evidence.

2. EU Member States have competence to regulate and tax alcohol. Minimum unit pricing is not a tax, but a floor price and as such is inconsistent with the operation of the free market in the EU, as an EU member state is in principle not allowed to intervene in competitive matters, such as pricing.

- Some groups advocate pricing interventions such as minimum unit price claiming that there is a public health justification for action which is seen to conflict with the principles of the Single Market. The evidence in support of the public health benefits of minimum unit price is unclear and has yet to be validated or tested.
- One of the issues currently under consideration in the European Court of justice is whether it is appropriate for national governments to adopt measures which impact on the operation of the Single Market when other ‘compliant’ measures are available. We believe that it is not.

3. There is no evidence that Minimum Unit Pricing of alcohol would promote public health and it fails to take into account differing taxations levels, consumer prices, consumption, cultures and harm across each of the EU Member States. For example, countries like Italy have comparatively low levels of alcohol taxation and low prices, yet they also have low levels of consumption at 6.9ltres per capita compared to the UK’s 10.2 litres. In other countries, such as Ireland for example, taxation and prices are much higher and so is consumption at 11.9 litres. This shows that there is no simple link between price and consumption across the EU. Similarly there is no simple link between consumption and harm. France has higher levels of overall consumption than the UK, but does not see the same levels of alcohol related harm.
4. Countries with the highest taxes on alcohol and the highest prices are often those where alcohol misuse is a problem. Ireland and Sweden both have high alcohol prices, but are perceived to have some of the highest levels of harm.

5. Minimum Unit Pricing could be considered to be a protectionist measure, particularly as individual Governments already have taxation raising powers available to apply to alcohol products. This could lead to concerns by the World Trade Organisation and non-EU states, which might see such a measure as a restriction on trade and potentially take action against it.

6. Should any strategy look to discuss the nature of pricing and alcohol, the WSTA would request that this focuses on the current mechanism member states have to influence the price of alcohol, namely the tax structures. As such it is critical therefore that all alcoholic beverages are treated/taxed fairly and that Government continues to press for the development of detailed rules for reduced alcohol wines. This is an area in which a reviewed strategy could more reasonably be involved and provide potential benefits to consumers in a less intrusive and possibly more effective way than Minimum Unit Pricing.

Annex 1

Industry action to tackle alcohol related harm

The alcohol industry in the UK has invested in a number of initiatives which support the promotion of responsible drinking and seek to tackle alcohol related crime and anti-social behaviour. The following are some examples of the schemes in which the industry has been working in partnership with Government, the police, local authorities and others.

- **Community Alcohol Partnerships.** CAP projects bring together local retailers, trading standards, schools and police to tackle the problem of underage drinking and associated anti-social behaviour in communities. They link alcohol education, enforcement measures and partnership working to tackle the demand and supply side of underage drinking. There are now over 60 operational CAPs across the UK, with plans in place to expand their role and scope. The schemes reduced alcohol related ASB in Barnsley by 30% and in Durham by 37%.

- **Challenge 25.** This is a strategy developed by retailers that encourages anyone buying alcohol who looks under 25 to carry acceptable ID. It is now widely used on our high streets and is recognised by 84% of 18-24yr olds in the UK. It has proved to be an effective tool to tackle underage purchases and has led to an estimated 11m challenges since its introduction. This has helped to reduce access to alcohol for young people which has supported the reduction in the proportion of pupils who had tried an alcoholic drink which dropped from 55% in 2006 to 39% in 2013 and the proportion of pupils consuming alcohol in the last week which dropped from 21% in 2006 to 9% in 2013.

- **The Portman Group** is the social responsibility body for alcohol producers. They operate a strict Code of Practice to ensure alcohol is marketed responsibly and does not appeal to children. This Code applies to all pre-packaged alcohol sold or marketed in the UK and they have recently launch a code to cover alcohol sponsorship.
too. Since the Portman Group was set up in 1989, they have banned over 130 irresponsible products in co-operation with retailers.

- **Drinkaware.** An independent charity supported by voluntary donations from across the drinks industry to equip people with the knowledge to make sensible decisions about how much they drink. They provide accessible, evidence-based information about alcohol and its effects to employers, young people, teachers, parents and community workers. Using a range of mediums, such as film, multimedia and TV, they help dispel myths and present the honest facts about alcohol. In 2011 Drinkaware had over 2.8m individual visitors to their website and have received funding from the industry of £5m over the past few years.

- **Best Bar None.** Best Bar None (BBN) is a national award scheme, supported by the Home Office, aimed at promoting responsible management and operation of alcohol licensed premises. Piloted in Manchester in 2003, it has since been adopted by 100 towns and cities across the UK and is now being taken up internationally.

- **Pub watch.** Pubwatch is a voluntary organisation set up to promote best practice through supporting the work of localised Pubwatch Schemes. Its aim is to achieve a safer drinking environment in all licensed premises throughout the UK. An evaluation report showed that the vast majority of local authorities (76%), Police (70%) and licensees (70%) who responded to the survey believe Pubwatch to be contributing to a safer drinking environment in the areas in which they operate.

You can read more on these and other schemes at: [http://www.portmangroup.org.uk/docs/default-source/recruitment-jds/local-alcohol-partnerships-.pdf?sfvrsn=0](http://www.portmangroup.org.uk/docs/default-source/recruitment-jds/local-alcohol-partnerships-.pdf?sfvrsn=0)

19 September 2014
Wine and Spirits Trade Association, British Beer & Pub Association, Scotch Whisky Association and The Scottish Licensed Trade Association — Oral Evidence (QQ 169-199)

Transcript to be found under British Beer & Pub Association
TUESDAY 18 NOVEMBER 2014

Members present
Baroness Prashar (Chairman)
Viscount Bridgeman
Lord Tomlinson

Examination of Witness

Dr Lars Møller, Programme Manager, Alcohol and Illicit Drugs, World Health Organisation Regional Office for Europe

Q74 The Chairman: Dr Møller, thank you very much indeed for your time this afternoon. I am Usha Prashar, and am the Chair of the Sub-Committee on Home Affairs. As you will be aware, we are taking evidence on the alcohol strategy. I will ask my colleagues to introduce themselves before we start.


Viscount Bridgeman: I am Robin Bridgeman. I am a Conservative Member of the House of Lords.

The Chairman: As you have been told, we are taking a transcript because not all Members of the Committee are here, so it is for their benefit. You will get an opportunity to see the transcript and if there is any supplementary evidence you want to give us you can do that. Before we start, is there a general comment or statement you want to make?

Dr Lars Møller: I am very pleased you are taking this opportunity to listen to different stakeholders and also I am very pleased to give the WHO view on this.

Q75 The Chairman: We are very much looking forward to hearing the view of the WHO. I will start with the first question. The 2012 evaluation of the previous strategy stated: “Collaboration at European level is a key element in achieving WHO objectives of reducing social disparities and health inequalities, balancing different interests and achieving inter-sectoral action to reduce alcohol-related harm”. Do you agree with that and, if you do, in what specific ways did the previous EU strategy contribute to achieving the WHO’s objectives and how satisfactory was the frequency and the quality of collaboration?

Dr Lars Møller: The WHO adopted the Health 2020 strategy recently. That is a new European health policy framework, which aims to support actions across Governments and society to
“significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality”. The two strategic objectives are “improving health for all and reducing health inequalities”, and “improving leadership and participatory governance for health”. Health 2020 is mainly a framework at the country level, but it also has some international aspects. Recently, we published a book on alcohol inequality where we focused on international collaboration because, in order to achieve that, we need to have more international collaboration to reduce poverty and increase social protection. The main aspect of the book is increased pricing policies, like minimum unit pricing.

The EU strategy—let us call it the old one—has started to work on that and there have been a few CNAPA meetings focusing on pricing aspects. The European Commission also supported a RAND study that very much linked the inverse relationship between pricing and alcohol consumption. Another area of collaboration between the WHO and the EC has been on monitoring where we have, together with the Commission, identified indicators to monitor the strategy and the situation in countries. This collaboration has been extremely valuable for WHO and also for member states because now we have only one system where we collect this information. Before we had different systems; now we have the same system and the same indicators.

The Chairman: Do you mean the same indicators as those of the European Union strategy?

Dr Lars Møller: We have developed them together, so we can use those to follow the strategy and our WHO policy papers. That way we have also been able to cofinance these activities.

The Chairman: What kind of activities have you cofinanced?

Dr Lars Møller: We have established an online information system on alcohol and health. It is part of a global system, but we also have a WHO regional system and an EU system. There are different platforms where you can enter. It is the same data but for many countries; it is just a filter. That gives data on consumption, on harm and on what the policy implementations are in countries.

Q76 The Chairman: Have you seen this collaboration get better over the years as the EU strategy has evolved?

Dr Lars Møller: Yes, I think so. We are part of a global system but, but we also wanted to benefit from what is going on in Europe, in the EU Commission and EU countries. We have identified a number of indicators that are collected only in Europe and we have changed the indicators over time, deleted some and added some new ones, according to need. I think it has been very valuable. We also got some good ideas. For instance, it was a Commission idea that we should collect information about good practice in countries. We have collected that and it has been published in the latest European Status Report on Alcohol and Health but soon it will be available at our online system. We will continue collecting this information to share good practice between member states.

Q77 The Chairman: From your point of view, what would be the added value of a new EU strategy as opposed to the WHO European action plan for 2012 to 2020?

Dr Lars Møller: There are two main components. One is the possibility of the European Commission working across sectors. We are a little more limited at WHO. We can only work
World Health Organisation—Oral Evidence (QQ 74-98)

with countries through their ministries of health. We can work with other sectors, but it has pass through the ministry of health. I think the EC has better links to the different ministries that have impacts on alcohol policies. Therefore, the EU can be used to focus on more cross-border issues, which we are not able to do in the same way. There could be EU rules on alcohol taxation, marketing and advertising, including cross-border advertising and online advertising. You could have maybe new legislation on alcohol labelling, which is lacking at the moment, and also on product warning messages and online sales, while continuing to have collaboration on research data gathering and monitoring.

The second is added components that follow new strategies, like we have seen with the old strategy, such as keeping a close network with member states—having meetings twice a year with CNAPA members—and having funds for implementation, monitoring and research. We are not able to support any research activities, so without this strategy there would not have been much research. It is very difficult for a researcher to find funding for alcohol research.

Q78 The Chairman: Because you work mainly through health departments, you think you have a much narrower focus, whereas the EU can work right across different sectors, which is an advantage to you?

Dr Lars Møller: It is.

The Chairman: Against that background, in what way should an EU strategy differ from the WHO framework? What would you like to see in the new alcohol strategy that would be different from what you have?

Dr Lars Møller: We have 10 action areas in our strategy and action plan, which is probably too many. Why not focus on the best parts? The best parts are the areas that are focused on pricing, taxation, availability and marketing issues. We know we would have a huge impact on consumption if we had good regulations on those. Also, it could be good to have something on drinking behaviour, such as drink-driving, workplaces, pregnancy and violence, and maybe also alcohol labelling. That would be a good topic.

The Chairman: These are the things that you cannot do?

Dr Lars Møller: We are doing it, of course, but we are not good at marketing or pricing issues. We have an impact on availability, but especially marketing and pricing is where we would see—

The Chairman: You can raise awareness about the impact of these, but you cannot do anything directly and you think the EU should be focusing on areas where it can have a real impact?

Dr Lars Møller: That would be perfect, yes.

The Chairman: That nicely leads to the next question. Lord Tomlinson.

Q79 Lord Tomlinson: I think you have already partly answered it because my question is about the 10 action areas identified in the WHO European action plan. Are any of them specifically relevant to the 28 EU member states, as opposed to the wider European region? You have clearly picked out three of them very specifically: availability, marketing and pricing. You have also referred to drink-driving, community and workplace action, but could you go into a little bit more detail on any of the other 10 areas? Forget the three areas of
availability, marketing and pricing, because they are very clear from what you have said, but which of the others do you think are particularly important to an EU strategy? Are they attainable through an EU strategy?

**Dr Lars Møller:** The EU has been at least cofinancing a lot of the research and the monitoring evaluations. I hope it will continue doing that, as it is the 10th action area in our policy. It is very important for us to continue this good collaboration we have established. The WHO is very poor, so we depend on having support from the Commission on this. We cannot do it alone, so it is very important for us to do it together. I hope, of course, that will continue into a new strategy.

**Q80 Lord Tomlinson:** Can I pursue that a little further? One of the things that has particularly interested Members of the Committee in our previous deliberations is the quality of the research and how the research all knits together. I was a little disturbed when I heard some evidence that said the research, as far as the EU was concerned, was rather demand-driven rather than goal-driven. I would have expected, particularly in collaborative research, to know where the gaps in the research knowledge were and concentrate demand for bids in that sort of area, but it seems to be much more demand-led by the researchers.

**Dr Lars Møller:** It is hard for me to answer that. We have been extremely happy with the research. Before we drafted our action plan—not the global strategy; our action plan goes into much more detail—we published a book, which I think was called *Alcohol in the European Union*, where we went through all the 10 action areas and the evidence for all these policies. A lot of that was based on the EU-supported research, so we had a very good evidence base when we drafted our action plan. We could have used some American research, because they have some good research there as well, but we wanted to have a more European focus on this. It was very helpful for us.

**Q81 Lord Tomlinson:** I will move on to another area. In the work that you have done, the research that you have undertaken at the WHO, do you see any differences in drinking patterns between, say, northern, southern and eastern European countries? If yes, should there be an EU strategy that takes these differences into account? We have certainly seen some differences in terms of outcomes, but I would be very interested to hear your view.

**Dr Lars Møller:** In our latest status report, *Alcohol in the European Union*, we looked into a new way of calculating standardised death rates—alcohol-attributable death rates—and we found quite remarkable differences just in the EU countries between west and east. We found a trend in all of the areas such as liver cirrhosis, violence, accidents and cancers from west to east, but especially with violence and accidents there are huge differences between east and west. For instance, between UK and Lithuania, we found 13 times difference in the totals. That cannot be explained by consumption alone, so it has to be some other factors. It could be policy implementation or enforcement, but I also suspect it is a lot to do with drinking behaviour, how you drink alcohol: whether you drink it a little more regularly, every day perhaps, or whether when you drink you are binge drinking. That is a clear difference between the west and east.

Also, we see that southern Europe has had a very rapid decrease in consumption and it is now at the same level as Nordic countries. For instance, Italy is still decreasing: 30 years ago they were drinking 20 litres per person a year of pure alcohol and now they are down to six
litres. It is a tremendous reduction that is hard to explain but, if you look at the policy implementation, they have a lot of policies on alcohol. So it can be partly explained.

Q82 Lord Tomlinson: Do you see part of that change, particularly in the southern wine-drinking countries, coming from the change in the common agricultural policy whereby it has become possible to distil poor-quality wine into industrial alcohol? Has that made a difference, now you don’t have to drink up your own wine lake?

Dr Lars Møller: I am sure the move from quantity to quality has had an impact and that is something we are promoting in some wine-producing countries outside the EU, for instance Moldova, which at the moment has huge quantities but poor quality. The experience from France and Italy was that the farmers earned the same amount. They did not decrease their income by producing less but quality wine. I think a lot of the decrease is also to do with the workplace, because no one can drink during work hours anymore. I think that was quite an influence in the culture: people were drinking throughout the day, and that disappeared. Maybe that explains some of the decrease.

You also asked me whether the same action areas should apply to all countries of the region. I think they should. Our action areas would fit very well globally.

Q83 Lord Tomlinson: You can follow that to the extreme. I have a great interest in the Scandinavian countries, in particular Sweden. The pattern of alcohol consumption and alcohol abuse in Sweden during the 1930s was so high that it persuaded the Social Democrats in Sweden to fight an election on a prohibition ticket. When they won and got their very restrictive alcohol policies, they felt it necessary to negotiate an exemption, a derogation from the Community rules on free competition. We know from that evidence that it has made a difference in almost every measurable fact, but you would not want to go as far as to commend that as a policy, would you?

Dr Lars Møller: No.

Lord Tomlinson: I thought not.

Dr Lars Møller: No, I do not think so, but if they asked me if they should abolish the monopoly I would say, “No, why do that?” It is a very good system. It is very easy to control availability and age limits. You can control the market very well and do not have to sell three for the price of two and things like that. It is a much better system that way. Iceland is now thinking about abolishing its monopoly, but our recommendation was that it would not be a wise move, because it is very well accepted by 70% of the population. In Sweden 85% support the monopoly. It is very well accepted. They should not change a good thing.

Lord Tomlinson: But it should not be made mandatory for others.

Dr Lars Møller: No. That is also in our action plan. If you have it, keep it, but we do not recommend it to others because it is very difficult. If you have not had it, then it is probably not possible to do it.

Q84 Viscount Bridgeman: Dr Møller, this very much follows from Lord Tomlinson’s question. I am asking you as an outside observer and a commentator on this, but do you think the policies relating to the pricing, availability and advertising of alcohol are likely to be put into effect equally in all EU member states? For instance, we have heard the special case of the Loi Evin in France, which was very restrictive particularly on tobacco but also on
alcohol. Is that the sort of pattern that you would recommend to be adopted in other states 
of the Union?

Dr Lars Møller: In my personal view, yes. When we discussed our action plan with the 
member states, the main problem with discussion and agreement was on marketing issues. 
It is a very difficult area and one where we have seen less progress in the EU during 
the strategy. We have monitored this and seen very good progress in all the other areas, but not 
in marketing. When we discussed it, member states were not very interested because we 
would like to have a policy option where you ban alcohol advertising. That would be the 
best, just like in the tobacco field. I also think that if we have a framework on alcohol, we 
could have it just on marketing. If we could have the marketing banned, then we would 
achieve a lot. There is so much marketing going on, so much of which is targeted at young 
people, which is what we should try to avoid.

Viscount Bridgeman: That marketing point has been taken up by witnesses we have heard, 
many of whom have commented on the absence of marketing. That takes us on to the 
attitude and the involvement of the producers. I think this is a theme that we shall be 
addressing later on in our meeting in this visit. It is very interesting you have made that point 
about marketing, which has certainly been picked up. As Lord Tomlinson said, there is such a 
difference across the states. Do you have any further comments on that?

Dr Lars Møller: We are working on an instrument through which we will be able to guide 
member states in a better way on alcohol policies. At the moment we have about 200 
indicators, so it is very difficult. We are trying to make a scoring mechanism for the 10 action 
areas, mainly so we can easily point out, “You are different in that area compared to the 
average of the European Union. Can we help you here; maybe suggest some changes in 
laws?”. We hope that that tool will be something we can use repeatedly, and get some kind 
of evidence that changes in policies will also change behaviour and consumption.

Q85 Viscount Bridgeman: I think you have very neatly answered my next question, which is 
about these indicators and how the WHO can help the European Union on that. I think you 
have answered that, have you not?

Dr Lars Møller: I was going to say “yes and no” to that question, because we have a 
monitoring system for consumption, harm and policies. We do not have a system for 
monitoring surveys based on individuals. That is where I think the Commission could support 
us. It is now supporting the ESPAD study of young people, which has been moved to Lisbon 
to the European Monitoring Centre for Drugs and Drug Addiction. We have discussed using 
the SMART survey system in EU countries to get more individual-based data that can also be 
used for policy-making. That is a very useful thing and we look forward to seeing that data.

We have better and better data on alcohol-related harm. We are also in a better situation, 
where we can calculate all the alcohol-attributable harm. As I said before, the huge 
difference between the UK and Lithuania on accidents and violence cannot be explained by 
consumption, so there must be something else. Maybe we can help countries to do 
something in that area, because that is almost like low-hanging fruit. We know it can be 
much better, so why not try to do it? The UK is doing very well on that.

Viscount Bridgeman: I think we are in the rising consumption category still, are we not?
**Dr Lars Møller:** Yes, but you are doing very well on violence and accidents, despite having a BAC limit of 0.8. I think there are only two countries globally left now.

**Viscount Bridgeman:** Us and Malta, I think. To sum up here, you can be a tremendous help with these benchmarks and with the EU processing your suggestions.

**Dr Lars Møller:** We do not put that many targets in our action plan, but if we get some of these policies going, it might be something we can use for policy implementation but also on harm. Of course, we can easily calculate what the average harm is and how many accidents and how much liver cirrhosis or whatever you have. “Are you doing worse or better?” is a very good indicator for countries, instead of giving specific targets. We have the NCD monitoring framework, where countries sign up to have a 10% reduction before 2020, which has almost been achieved already. At the moment in Western Europe and in EU countries, there is a 2% decrease a year in consumption.

**Q86 The Chairman:** Before I ask my last question, can I ask another question in relation to research? The EU has a different definition of what is a child, what is a young person and what is an adult. Do you have your own criteria for defining what is a child, adult and young person? Could EU research adopt them?

**Dr Lars Møller:** I think in WHO terminology, adolescent is below 25 years and child is below 18. That is what I think, but I am not sure about that definition.

**The Chairman:** Would there be some benefit in there being some synergy between your definition and that of the EU? I see heads shaking at the back.

**Dr Lars Møller:** They had better answer then.

**The Chairman:** We can come back to them.

**Q87 Lord Tomlinson:** Before you come to your last question, Chair, could I go back to the 10 points in the plan? I had a little difficulty in understanding precisely what a couple of them were. “Reducing the negative consequences of drinking and alcohol intoxication”—is that primarily medical consequences? What do you have in mind?

**Dr Lars Møller:** No. When people are intoxicated, we have much more violence and more accidents.

**Lord Tomlinson:** When you say “accidents”, are you thinking of car accidents particularly?

**Dr Lars Møller:** Yes, but we have a special section on drink-driving. It is mainly on violence: violence in bars, restaurants and streets but also domestic violence. Consumption is moving from on-premise to off-premise now, so we might see more domestic violence.

**Q88 Lord Tomlinson:** The other one was on reducing the public health impact of illicit alcohol and “informally produced alcohol”—“informally produced alcohol” is a very elegant phrase, if I may say so. How wide a problem is that?

**Dr Lars Møller:** In the European Union, it is not a big problem. It is a very limited problem, but last year we had an incident in the Czech Republic where almost 40 people died from counterfeit alcohol. It pops up, but we rarely see it now. Home production also seems to be quite safe where it happens. What we call the informal production of alcohol, and unregistered consumption, in the EU is now less than 10% of the total consumption. It is decreasing. In some other parts of the world it is 30% or 50%, especially in those countries...
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where you have a lot of home production: wine production and distilleries. Hungary is probably going up now because they have legalised it.

Q89 Viscount Bridgeman: I do not think we have talked about minimum pricing, which is a very hot potato. What is the WHO view on that?

Dr Lars Møller: In our action plan we are supporting that as a policy option. We are very much looking forward to that possibly happening. From the modelling and the research we have seen, it looks like it is a good way forward and it is also something that will reduce inequalities. It will target those who drink too much, young people and those with social inequalities, so it will target those who have less money the most. We strongly believe this is a good way forward.

Q90 The Chairman: That leads to the next question. What role should the alcohol industry play in the development and implementation of the EU strategy? What are the advantages and disadvantages of co-operation between these two sectors?

Dr Lars Møller: We have industry people here. On the WHO side we are quite clear on that. We do not work with the alcohol or tobacco industry. We have no connection with them. At headquarters, because it is put into the resolution, they have a yearly meeting with the economic operators. When we help countries in drafting national policies we tell them, “Do this alone. This is a public health concern. It is not an industry concern. You can use the industry maybe to implement some of your regulations and rules, but they should not be at the table”.

The Chairman: You are making a distinction: there should be no involvement in policy development but you work with the industry on the implementation?

Dr Lars Møller: We know some countries are doing that, and there are some voluntary agreements. I am not very convinced it is working. It is a way forward and you can do something that way, but it is much better if you have regulations and laws for protection and do not rely on voluntary agreements. That is the official view of the WHO, although there is some discussion at the headquarters level now on how to work with the private sector.

Q91 The Chairman: From your experience, does the involvement of industry at implementation stage become difficult if it has not been involved at the policy development stage?

Dr Lars Møller: It is very clear that the industry does not want to have any population-wide measures. It wants to have individual-based approaches to change people’s behaviour, such as targeting those who drink too much. That is completely different from our evidence. I do not know if you have seen ICAP’s paper, Guide to Creating Integrative Alcohol Policies, on how to make policies in countries. For me, there is no evidence behind this: it does not make any sense to do it that way. We believe in population-based approaches to change consumption, but we have some areas where we influence the health sector in our action plan.

We also need to have some kind of high-risk approach to identify those who drink too much. We recommend that countries have screening and brief interventions, like you do very well. The UK is the best at doing that. It is very necessary because we have 20% who are drinking too much—5% are actually dependent, but 20% drink too much and they have to be
identified and helped at an early stage before it goes wrong. We have published a number of papers on that, but I think policies should be based on population-wide approaches. That is where we have good evidence for change. We do not believe that you can reduce harm without having a reduction in total consumption. One follows the other. We know that from the literature. It is very closely inverse-related.

**The Chairman:** Strategies should be targeted at sections of communities where you think they are drinking too much, regardless of age. That would include those of whatever age within the 5% who are dependent and the 20% who are drinking too much. It is not aimed at young people or old people?

**Dr Lars Møller:** No. It would try to target everybody. That would also have a huge focus on drinking and driving, drinking and working, drinking and being pregnant, and things like that. You cannot avoid it, and we have a section in our action plan on community interventions where we very much focus on that, but on policies, no. That is different.

**Q92 Lord Tomlinson:** Could I go back to your list of 10 and to the drink-driving policies and countermeasures? Do you believe that we will be able to get effective countermeasures without moving towards some degree of harmonisation of the drink-driving limits? You have referred to the fact that the United Kingdom is one of two that has the 0.8 limit. Parts of the United Kingdom, such as Scotland, are already contemplating reducing it. Would that ever be the kind of thing that you campaigned on? Would you just recommend it—or not even recommend it?

**Dr Lars Møller:** Sometimes we recommend that it should not be higher than 0.5. That is a WHO recommendation.

**Lord Tomlinson:** That is there as a recommendation.

**Dr Lars Møller:** Of course it is up to countries, but it might be useful to have different limits for professional drivers or novice drivers. In some countries they have zero limits or 0.2 for that category, so that could be helpful. I do not know if the European Union can do anything, because you are actually doing quite well at 0.8 in the UK. We know it does reduce the number of traffic accidents involving alcohol when you reduce it, but even when the number goes down, about 20% to 25% of casualties are due to the involvement of alcohol. It is a problem, but it is an area where we see the best progress globally. It is a steep curve going down. More countries are focused on that. Industry is also very focused on that and it is something they promote.

**Q93 Lord Tomlinson:** Whatever the legal limit is, would you favour the public health message and the public safety message being that the only safe limit to get behind the wheel of a car or a lorry is zero?

**Dr Lars Møller:** It is difficult to measure zero because you can eat something and produce alcohol, so 0.2 might be very useful. I think to have that would probably be the best. Also nowadays if you are not drinking the best excuse is, “No, I am driving”—or, “I am pregnant”, or, “I am Muslim” maybe.

**Q94 The Chairman:** Can I ask one last question? Are you working closely with those who are developing the EU strategy now? Are you trying to influence them?

**Dr Lars Møller:** No, not all.
The Chairman: Not at all? So there is no interaction between you?

Dr Lars Møller: We have an observer status in the CNAPA group. The group has drafted a scoping paper, which we have seen all of but not commented on. We did not want to influence that at all.

The Chairman: Why not?

Dr Lars Møller: Because we have this observer status, we have not been asked to do it.

The Chairman: You do not try to influence the policies? You influence country policies, but you do not influence the policies of multilateral organisations?

Dr Lars Møller: We mainly do it through discussions individually with countries if they ask us, but we do not do it on the paper with the Commission. We were not invited to do it, so I did not want to do it.

Lord Tomlinson: But a lot of the research is cofinanced with the European Union.

Dr Lars Møller: A lot of the monitoring, yes, that is right. We do not have a contract at the moment with the Commission, but it has adopted a new action plan on young people and binge drinking and, without funding, we have agreed to build up a monitoring system for that. So it is also in our interest.

Q95 The Chairman: This may be unfair and you do not have to answer the question, but if you were developing the strategy for the European Union at this stage what would you see as having the most priority? What would you like to see in that strategy?

Dr Lars Møller: The cross-border issues, so something on taxation. That would be fantastic. You are a little better off in the UK. You have a tunnel, but it is not that easy to go to the next country. I am Danish and in Denmark, for example, there is no way they can increase taxation and the prices because people will go to Germany, and then they are not only buying alcohol but a lot of other stuff. That is always an issue. We do not have evidence for that, but that is what we hear. However, to protect young people, we should have high prices. They will never go to Germany because they buy their alcohol one hour before they are drinking it. To protect them, high prices would be good. Cross-border alcohol marketing and advertising is very difficult to control with satellite and cable TV and so on, so that is something the EU could do. As we said, there is also labelling. Online sales of alcohol is probably an issue that is coming up, and then research. I would think those are the areas.

Q96 The Chairman: Where do you think the gaps are on research?

Dr Lars Møller: It is hard to tell. We know very little about how to change behaviour, but we know that policies do change behaviour. We can see that with the smoke-free environment. That does change our attitudes and behaviour, so politicians can actually change behaviour just by regulating it. A little more about behaviour, binge drinking and so on would be interesting. How can we change those behaviours in those countries? We have these differences: some countries binge drink, while other countries do not, and we see much more harm when you binge drink. That is an area we do not know much about. We do not have very good evidence about whether education, training and awareness has any impact. So far the evidence is that it is not very useful. It might change the attitudes a little bit, so you can adopt new laws and get them accepted by the population.
We do not know how to change behaviour, maybe because we are not good enough in the social marketing of our health messages. The industry is very good on marketing its products, because of course it has more resources. Public Health England said the other day that the industry has £800 million to use a year on alcohol advertising and Public Health England has £4 million to do the opposite. We cannot compete with the industry.

The Chairman: Indeed, that tells the story.

Q97 Viscount Bridgeman: Dr Møller, you said there are difficulties about addressing binge drinking. This is a very fast-moving problem. Recently in the British press there has been evidence that binge drinking is now very common among women at a higher social level and also older, middle-aged women. It is a fast-moving problem, is it not?

Dr Lars Møller: Yes, it is, and especially with young people. I am referring to young people because I have seen the ESPAD studies with 15 and 16 year-olds. One-third or one-fifth of that age group reported being drunk during the last month. In Denmark it is more than one-third.

Q98 Lord Tomlinson: Can I ask one last point specifically? One of our written pieces of evidence strongly supports a change in alcohol labelling to include the calorific value. Do you have any views on that at all?

Dr Lars Møller: I think that would be very useful, because nobody knows how many calories there are in drinks or in mixed drinks or in beer. Recently we produced an infographic that we put on our Facebook site of a young woman drinking; nothing special, it included a short agenda, and then how much she was drinking and how many calories were in her intake. It was not heavy drinking but for that alone it was 12 kilos a year. I think that information would target a lot of young people, especially women. I think it would be useful information. Why do we have no access to that information? They need to put everything on a bottle of water. If you add 1.2% of alcohol you can take everything off except the alcohol content. With wine only, you also have to put sulphites in. It does not make sense—we do not have the allergens, the additives or whatever. We should have access to that information and health warnings might also have a little impact. I do not think it is a lot of impact, but we saw there was some impact on the tobacco side when that changed. Maybe that was also the whole packaging and so on, but I think it would have an impact.

The Chairman: Is there anything else you want to say to us that we have not asked you about?

Dr Lars Møller: No. You asked everything. You are very well informed.

The Chairman: Thank you very much indeed and if there is anything you want to send us as supplementary evidence, please feel free to do so.

Dr Møller: I would say the same. If you have any other questions, please just let me know.

The Chairman: We are very grateful to you for giving us your time. Thank you very much indeed.