



Department of  
**Health, Social Services  
and Public Safety**

[www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)



**The Scottish  
Government**



*Consultation on options for improving  
information on the labels of alcoholic drinks  
to support consumers to make healthier choices  
in the UK*

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# Consultation Summary Page

**Date consultation launched:** 15 February 2010

**Closing date for responses:** 9 May 2010

## Who will this consultation be of most interest to?

Alcohol producers, retailers who sell 'own label' alcohol, trade associations, enforcement agencies, bodies with an interest in public health, and consumers.

## What is the subject of this consultation?

How best to improve unit and health information for consumers on alcohol labels, whether by a renewed voluntary agreement or a mandatory requirement through legislation.

## What is the purpose of this consultation?

To seek the views of alcohol producers and other stakeholders on the options for improving the labelling of alcoholic drinks.

Responses to this consultation should be sent to the following email addresses depending upon their geographical relevance:

Responses relating only to England: [Englandalcohollabelling@dh.gsi.gov.uk](mailto:Englandalcohollabelling@dh.gsi.gov.uk)

Responses relating only to Wales: [Walesalcohollabelling@dh.gsi.gov.uk](mailto:Walesalcohollabelling@dh.gsi.gov.uk)

Responses relating only to Scotland: [Scotlandalcohollabelling@dh.gsi.gov.uk](mailto:Scotlandalcohollabelling@dh.gsi.gov.uk)

Responses relating to Northern Ireland: [NorthernIrelandalcohollabelling@dh.gsi.gov.uk](mailto:NorthernIrelandalcohollabelling@dh.gsi.gov.uk)

Responses relating to the whole UK: [UKalcohollabelling@dh.gsi.gov.uk](mailto:UKalcohollabelling@dh.gsi.gov.uk)

Postal replies should clearly state which territory they apply to and be sent to: Alcohol Labelling Consultation, 628 Wellington House, 133-155 Waterloo Rd, SE1 8UG

## Is an Impact Assessment included with this consultation?

Yes

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# Detail of Consultation

## Introduction

This consultation is on the options for improving unit and health information on the labelling of alcoholic drinks in the UK. This is a joint consultation between the Department of Health and the Devolved Administrations. Domestic provisions for labelling alcohol are devolved under the Scotland Act, the Government of Wales Act 2006 and the National Assembly of Wales (Transfer of Functions) Order 1999/672 and the Northern Ireland Act 1998. The Devolved Administrations will each take account of the responses to this consultation, including in particular those from within their respective countries, before deciding on their

## Proposals

### The key proposal is:

That one option for action needs to be chosen, to improve unit and health information for consumers on alcohol labels within a reasonable timescale.

## Consultation Process

This consultation is intended to obtain views and information from stakeholders on the options to improve unit and health information in the labels of alcoholic drinks. Below are some specific questions to which we would welcome responses. Specific responses are sought to enable the UK Government and the Devolved Administrations to make decisions on the best option and on the detail of legislation, should that be the option chosen.

Questions are for alcohol producers, retailers who sell 'own label' alcohol, trade associations and enforcement agencies, bodies with an interest in public health, other agencies and consumers interested in this area. Please provide responses either on this sheet or in a separate letter.

## Responses

The deadline for responses is 9 May 2010.

Please state in your response whether you are responding on behalf of an organisation/company (including details of any stakeholders your organisation represents) or as a private individual. Wherever possible, responses should be accompanied by references to research or other evidence.

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Freedom of Information (Scotland) Act 2005, the Data Protection Act 1998 (DPA), the Environmental Information Regulations 2004) and Environmental Information (Scotland) Regulations 2004.

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and that deals, among other things, with obligations of confidence. In view of this, it

would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department of Health.

The Department of Health will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties. However, please be aware that it will be shared with the Devolved Administrations.

**Thank you on behalf of the Department of Health and the Devolved administrations for participating in this consultation.**

## Other relevant documents

### **Food Safety Act 1990 (c 16)**

[http://www.opsi.gov.uk/acts/acts1990/ukpga\\_19900016\\_en\\_1](http://www.opsi.gov.uk/acts/acts1990/ukpga_19900016_en_1)

### **Alcohol Harm Reduction Strategy for England 2004**

[www.strategy.gov.uk/work\\_areas/alcohol\\_misuse/index.asp](http://www.strategy.gov.uk/work_areas/alcohol_misuse/index.asp)

### **Safe. Sensible. Social: The next steps in the National Alcohol Strategy 2007**

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH\\_075218](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_075218)

### **Safe.Sensible.Social – Consultation on further action 2008**

[http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH\\_086412](http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_086412)

### **Safe.Sensible.Social – Consultation on further action consultation report December 2008**

[http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_091369](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_091369)

### **Monitoring Implementation of Alcohol Labelling Regime (including advice to women on alcohol and pregnancy (CCFRA) 2008**

[http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH\\_085390](http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_085390)

### **Second Stage Monitoring Implementation of the Voluntary Labelling Agreement (including advice to women on alcohol and pregnancy (Campden BRI) 2009**

[http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH\\_112472](http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_112472)

**Know Your Limits** website <http://www.units.nhs.uk/>

***A Review of Research into the Impacts of Alcohol Warning Labels on Attitudes and Behaviour***, Centre for Addictions Research of BC, February 2006

**Proposal for a regulation of the European Parliament and of the Council on the provision of food information to consumers**, Commission of the European Communities, 2008/0028 ( COD)

**Changing Scotland's relationship with alcohol: a discussion paper on our strategic approach** : <http://www.scotland.gov.uk/Publications/2008/06/16084348/20>

**Analysis of Responses to the Consultation on the Scottish Government's Strategic Approach to Changing Scotland's relationship with Alcohol:**

<http://www.scotland.gov.uk/Publications/2009/02/24154414>

**Changing Scotland's Relationship with Alcohol: A Framework for Action:**

<http://www.scotland.gov.uk/Publications/2009/03/04144703>

**Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018.**

<http://wales.gov.uk/topics/housingandcommunity/safety/publications/strategy0818/?lang=en>

# BACKGROUND

## The Importance of Alcohol Labelling

The risk of harm from drinking above the Government guidelines (that men should not regularly drink more than 3–4 units per day; and women should not regularly drink more than 2–3 units per day) increases the more alcohol people drink and the more often people drink above these guidelines. For example, drinking alcohol regularly at guideline levels carries a 1% lifetime risk of dying from an alcohol-related cause. Drinking regularly at more than double these levels increases the lifetime risk to 10%. Drunkenness or 'binge' drinking on single occasions is additionally associated with injuries, accidents, violence, and crime. Excessive alcohol consumption also causes reduced productivity, unemployment, and other harms.

Over a quarter of the adult population (9 million adults) in England drink above the Government guidelines. These 9 million adults drink three quarters of all the alcohol consumed in England. The Scottish Government estimates that up to 50% of men and 30% of women in Scotland may be regularly exceeding the sensible drinking guidelines and alcohol contributes to 1 in 20 deaths in Scotland. In Wales, 45% of adults report drinking above the guidelines on at least one day in the previous week, including 28% who report binge drinking.

At higher risk of developing chronic ill health are the 2 million of these who regularly drink at higher-risk levels, that is, they regularly drink more than double the Government guidelines. In Scotland the scale of the problem is shocking, with alcohol-related liver disease now considered by the Chief Medical Officer as one of 4 'big killers', alongside cancer, heart disease and stroke. Alcohol-related mortality rates in Scotland have doubled over the last 15 years and women in Scotland are also as likely to die of chronic liver disease and cirrhosis as men in England. Around 1,000 deaths are attributable to alcohol per year in Wales. In the UK as a whole, those drinking regularly at more than double Government guidelines drink a third of all the alcohol consumed in the country.

If consumers are given advice about the level of, and health implications of, their alcohol consumption by health professionals, evidence shows that one in eight individuals will choose to reduce their consumption to within lower-risk levels. Without unit and health information on product labels, it is much harder for people to monitor and control their consumption and the benefits of NHS preventive advice can be put at risk.

The need for information on alcohol unit content and daily guidelines is shown by the relatively low numbers who are able correctly to state the Government guidelines for lower-risk drinking. An official UK survey conducted in 2009<sup>1</sup> found that 63% of drinkers could say correctly, what a unit measure for beer is; 69% could say this for spirits; but only 27% could say this for wine. The figures are slightly higher for those who drink more often. However, only 13% of adults in 2009 said they kept any kind of check on how many units they drink.

The same survey found that 90% of adults had heard of measuring alcohol consumption in units. However, while 75% had heard of the Government guidelines only 44% of these (i.e., 28% of adults) could roughly state the correct the guidelines for men and women.

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<sup>1</sup> Office for National Statistics (2010) *Drinking: adults' behaviour and knowledge in 2009*. See <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=6990>

A recent paper for the EU Alcohol & Health Forum<sup>2</sup> reviewed research on the effectiveness of warnings and other information on alcohol labels. It concludes that such statements 'have the potential to inform, raise awareness, and motivate risk reduction' but that 'they are unlikely to have major effects on behaviours if implemented as a stand-alone measure'.

A further paper for the Forum<sup>3</sup> reviewed a number of studies. A study of health information labels in Victoria, Australia found that:

- an impact was more likely over time than on immediate behaviour change;
- labels most likely to be effective were those linked with media campaigns;
- consumers saw value in providing calorie content on alcohol labels.

A study found that the introduction of unit information on alcohol labels in Australia in 2005 led to increasing awareness of the concept of a 'standard drink'. Without this, drinkers often under-estimated alcohol content. Other studies have found potential for warning labels to influence behaviour, good public support for warning labels, and that implementation of labelling initiatives is low cost. Alcohol pregnancy warnings have shown good levels of awareness and recall. Telephone surveys carried out in France both before and after introduction of a mandatory pregnancy logo found small but consistent shifts towards increased risk awareness and social norms that support abstinence during pregnancy.

We do not view information on labels as a stand-alone measure, but as part of a wide-ranging campaign to raise consumer awareness and education on the health risks linked to alcohol consumption. Government campaigns seek to improve alcohol unit literacy and public understanding of the risks of regularly drinking more than the recommended limits so that consumers can make informed and healthier decisions about when and how much they drink. It is, however, evident that an inability to estimate alcohol intake must undermine the capacity and motivation to moderate consumption. As such, knowledge of units for individual drinks and understanding of their relation to Government guidelines for lower risk consumption are essential tools, with information on labels a central requirement.

## **The Origins of Unit and Health information on labels**

The UK Government and the Devolved Administrations are committed to improving information on alcohol product labels.

The UK Government first agreed with the alcohol industry that alcohol unit content should be included on alcohol drinks labels in 1998.

The UK alcohol industry (a range of trade associations and organisations) launched a Social Responsibility Standards document on 18 November 2005. This document made a commitment to including a lower-risk drinking message on packaging, advertising and at point of sale, following on from a proposal in the Government's 2004 Alcohol Harm Reduction Strategy for England.

In 2006, the then Minister of State for Public Health, Caroline Flint MP, asked that a small group of alcohol industry representatives work with Department of Health officials to develop a range of lower-risk drinking messages and unit information that could be displayed on alcoholic drinks labels. She asked that the group consider the standardisation of such messages.

## **Progress of the Voluntary Agreement with Industry**

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<sup>2</sup> Consumer labelling of alcoholic beverages, Current Situation in the EU and options for further voluntary action, November 2009

<sup>3</sup> Labelling initiatives, a brief summary of health warning labels on alcoholic beverages, Eurocare, August 2009

In May 2007, the Department of Health reached a UK wide voluntary agreement with the alcohol industry to include alcohol unit and health information on labels of alcoholic drinks. Government stated that we expected the majority (at least 50%) of labels (estimated by market share) to include five defined elements of information by the end of 2008.

The elements of information agreed with industry were:

- i. the drink's unit content, to the nearest decimal point; unit content must always be shown per container; for wine and spirits, this may be shown in addition per 125ml wine glass or per 25ml spirits glass
- ii. the recommended Government lower-risk drinking guidelines: "UK Chief Medical Officers recommend men do not regularly exceed 3-4 units daily and women, 2-3 units daily"
- iii. the website address of the independent charity, the Drinkaware Trust – [www.drinkaware.co.uk](http://www.drinkaware.co.uk) – or as an alternative, the Drinkaware logo as set out at Annex A (iii)
- iv. "Know Your Limits" or "Enjoy Responsibly" or 'Drink Responsibly' as heading

The agreement also encouraged those producers willing to do so to include:

- v. the short version of the reworded alcohol in pregnancy message as agreed by the four Chief Medical Officers of the United Kingdom:

*"Avoid alcohol if pregnant or trying to conceive".*

The Government accepted that labels might, as an alternative to the textual pregnancy warning, carry a circular logo, ('the logo used in France') showing the silhouette of a pregnant woman holding a wine glass, with a line struck across it.

Government indicated a strong preference for the agreed pregnancy text to be used on labels, rather than the logo; and industry has been encouraged to implement this.

Government stated in the agreement that it would only treat labels which include the pregnancy warning, or alternative logo, as adequately implementing the voluntary agreement.

The voluntary agreement was to be the subject of independent monitoring.

Full text of the voluntary agreement was set out in a Memorandum of Understanding (MoU), and can be found at [Annex A](#).

## Monitoring the Voluntary Agreement

In June 2007, the UK Government published *Safe. Sensible. Social. – the next steps in the National Alcohol Strategy*, which set out the Government's wide-ranging strategy to tackle alcohol harm, including health harm, alcohol-related crime, and harm to children and young people from alcohol.

This strategy is based on:

- (i) **Informing and supporting people to make healthier and more responsible choices:** through national campaigns, providing better education and information for adults and young people; and providing unit and health information on labels.
- (ii) **Creating an environment in which the healthier and more responsible choice is the easier choice:** through the licensing and enforcement regimes, through a proposed mandatory code for alcohol retailing, and considering further restrictions on irresponsible ways of promoting alcohol and ensuring information on alcohol units and Government guidelines is widely available.
- (iii) **Providing advice and support for people most at risk:** through earlier identification of people whose consumption is damaging their health, and providing advice, intervention and, as needed, specialist NHS treatment.
- (iv) **A delivery system that effectively prioritises and delivers action on alcohol misuse:** through the World Class Commissioning programme to strengthen local commissioning of services, including alcohol services, and additional central and regional support, alongside local accountability.

The Strategy included a commitment by Government to monitor the extent to which the elements of the voluntary labelling regime have been implemented; and to consult on legislative options should its expectations not be met. A first stage of independent monitoring was conducted in March 2008 and the results were published in June 2008.

The research found that lower-risk drinking information on labels of alcoholic drinks was only being used to a limited extent and that there was wide variety in the elements included on the labels and how they were portrayed.

*Safe.Sensible.Social – Consultation on further action*, was published by the Department of Health on 22 July 2008, and noted that initial independent monitoring from samples taken in March 2008 had found low levels of compliance with the voluntary agreement and asked:

*“If there continues to be slow progress in implementing a voluntary labelling scheme, should the Government take the next steps to make it a legal requirement to include health and unit information on all bottles and cans?”*

Respondents to the consultation in general strongly supported the idea of introducing a regulatory requirement on labelling, if there continued to be slow progress.

A second stage of independent monitoring was conducted using samples taken in April 2009. This found that the Government's expectation that the majority (at least 50%) of labels should be covered by the end of 2008 was a very long way from being achieved, with only 15% of labels having an 'acceptable' content. Industry provided information on its plans for future labels. Taking account of such labels 'in the pipeline' would mean 19% of labels becoming acceptable in content during 2010.

It is clear that the cider sector has made substantive progress and we can expect further roll-out of the label content expected in the voluntary agreement. This is also true of supermarket 'own label' products.

Some major beer producers such as, Heineken and Molson Coors are making substantive progress, providing good quality information on their labels.

The wine sector has made least progress, no doubt affected by the preponderance of imports and the small market share held by large producers. One major wine producer cites as the reason for this that all of its products are bottled in the UK for the European market, and putting the UK CMOs' guidelines would restrict their ability to sell standard product across Europe.

In contrast, there are some major beer producers who do produce solely for the UK market, but are not implementing key elements of the agreement. Their current refusal to do so is a major blockage in gaining widespread uptake across Industry.

The Department of Health has recently contacted key producers and sought further assurances on progress. In particular we are pleased to note a public commitment to support the 2007 agreement from Diageo as well as indications of support from the brewer, Greene King, cider producer, Aston Manor, and major Chilean wine producer Concha y Toro, and three other spirits producers. We also have indications that the recent purchase of Tennents by C&C Group will result in a change in labelling policy on the major beer sold in Scotland.

### **The Devolved Administrations have their own powers to legislate on food labelling.**

*Changing Scotland's Relationship with Alcohol: A Framework for Action*, published by the Scottish Government in March 2009, stated a belief "that alcohol labelling could be significantly improved and that it would be desirable to introduce mandatory product labelling in line with the voluntary agreement on labelling currently operating across the UK".

*Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018* sets out how the Welsh Assembly Government will tackle the harms associated with alcohol and drug misuse. Improving information to consumers about unit content and sensible drinking levels is consistent with the second key action area in the strategy, which is to prevent harm by providing information about the harms associated with drug and alcohol misuse.

The action plan to address young people's drinking in Northern Ireland contains a commitment to work with other UK jurisdictions to ensure improved information is widely available on relevant labels.

## **Developments in the EU – Calorie information on alcohol labels**

The European Commission's proposal for Regulation on the provision of Food Information to Consumers (COM(2008)40 final) is currently under discussion in the European Parliament and the Council. The proposal requires, in principle, information to be given on ingredients of alcoholic beverages, along with nutrition and calorie information, but would grant a 5-year exemption to wine, spirits, and beer pending consideration by the Commission and the preparation of a report as to how these rules should apply.

The UK Government (and the Devolved Administrations) thinks that consumers should have the same energy information on alcohol labels as on labels of other foodstuffs. Alcohol forms 7% of energy intake on average for UK consumers – this will be higher for drinkers of alcohol and much higher for heavy consumers. The UK Government will continue to argue for this in the European Council.

### **Health harms from Alcohol**

Excessive alcohol intake is nearly as big a health risk for the UK public as a whole as obesity. Regular alcohol consumption above lower risk levels causes a multitude of chronic diseases, particularly heart and circulatory diseases, certain cancers, diseases of the liver, mental illnesses, and dependency. Alcohol's contribution to obesity is significant, but a small part of this picture.

The North West Public Health Observatory published 'Alcohol-attributable fractions for England'. This study looked at hospital admissions in England and identified 47 conditions either wholly or partially attributable to alcohol consumption. Examples include stroke, heart failure, liver disease, pancreatitis, road accidents and fall injuries. The report is available at ; <http://www.nwpho.org.uk/information/>

Knowing the facts about alcoholic drinks allows consumers to make informed choices about what they drink. Information about alcohol unit content is important as it informs people of the relative strengths of different products. Information on the unit content of particular drinks can help consumers estimate how much they really drink compared to recommended daily limits. Information on calorie content can also influence level of consumption and choice of product.

As well as information specific to a particular product, warning labels on alcoholic drinks can be a useful way of raising awareness about potential health risks and responsibilities around drinking alcohol such as drinking during pregnancy.

The likely future inclusion of calorie information on alcohol labels suggests that we need to aim for alcohol unit and health information to be included on the vast majority (at least 75%) of labels in the longer term, to ensure that consumers receive all the information that they need to make informed choices.

# Purpose of this consultation

While the results of independent monitoring based on samples taken at April 2009 are disappointing, the UK Government acknowledges the real efforts by some parts of the alcohol industry to implement the voluntary agreement. The disappointing results overall mean that there may rightly be some scepticism on how far any agreement could enable the majority of off-trade consumers consistently to see the unit and health information they need. We are nevertheless open to further discussions on how partnership with industry could deliver this information.

Should the Government find that it is not possible to enter a credible, voluntary agreement on alcohol labelling with the alcohol industry, we would consider a mandatory requirement through notifying draft regulations to the EU. It is a particular concern that a future EU requirement for calorie labelling on alcohol labels, which the UK Government supports, should be complemented by alcohol unit and health information being also widely available on labels.

The progress to date suggests there are four key issues any option would need to address:

1. How to ensure those companies who are currently not participating do so
2. How to improve awareness of the UK CMOs' drinking guidelines with consumers, with improved uptake of this on labels playing an important part
3. How to ensure the majority (at least 50%) of the market is covered in the near term (2012) and that this progress is continued to cover the vast majority (at least 75%) by 2014
4. How to ensure consistency and clarity in labelling to provide useful information to consumers

The Government now needs to come to a conclusion on which of the options presented will be the most targeted and proportionate way of delivering the Government's objective of ensuring that unit and health information is carried on a majority (at least 50%) of labels in the UK in the short term, and a vast majority (at least 75%) of labels in the medium term.

- Whether we should allow the current voluntary agreement to continue (**Option 1**). As already noted, information on amended labels 'in the pipeline' suggests that 19% may be acceptable during 2010. Diageo has recently announced that it intends to support the 2007 voluntary agreement. This may take labels deemed acceptable up to about 28%. Further roll-out of labels by larger producers and the large supermarkets (for their 'own label' brands) already supporting the agreement could take off-trade market coverage towards 35%-40% by the end of 2011 or early 2012. This takes no account of the need to improve clarity and legibility for some labels. Prospects for further improvement would be unclear, given that two of the biggest producers on the UK market have refused to implement the agreement.
- Whether there is any real prospect for a targeted and *strengthened* self-regulatory agreement with the alcohol industry to improve the coverage and consistency of unit and health information on labels. Whilst this would be less burdensome on industry (particularly smaller companies) this would need to include specific commitments by individual major producers and retailers with specific agreed timescales. It is unclear yet whether such an option (**Option 2**) has support from enough major players in the industry, including all members of the Portman Group. Option 2 is therefore framed as an invitation and a challenge to the industry to make clear whether such an option is realistically available and whether the Government's minimum requirements for market coverage can be met.

- Whether a mandatory requirement (**Option 3**) with its associated costs, including those for small producers, is required to deliver the wide and consistent coverage needed for labelling information to play its necessary part in informing the public. Government is clear that the limited and variable market coverage achieved to date, three years after a voluntary agreement was agreed, is not adequate. An outline of content for possible regulations is set out and comments are sought on this. Should the Government choose Option 3, it would not need to consult again before taking the next steps towards making regulations.

This consultation includes the above three possible options, on which comments are now sought. If the Government does conclude that legislation is the best option, taking account of responses to this consultation, it would expect to notify draft regulations to the EU Commission in Summer 2010.

### **Scottish Government views:**

In *Changing Scotland's relationship with Alcohol: A Framework for Action*, the Scottish Government stated that "we continue to believe that alcohol labelling could be significantly improved and that it would be desirable to introduce mandatory product labelling in line with the voluntary agreement on labelling currently operating across the UK".

Findings from the monitoring of the voluntary agreement show that industry has not been able to deliver with only 10% of labels fully complying with all five elements of the agreement. Even if a wider interpretation of the criteria is used i.e. labels that are 'acceptable' or within the "spirit" of the 2007 MoU, this only brings compliance up to 15%.

In light of the low level of compliance with the voluntary agreement, Scottish Government would need to be persuaded of the willingness and ability of the industry to deliver an acceptable level of compliance to a reasonable timescale in order for options 1 and 2, outlined below, to be considered.

We see clear advantages for both consumers and the industry from a UK-wide approach to labelling of alcohol products, hence our participation in this joint consultation. However, any decision as regards labelling in Scotland ultimately rests with the Scottish Ministers and the Scottish Parliament.

### **Views of the Welsh Assembly Government**

As noted above, improving information to consumers about unit content and sensible drinking levels is consistent with the second key action area in the Welsh Assembly Government's substance misuse strategy, '*Working Together to Reduce Harm*', which is to prevent harm by providing information about the harms associated with drug and alcohol misuse.

The Welsh Assembly Government's view is that voluntary, industry led initiatives are not an alternative to firm Government action in tackling alcohol related harms. Further, we have noted the very disappointing levels of compliance with the voluntary agreement. On that basis, the Welsh Assembly Government has very significant doubts about the credibility and viability of pursuing a renewed voluntary agreement. Like the Scottish Government, we would need to be persuaded of the willingness and ability of the industry to deliver a very significantly improved level of compliance within a reasonable timescale in order for options 1 and 2, outlined below, to be considered.

The Welsh Assembly Government does recognise the advantages of a consistent approach to alcohol labelling across the UK, and for this reason has agreed to participate in this single, UK-wide consultation. Subject to the outcome of this consultation, our preference is for a co-ordinated UK approach towards legislating for health and unit information on alcohol labels.

However, the relevant powers to introduce legislation are devolved to Welsh Ministers insofar as they are applicable in Wales, and the Welsh Assembly Government reserves the right to consider legislation for Wales, even if this is not the outcome in other parts of the UK, following consultation.

**Department of Health, Social Services, and Public Safety Northern Ireland (DHSSPS) views:**

In *Addressing Young People's Drinking in Northern Ireland*, DHSSPS commits to working with the other UK jurisdictions and key stakeholders to consider how the current agreement on labelling can be strengthened.

We too see clear advantages for both consumers and the industry from a UK-wide approach to labelling of alcohol products, hence our participation in this joint consultation. However, any decision as regards labelling in Northern Ireland rest with the Northern Ireland Assembly.

## The Options

### Option 1 (“Do Nothing”)

This would continue the voluntary agreement as set out in the 2007 MoU. Content of the MoU is set out at Annex A.

Given the progress so far of industry in complying with the voluntary labelling agreement and the opposition of some major producers, there is no clear, early prospect that the majority (at least 50%) of products on the market will carry all five elements and it seems unlikely that compliance would progress much beyond 35%-40% coverage in the short to medium term. Unless there is a credible expression of determination by all alcohol producers and ‘own label’ retailers to implement a renewed voluntary agreement, there must be doubt on how far Option 1 would contribute to the Government’s policy of informing and supporting people to make healthier and more responsible choices in the near future.

As described in the findings of the second stage monitoring, information on labels ‘in the pipeline’ suggests that 19% will be ‘acceptable’ by mid-2010. Diageo’s decision to support the voluntary agreement would raise this by about 9%. Other producers and supermarkets currently partly compliant may become fully compliant by the end of 2010 or later, which should raise the ‘acceptable’ level towards 35%-40% by the end of 2011 or early 2012. However, without some further commitment, government has no assurance that adequate standards of clarity and legibility will be delivered – this has been a problem for a substantial minority of labels.

The 2007 MoU was a compromise in respect of advice on alcohol and pregnancy. Some producers did not support this part of the Government’s requirement. The MoU included encouragement to include this element for those producers willing to do so. The Department made clear in the MoU that it would not treat labels without advice on alcohol and pregnancy as acceptable.

It could be possible to give further guidance on clarity, legibility and format to improve consistency. This is an issue of concern with some of the alternative logos for advice on alcohol and pregnancy and more broadly. The evidence is that information on labels can only be effective if consumers stand a chance of seeing it.

Independent monitoring of compliance would continue.

#### Questions relating to Option 1.

**Q1:** Do you support a continuation of the current voluntary agreement with the alcohol industry? Please give reasons for your answer. You will need to also consider the questions relating to the other options, the Impact Assessment and the background information.

## Option 2 (“Self-regulation”)

This would be a renewed and strengthened self-regulatory agreement with the alcohol industry, to improve both coverage and consistency of the expected unit and health information on labels. It would include specific commitments by individual major producers and retailers with specific agreed timescales.

The UK Government has undertaken an assessment of the potential for market coverage if around 40 major companies complied attached at Annex B. It is estimated that nearly 60% off-trade market coverage could be achieved if the five major beer producers, seven major spirits producers, five major wine producers, and three cider and perry producers not implementing the 2007 agreement in full at April 2009, when samples were taken for monitoring by Campden BRI, would be willing to change their stance. The UK Government believes this is a realistic assessment of potential delivery in the near term (taken to be 2012).

Of the companies who were not fully compliant, at February 2010, one beer producer, three spirits producers, one wine producer, and one cider producer, all of whom are in the top ten producers by market share for their sector, have indicated their intention to support the 2007 agreement. Producers already partially complying would need to comply fully. We have also assumed that major UK supermarket ‘own label’ alcohol would comply fully by the end of 2010. The British Retail Consortium commitment to the European Alcohol and Health Forum was for 50% compliance at the end of 2008 and 100% at the end of 2009. Campden BRI findings for April 2009 were below the commitment for end of 2008, but at February 2010, the BRC states that it believes compliance is over 90%.

At least a 50% level of overall delivery is around the minimum Government could accept in the near term, as the minimum market coverage that would allow the majority of consumers to have a chance to see unit and health information on labels regularly. Delivery to this level within a reasonable timescale, such as the end of 2012 at the latest, depends on the willingness of major producers to make a commitment to this. There is reason for some scepticism inasmuch as some major producers in particular did not in practice support the 2007 voluntary agreement and some still oppose this. Nevertheless, the Government would welcome discussions with alcohol producers and retailers on the potential for any renewed and strengthened agreement of this nature. In the medium term (2014) Government would expect to see the vast majority (at least 75%) compliant.

Some industry comments on the Department’s July 2008 consultation ‘*Safe.Sensible.Social – Consultation on further action*’, suggested that consideration should be given to ‘innovative, co-regulatory options’ including in the area of information on labels. The main potential vehicle for such options would be the Portman Group of alcohol producers and its code of practice. Government believes it could help to give confidence that future producer commitments on labelling would be delivered, if the Portman Group code supported this. Guidance associated with the code has supported the inclusion of unit content on labels of alcohol bottles and containers since an agreement with the Department of Health in 1998.

Government would propose to focus any strengthened agreement on its core requirements:

- Unit content for the bottle or container – this may be supplemented by unit content of a specified glass for wine and spirits
- UK Chief Medical Officers' guidelines on daily limits for lower risk regular consumption
- UK Chief Medical Officers' advice on alcohol and pregnancy; an alternative logo is acceptable

A responsibility message, with acceptable variants, and a website address for the Drinkaware Trust would be optional elements; both might be grouped with the core information.

The reasons for focussing more clearly on the Government's core requirements are:

- Priority and clarity – advice to consumers on unit content and guidelines for regular daily consumption, along with a warning on alcohol and pregnancy are seen by Government as the priority needs for information to consumers. While responsibility messages and the Drinkaware address are helpful, Government would not see a need to be prescriptive on whether and how those are shown. Consumer research during the consultation will test what consumers see as their priority.
- Most forms of current responsibility messages and the Drinkaware weblink were already in use before the 2007 agreement and were included in the agreement at industry's request.
- Reducing burden on industry – the tighter core requirements also help to ensure that any strengthened voluntary agreement, or legislation (Option 3), minimises the numbers of labels that may need to be changed.

Any strengthened agreement, to be viable, would need to continue to be United Kingdom wide. Devolved Administrations for Scotland, Wales, and Northern Ireland have their own legislative powers on food and drinks labelling. They will each take account of the responses to this consultation, both from across the UK and particularly from within their respective countries, before deciding their support for this option.

Guidance on clarity, legibility and format, to improve consistency, should be part of any new agreement.

Government would also welcome any specific additional commitments to the above that could further enhance consumer awareness of these core requirements, especially the CMO guidelines on regular daily consumption, through, for example point-of-sale displays, in-store magazine communications or other means such as "bottle collars".

Independent monitoring of compliance would continue.

## Questions relating to Option 2.

- Q1:** Do you support a strengthened self-regulatory agreement with the alcohol industry (Option 2)? Please explain (a) how this could improve coverage to inform consumers and (b) how the consistency and accuracy of unit and health information on labels could be improved for consumers, as compared with the findings on the current voluntary agreement. If you are an industry body, please provide evidence for any strengthened industry body commitment to a renewed agreement. You will need also to consider the questions below, the Impact Assessment and the background information.
- Q2:** Are there any changes to the current option content that will improve understanding of this information.
- Q3:** Do you think that there should be criteria set to improve the visibility of the proposed information and ensure that it is readable? If so, what should this be?
- Q4:** Would there be any one-off costs for your business or those that you represent as a result of Option 2? If so, how much? Will these be costs from changing labelling or new labels and if so, could you please quantify them? Please state whether you are a micro, small, medium or large business.
- Q5:** Would the proposed content of the Government's requirement for the labelling of alcoholic drinks under Options 2 result in ongoing costs or benefits to your business or the businesses you represent? If so, could you please quantify them?
- Q6:** Would there be any other effects of the proposed requirements under Options 2 on the labelling of alcoholic drinks for your business or those that you represent? If so, could you please quantify them?
- Q7:** Are you content with the period proposed for the introduction of Option 2 (end 2012)? If not, please explain what difficulties may arise from this length of time for implementation.
- Q8:** Are any exemptions or modifications needed for labels on particular classes of alcohol product or for particular alcohol businesses such as small producers? If so, please explain how these should operate.
- Q9:** Are any sanctions you anticipate could apply to individual companies or brands which do not abide by the self-regulatory agreement?
- Q10:** Given the apparent difficulty for some businesses in using the CMO guidelines in their current format on labels, do you have alternative suggestions on how those companies could best communicate the guidelines to consumers?
- Q11:** If you are a consumer or a group representing the interests of public health or consumers, would there be any benefits or disadvantages to you or the people you represent as a result of the proposed requirements under Option 2 on the labelling of alcoholic drinks? Please provide details.

## Option 3 ("Mandatory")

This would be a mandatory requirement through regulations made under the Food Safety Act 1990.

Respondents to the UK Government's 2008 consultation were strongly in favour of the introduction of legislation making unit and health information mandatory, if there continues to be slow progress in implementing the voluntary labelling scheme. Several industry bodies stated that most of their members already provide unit information. Others suggested unit information was already currently available through a company website.

Government is clear that the limited and variable market coverage achieved at April 2009, three years after a voluntary agreement was concluded, is not adequate to meet the needs of consumers for unit and health information on alcohol.

Government would propose to focus any regulations on three core requirements:

- Unit content for the bottle or container – this may be supplemented by unit content of a specified glass for wine and spirits
- UK Chief Medical Officers' guidelines on daily limits for lower risk regular consumption
- UK Chief Medical Officers' advice on alcohol and pregnancy; an alternative logo is acceptable

A responsibility message, with acceptable variants, and a website address for the Drinkaware Trust would be accepted as optional elements; and both may be grouped with the core information.

The reasons for focussing more clearly on the Government's core requirements are:

- Priority and clarity – advice to consumers on unit content and guidelines for regular daily consumption, along with a warning on alcohol and pregnancy are seen by Government as the priority needs for information to consumers. While responsibility messages and the Drinkaware address are helpful, Government would not see a need to be prescriptive on whether and how those are shown. Consumer research during the consultation will test what consumers see as their priority.
- Most forms of current responsibility messages and the Drinkaware weblink were already in use before the 2007 agreement and were included in the agreement at industry's request.
- Reducing burden on industry – the tighter core requirements also help to ensure that any strengthened voluntary agreement, or legislation (Option 3), minimises the numbers of labels that may need to be changed.

An outline of content for possible regulations is set out at **Annex C** and comments are sought on this. We are inviting views as to whether the proposed content seems reasonable and proportionate and whether there are any issues that have not been addressed. A more detailed list of questions can be found below. This is not a proposal for detailed regulation text but is intended to give an outline of the possible substantive content of a regulation. Respondents should not try to draft their own regulations but we would welcome comments regarding the content.

Should Government choose Option 3, it would not need to consult again before taking the next steps towards making regulations and we would, therefore, encourage all stakeholders to consider and comment on these proposed regulations, even if they do not agree with them in principle.

Any regulations would need to be notified to the EU under Directive 2000/13 on Food Labelling. Before coming into force, the regulations would need to be approved by the European Commission, after taking account of comments from Member States and others.

Subject to this consultation, it would be possible for the UK Government to notify draft regulations for England to the EU in the Summer of 2010, with a 3-month notification period ending in Autumn 2010. Regulations could be brought into force subsequently.

Domestic provisions for labelling alcohol are devolved under the Scotland Act, the Government of Wales Act 2006 and the National Assembly of Wales (Transfer of Functions) Order 1999/672 and the Northern Ireland Act 1998. The Devolved Administrations will each take account of the responses to this consultation, particularly those from within their respective countries, before deciding on their support for this option.

The UK administrations would need to demonstrate to the EU why a new barrier to trade would be justified on public health grounds, as required by Article 30 of the Treaty of Rome. We are confident of being able to show such a justification. This has been accepted for other notifications on alcohol labelling, such as French legislation in 2006 for a warning on alcohol and pregnancy.

Mutual recognition is the principle in EU law under which Member States must allow goods legally sold in another Member State to be sold in their own territory. This principle applies to non-harmonised goods, i.e. those not already covered by EU-wide legislation setting common requirements that all products of a particular type placed on the EU market must meet. Directive 2000/13 on Food Labelling provides for a framework of harmonised requirements, but with very limited requirements for labelling of alcohol. The Directive allows Member States to impose specific requirements of their own, if justified on public health grounds and subject to EU approval.

If such a requirement were agreed for a UK notification of regulations on unit and health information, the principle of mutual recognition is likely to mean that the UK must accept equivalent information on labels originating from other Member States. In the case of French legislation already mentioned, the EU decided that other Member States' products must comply by including an equivalent pregnancy warning in order to trade within France.

There are also precedents for UK legislation on food labelling, which do not apply to other EU Member States' products. In general, these lack the strong public health grounds which would justify a UK requirement for unit and health information applied to all labels of alcohol products marketed in the UK off-licensed trade. The draft Impact Assessment assumes that all other EU Member States alcohol products would be required to comply.

A mandatory requirement could have drawbacks in a number of areas. These could include:

- A reduction of consumer choice, through smaller companies in particular deciding not to supply particular products to the UK market; for some producers which currently supply common labels to a number of EU countries, there could be continuing costs in setting up labelling lines for the UK only. For others, the costs would be 'one-off' in creating a new label design.
- the creation of a disproportionate burden on smaller businesses, including those outside the UK
- decreased flexibility to evolve labels on products through a requirement to notify the EU each time and
- the imposition of monitoring and enforcement costs on the public purse.

### Questions relating to Option 3.

- Q1:** Do you support legislating for a mandatory requirement on labelling (Option 3)?
- Q2:** Are there any changes to the proposed option content that improve understanding of this information?
- Q3:** Do you think that there should be criteria set to ensure the visibility of the proposed information and ensure that it is readable? If so, what should this be?
- Q4:** Whether or not you support a mandatory requirement, are you content that the content of possible regulations on the labelling of alcoholic drinks outlined below is both reasonable and proportionate? If not, what amendments would you like to see made and why?
- Q5:** Are there any other additions, amendments or deletions you would like to see made to the proposed content? If so, what changes would you like to be made and why?
- Q6:** Will there be any one-off costs for your business or those that you represent as a result of the outlined content for possible regulations on the labelling of alcoholic drinks under Option 3? If so, how much? Will these be costs from changing labelling or new labels and if so, could you please quantify them?
- Q7:** Will the proposed content of the regulations under Option 3 result in ongoing costs or benefits to your business or the businesses you represent? If so, could you please quantify them?
- Q8:** Will there be any other effects of the proposed requirements under Option 3 on the labelling of alcoholic drinks for your business or those that you represent? If so, could you please quantify them?
- Q9:** Are you content with the suggested implementation period for Option 3 (two years from making regulations)? If not, please explain what difficulties may arise from this length of transitional period.
- Q10:** Are any exemptions or modifications needed for labels on particular classes of alcohol product or for particular alcohol businesses such as small producers (e.g. for small packages or specific products)? If so, please explain how these should operate.
- Q11:** For enforcement agencies, what costs or benefits would you incur as a result of the proposed content of the regulations for Option 3 on the labelling of alcoholic drinks? Please quantify these costs or benefits if you can.
- Q12:** If you are a consumer or a group representing the interests of public health or consumers, would there be any benefits or disadvantages to you or the people you represent as a result of the proposed requirements under Option 3 on the labelling of alcoholic drinks? Please provide details.
- Q13:** If you are a small business or their representative organisation, to what extent would you or the businesses you represent be particularly affected by the regulations on the labelling of alcoholic drinks? Please provide details of benefits and costs if you can.
- Q14:** If you are a business particularly serving minority ethnic communities, or their representative organisation, to what extent would you/the businesses you represent be affected by the proposed content of the regulations on the labelling of alcoholic drinks?

Please provide details of benefits and costs if you can.

**Q15:** For all businesses, would the proposed content of the possible regulation of labelling alcoholic drinks have any effect, whether beneficial or detrimental, on competition between you and other businesses? If so, please specify.

**Q16:** For all businesses, would the proposed content of the regulations on the labelling of alcoholic drinks have any effect on your trade across the EU or/and beyond? If so, please specify and/or suggest any modifications.

## General Questions

- Q1:** Considering all options presented, which do you believe would be the most proportionate way of the Government achieving its objective of ensuring that a majority (at least 50%) of labels carry unit and health information in the near term (2012) and a vast majority (at least 75%) in the medium term (2014)?
- Q2;** Are there any further costs and benefits to identify for any of the options?

# Summary findings of the second stage independent monitoring conducted by Campden BRI

Detailed findings are included in the Campden BRI report at [http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH\\_112472](http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_112472)

1. Findings from Stage 2 monitoring, based on samples taken in April 2009, show that:
  - 15% of labels [6% in 2008] had all five elements acceptable in content. 13% also met standards of legibility and clarity.
2. Looking at information on labels 'in the pipeline' in coming months<sup>4</sup>:
  - 19% of labels are expected to have all five elements acceptable in content
3. Some individual elements of information had greater coverage than others, although labels had to contain all 5 to be compliant.

Compliance on the three core elements:

- 67% of labels covers unit content
- 41% had an acceptable pregnancy warning
- 17% were acceptable for the content of lower risk drinking guidance

Compliance on the other two elements:

- 58% covers reference to the Drinkaware website
- 49% of 'responsibility messages' or slogans

Comparisons by product sector in 2009 are:

## *Beer*

- 13% of labels had all five elements 'within the spirit' of the MoU

## *Cider and perry*

- 32% of labels had all five elements 'within the spirit' of the MoU

## *Spirits*

- 9% of labels had all five elements 'within the spirit' of the MoU

## *Wine*

- 9% of labels had all five elements 'within the spirit' of the MoU

The second stage findings also show:

- A surprisingly wide variation of content. Some labels mixed brand advertising with a public health or responsibility message. Some of these messages are of long standing and are for labels which have not been changed to reflect the 2007 MoU. Others altered the wording of Government's lower risk drinking guidance in ways that change its meaning or risk confusion to the public. Some variations give advice on alcohol and

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<sup>4</sup> Industry has not informed us of the timescales for planned label changes; these may be a few months or up to 9 months ahead, as this is a common planning horizon for labelling changes.

pregnancy inconsistent with official Government advice. We could not treat such variants as acceptable, but we have accepted some others not strictly in accord with the 2007 Memorandum of Understanding (MoU) as 'acceptable' or 'within its spirit'. This is likely to mean some reduction in consistency and impact on the public within the label content counted as acceptable.

- A significant number of labels were found to be of a poor standard of legibility or clarity. While these are all included in the 'acceptable' count, such labels should be improved if consumers' needs for readily accessible information are to be met.
- Against the Government's expectation for majority market coverage by the end of 2008, the outcome of just 15% market coverage is clearly disappointing. This would be 13% if unclear or illegible information were not counted. We have taken into account labels 'in the pipeline', based on information received from the industry – about 19% of labels should have content in the spirit of the MoU by Summer 2010.

*[The text of the 2007 Memorandum of Understanding is included here to inform any comments in support of a renewed voluntary agreement]*

### **Inclusion of Sensible Drinking Messages on Alcohol Labels: Memorandum of Understanding between the Department of Health and the Alcohol Industry**

1. This MoU is being agreed between the Department of Health and representatives of the alcohol industry, following consultation, in respect of a voluntary scheme for the inclusion of Sensible Drinking Messages (SDM) on alcohol labels. The scheme is UK wide.
2. The Government recognises that it may not be practicable or may be disproportionately costly for labels of some products to carry all or any aspects of the SDM.
3. Providing the SDM and unit information on alcohol labels should result in many more people using unit information. However, the Government recognise that this will not in itself result in fewer people drinking at hazardous or harmful levels. Including clear and unequivocal information about alcohol content and the Government's advice on daily thresholds for sensible drinking for adults and pregnant women on alcohol labels and containers will play a part in supporting a wider Government-led campaign. Most importantly, a campaign supported by unit information should enable people more easily to assess their own consumption and exercise choice in avoiding drinking at hazardous or harmful levels.
4. Within England, Government will be running a cross-government social marketing and advertising campaign on which expenditure next financial year (2008-09), will be of the order of £10 million. Because unit awareness underpins so much of the sensible drinking agenda, it will be a substantial element of this campaign. The Department also expects to be able to commit a small amount of additional resource within this financial year so that work can start in time for the campaign to run alongside implementation of the labelling changes. The Government looks forward to discussing with the Drinkaware Trust how our respective resources can be used to maximum effect and complement each other.
5. The Government intends to work in partnership with and with the support of the alcohol industry and with Drinkaware to raise awareness of the sensible drinking message (SDM), and to progress relevant actions arising from the new English Alcohol Strategy expected to be published in June 2007.
6. The only group of healthy adults where the advice on daily thresholds for sensible drinking for adults does not apply is pregnant women or those attempting to conceive. For this reason a separate recommendation for this group is part of the overall SDM. An updated wording of this recommendation, based on analysis of the available evidence, has recently been agreed by the Government for England and the Devolved Administrations for Scotland, Wales and Northern Ireland as well as each of their Chief Medical Officers (CMOs).
7. The advice is:  
*“As a general rule, pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to protect the baby, they should not drink more than 1 to 2 units of alcohol once or twice a week and should not get drunk.”*

The advice may be abbreviated to:

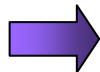
*“Avoid alcohol if pregnant or trying to conceive”.*

8. The Department of Health will make this advice available to GPs and other healthcare practitioners in England to assist them in giving clear advice to their patients. The Department will be cascading the reworded advice through normal professional and NHS channels in England to ensure that healthcare professionals are aware of the revised advice, and that the advice is consistent across the four UK countries. The other UK health departments will do likewise. Amendments to relevant Government publications are already being printed.
9. Government has consulted industry on inclusion on packaging/labels of the wording. Although the abbreviated wording above is the Government's preferred option, as an alternative the logo used in France is acceptable to Government.
10. The Government understands that industry is prepared to take a positive approach to its role in communicating the revised pregnancy guidance and is exploring the most effective way to implement this, including labelling, in parallel with the Government's enhanced communication of the Sensible Drinking Message. The Government also understands the industry trade associations' position to be that in the meantime their members who wish to do so may include the Government's advice on alcohol in pregnancy.
11. All other information about avoiding risks, including information targeting particular groups who may be at more risk than others, will be made available through a wide range of other sources including [www.drinkaware.co.uk](http://www.drinkaware.co.uk) developed for the groups they are targeted at.
12. The Department confirms that, as part of the current Alcohol Harm Reduction Strategy for England and the forthcoming renewed Strategy, the Government has no plans to seek the placement of additional messages or warnings. We fully recognise the considerable technical and financial investment necessary to implement this scheme would make it unreasonable for us to seek any changes in the content of the proposed messages, which are made voluntarily by the industry.
13. The industry will provide information on implementation and planned adoption to allow the Government to undertake a review of progress towards the end of 2008. The Government understands that inclusion of the SDM will generally happen as part of normal industry cycles for making changes to labels. The Government hopes that the majority (at least 50%) of product labels will carry the SDM towards the end of 2008.
14. The format for SDM content enclosed with Caroline Flint MP's consultation letter of 23<sup>rd</sup> February 2007 has been revised to take account of discussions between the Government and industry representatives leading up to agreement of this MoU. The format may be read as illustrating the understanding that any labelling might include:
  - Unit labelling
  - Sensible Drinking Messaging
  - Drinkaware Trust
  - Daily benchmarks
  - Pregnancy information

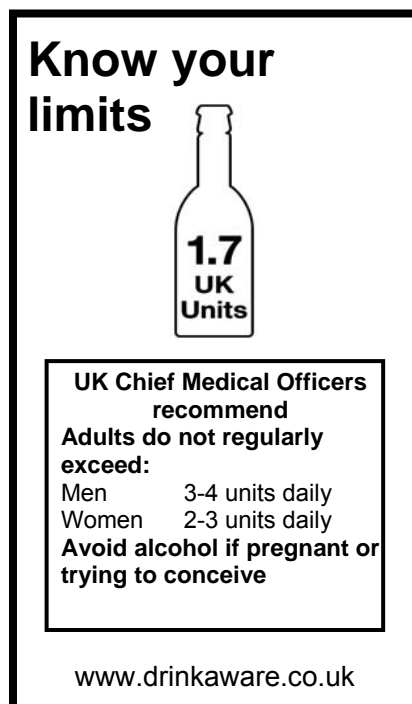
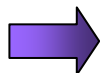
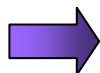
*Final, 24th May 2007*

# Proposed label format [included in 2007 MoU]

- Using the full formula of 5 elements (see document on technical issues).
- 'Know your limits' or 'enjoy responsibly' or 'drink responsibly' as heading.



- Message for pregnancy etc to be included beneath unit advice; French logo is an acceptable alternative
- Website address or Drinkaware logo to be included



- Prefer to see decimal point to know the exact amounts of alcohol units in bottle
- For wine/spirits, would like to see units by glass and bottle (see document on technical issues)



- Table format is preferable for unit advice



## Size and placement:

- Must be legible
- Must stand out from other messaging

## ANNEX B

### Potential market coverage for a strengthened voluntary agreement on unit and health information on alcohol labels

#### Off-trade Product share by Pure Alcohol

[converted Nielsen data on alcohol trade]

	All [RTDs not included]	Of which, Portman Group	April 2009 off-trade % market coverage of DH label information	Potential off-trade % market coverage from a strengthened voluntary agreement <sup>5</sup>
<b>Beer</b>	<b>27%</b>	<b>21%</b>	<b>4%</b>	<b>21%</b>
<b>Wine</b>	<b>37%</b>	<b>3%</b>	<b>4%</b>	<b>14%</b>
<b>Spirits</b>	<b>27%</b>	<b>10%</b>	<b>4%</b>	<b>17%</b>
<b>Cider/perry</b>	<b>7%</b>	<b>4%</b>	<b>3%</b>	<b>6%</b>
<b>Total</b>	<b>100%</b>	<b>38%</b>	<b>15%</b>	<b>58%</b>

<sup>5</sup> Full realisation depends on commitment by companies not implementing the 2007 agreement in full at April 2009 when Campden BRI took samples for monitoring:

- three major beer producers,
- seven major spirits producers,
- five major wine producers, and
- three cider and perry producers

## Outline content of possible regulations on the labelling of alcoholic drinks (Option 3)

### 1. Unit and health information on alcoholic drinks

- (1) Subject to subparagraphs (2) and (3) below, the containers of all alcoholic drinks should be marked or labelled with the following information -
- (i) the drink's unit content, to the nearest decimal point; unit content must always be shown per container; for wine and spirits, this may be shown in addition per 125ml wine glass or per 25ml spirits glass respectively; it is recommended that unit content be show in the form of an icon as shown at Annex C(ii).
  - (ii) the recommended Government lower-risk drinking guidelines: "UK Chief Medical Officers recommend men do not regularly exceed 3-4 units daily and women, 2-3 units daily"
  - (iii) the short version of the alcohol in pregnancy message as agreed by the four Chief Medical Officers of the United Kingdom:  
*"Avoid alcohol if pregnant or trying to conceive".*
- (2) As an alternative to the pregnancy advice text required under subparagraph (1)(iii), containers of alcoholic drinks may instead be marked or labelled on the brand label, or on the most visible surface of the container with a symbol or pictogram, ('the logo used in France') showing the silhouette of a pregnant woman holding a wine glass, with a line struck across it. See example Annex C(i).
- (3) No unit and health information as referred to in subparagraphs (1) and (2) should be required on any outer packaging holding bottles or containers which are labelled correctly.
- (4) The following optional information may also be shown, grouped with the required unit and health information
- (iii) the website address of the independent charity, the Drinkaware Trust – [www.drinkaware.co.uk](http://www.drinkaware.co.uk), or alternatively, the Drinkaware logo as set out at Annex A (iii) may be shown
  - (iii) A responsibility message such as "Know Your Limits" or "Enjoy Responsibly" or 'Drink Responsibly'

### 2. Grouping of Information

Regulations would require:

- the required information must be easy to understand, clearly legible and indelible and, when an alcoholic beverage is sold to the ultimate consumer, the particulars must be marked in a conspicuous place in such a way as to be easily visible
- the required information shall not in any way be hidden, obscured or interrupted by any other written or pictorial matter
- the required information must appear in the labelling in the same field of vision

Possible exemptions for small bottles on the lines of the Food Labelling Regulations 1996, regulation 26, may be considered. This is an exemption for bottles 'the largest surface of whose packaging has an area of less than 10 square centimetres'.

In addition guidance under the Food Safety Act 1990 may recommend as good practice that the required unit and health information and the alternative logo referred to in paragraph 1(2) should be –

- (a) grouped together in the same place on the label
- (b) within a defined border

See example Annex C (ii)

The guidance may cover legibility and clarity issues for the alternative logo referred to in paragraph 1(2).

General Food Standards Agency guidance on food labelling provides guidance on clarity and legibility and would be relevant as guidance for these requirements available at:  
<http://www.food.gov.uk/foodindustry/guidancenotes/labelregsguidance/clearfoodlabelling>

## The French Logo

The French logo



# Proposed label format

**Know your limits**

**1.7  
UK  
Units**

**UK Chief Medical Officers  
recommend  
Adults do not regularly  
exceed:**  
Men 3-4 units daily  
Women 2-3 units daily  
**Avoid alcohol if pregnant or  
trying to conceive**

[www.drinkaware.co.uk](http://www.drinkaware.co.uk)

← Optional

← Optional

17 August 2009

## Drinkaware Logo

**D**RINKAWARE.CO.UK

# Impact Assessment

## Summary: Intervention & Options

Department /Agency:  
Department of Health

Title:  
Impact Assessment of regulations to place unit and health information on alcoholic drink labels

Stage: Consultation

Version: Final

Date: 15 February 2010

Related Publications: The Alcohol Harm Reduction Strategy for England (HM Government 2004), *Safe Sensible Social – next steps in the National Alcohol Strategy* (HM Government 2007), *Safe Sensible Social. – Consultation on further action* (HM Government, July 2008) *Safe.Sensible.Social - Consultation on further action: Consultation Report* (HM Government, December 2008)

Available to view or download at:

[http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_112472](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_112472)

Contact for enquiries: **Matthew Carden**

Telephone: **020 797 24099**

**What is the problem under consideration? Why is government intervention necessary?**

Alcohol misuse results in a substantial external cost of between £17billion and £25 billion per annum; this includes an estimated cost to the health service of £2.7 billion per annum. Office for National Statistics (2010) *Smoking and Drinking Among Adults*, General Household Survey, 2008.

The number of deaths linked to alcohol consumption are double the number recorded in 1991. In England in 2008/9, there were estimated to be around 945,223 hospital admissions for disease or illness related to alcohol, which is 7% of all hospital admissions, and they continue to rise. North West Public Health Observatory (2008), 'Local Alcohol Profiles for England'. See <http://www.nwph.net/alcohol/lape/>

One element of the Government's alcohol strategy is informing and supporting people to make healthier choices. Although Government campaigns have raised awareness of units of alcohol, many people find it hard to relate them to what they drink. Alcohol unit and health information on product labels is intended to provide information to consumers to help them more easily monitor their own alcohol consumption.

**What are the policy objectives and the intended effects?**

The long-term goal of the Government's alcohol strategy is to minimise the health harm, violence and anti-social behaviour that is associated with alcohol misuse, while ensuring that people are able to enjoy alcohol safely and responsibly.

By improving the coverage and consistency of the provision of unit and health information as an integral part of alcoholic drink labels, consumers will increasingly get consistent information with which to make decisions about what product to choose and how much of it to drink, which is crucial to delivery of the alcohol strategy and to supporting the Know Your Limits campaign.

**What policy options have been considered? Please justify any preferred option.**

1. Continue with the current voluntary agreement as set out in the 2007 MoU.
2. A renewed and strengthened agreement with the alcohol industry to improve the coverage and consistency of unit and health information on labels. To include specific commitments by individual major producers and retailers with specific agreed timescales.
3. A mandatory requirement through regulations made under the Food Safety Act 1990.

**When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?** Two years after implementation of either option 2 or option 3. Implementation of option 3 would be two years after the making of regulations. The Food Standards Agency have advised that 2 years is sufficient to allow changes to labels to be incorporated into label redesigns that would have occurred anyway.

**Ministerial Sign-off** For consultation stage Impact Assessments:

*I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.*

Signed by the responsible Minister:



Date:

10/2/10



## Summary: Analysis & Evidence

Policy Option: 3	Description: Oblige alcohol producers, through legislation, to place alcohol unit and other health-related information on alcohol product labels.
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COSTS	<b>ANNUAL COSTS</b>	Description and scale of <b>key monetised costs</b> by 'main affected groups':  See evidence in paragraphs 53-55.
	<b>One-off</b> (Transition) <b>Yrs</b>	
	<b>£ unknown</b> 2	
	<b>Average Annual Cost</b> (excluding one-off)	
<b>£ unknown</b>	<b>Total Cost (PV)</b>	<b>£ unknown</b>

Other **key non-monetised costs** by 'main affected groups' Estimated £1,000 one-off cost per Stock Keeping Unit to redesign labels and reconfigure printing equipment. Total one-off cost is reduced with a longer lead-in time. Loss in retailer/producer revenue and tax revenue due to reduced consumption. The Technical Appendix shows the outcomes from reduced consumption of 0.02%, 0.1% and 1%.

BENEFITS	<b>ANNUAL BENEFITS</b>	Description and scale of <b>key monetised benefits</b> by 'main affected groups'  See evidence in paragraphs 56-58.
	<b>One-off</b> <b>Yrs</b>	
	<b>£ 0</b> 10	
	<b>Average Annual Benefit</b> (excluding one-off)	
<b>£ unknown</b>	<b>Total Benefit (PV)</b>	<b>£ unknown</b>

Other **key non-monetised benefits** by 'main affected groups' Life-years saved and reduced external costs of alcohol misuse due to reduced alcohol consumption (and therefore reduced external costs and saved life years). Evidence to put a precise value on the reduced consumption is not available but there is some effect. The Technical Appendix presents benefits arising from consumption reductions of 0.02%, 0.1% & 1%.

**Key Assumptions/Sensitivities/Risks \*\*** While the evidence is that education and information alone will not secure behaviour change, they are expected to have an important impact as part of the Government's wide-ranging strategy to reduce harm. There are reasons to expect an effect (and therefore a net benefit) of labelling alcohol products. This benefit however, based upon a compliance rate of the voluntary agreement, is likely to be statistically undetectable as an isolated strand of the Government's strategy.

<b>Price Base</b>	<b>Time Period</b>	Net Benefit Range (NPV) £ unknown	NET BENEFIT (NPV Best estimate) £ unknown
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<b>What is the geographic coverage of the policy/option?</b>	England				
<b>On what date will the policy be implemented?</b>	N/A				
<b>Which organisation(s) will enforce the policy?</b>	Trading Standards				
<b>What is the total annual cost of enforcement for these organisations?</b>	£ unknown				
<b>Does enforcement comply with Hampton principles?</b>	Yes				
<b>Will implementation go beyond minimum EU requirements?</b>	Yes				
<b>What is the value of the proposed offsetting measure per year?</b>	£ N/A				
<b>What is the value of changes in greenhouse gas emissions?</b>	£ N/A				
<b>Will the proposal have a significant impact on competition?</b>	No				
<b>Annual cost (£-£) per organisation</b> (excluding one-off)	<table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 25%; border: 1px solid black;">Micro</td> <td style="width: 25%; border: 1px solid black;">Small</td> <td style="width: 25%; border: 1px solid black;">Medium</td> <td style="width: 25%; border: 1px solid black;">Large</td> </tr> </table>	Micro	Small	Medium	Large
Micro	Small	Medium	Large		
<b>Are any of these organisations exempt?</b>	<table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 25%; border: 1px solid black;">No</td> <td style="width: 25%; border: 1px solid black;">No</td> <td style="width: 25%; border: 1px solid black;">N/A</td> <td style="width: 25%; border: 1px solid black;">N/A</td> </tr> </table>	No	No	N/A	N/A
No	No	N/A	N/A		

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

<b>Increase</b> £	<b>Decrease</b> £	<b>Net Impact</b> £	
Key: <span style="background-color: #ffff00; padding: 2px;">Annual costs and benefits: Constant Prices</span>		<span style="background-color: #e0ffe0; padding: 2px;">(Net) Present Value</span>	

## Introduction

1. The Government's alcohol strategy, (June 2007, *Safe. Sensible. Social. – the next steps in the National Alcohol Strategy*), set out the Government's wide-ranging strategy to tackle alcohol harm, including health harm, alcohol-related crime, and harm to children and young people from alcohol.
2. If the strategy is to make an impact the Government and other stakeholders, including the alcohol industry, must play a role in engendering behavioural change in respect of alcohol consumption. The strategy aims to focus our efforts to help those drinkers who are at greatest risk of harming themselves or others – young people under 18 who drink alcohol, 18-24 year old binge drinkers and higher-risk drinkers.
3. The Government strategy is based on:
  - (i) Informing and supporting people to make healthier and more responsible choices through
    - national campaigns,
    - providing better education and information for adults and young people;
    - providing unit information;
    - as well as targeted support for increasing-risk and higher-risk drinkers
  - (ii) Creating an environment in which the healthier and more responsible choice is the easier choice through
    - licensing and enforcement regimes,
    - a mandatory code for alcohol retailing,
    - considering further restrictions on irresponsible ways of promoting alcohol and
    - ensuring information on alcohol units and Government guidelines is widely available.
  - (iii) Providing advice and support for people at most risk through
    - earlier identification of people whose consumption is damaging their health,
    - providing advice, intervention and,
    - as needed, specialist NHS treatment.
  - v) A delivery system that effectively prioritises and delivers action on alcohol misuse through
    - the World Class Commissioning programme to strengthen local commissioning of services, including alcohol services, and
    - additional central and regional support, alongside local accountability
4. While each individual needs to take responsibility for their own alcohol consumption and to be aware of how their drinking could affect their health, their family, children and friends; we must ensure that people know the consequences of drinking and have unit and health information about the alcohol products they buy so they can decide how much they are going to drink.
5. Government campaigns seek to promote literacy about alcohol units and health harms. They should be linked with unit and health labelling on alcoholic drinks, as estimating units in drinks and therefore personal consumption is the main tool for personal risk assessment. The Department of Health does not see unit and health information on labels as a stand-alone measure, but as part of a wide ranging campaign to raise consumer awareness and education on the health risks linked to alcohol consumption. These seek to improve alcohol

unit literacy and public understanding of the risks of excessive consumption so that consumers can make informed and healthier decisions about when and how much they drink.

6. One publication<sup>6</sup> notes that, 63% of drinkers could say correctly, what a unit measure for beer is; 27% could say this for wine; and 69% for spirits. The figures are slightly higher for those who drink more often. Only 13% of adults in 2009 said they kept any kind of check on how many units they drink.
7. In 2009, 90% of adults had heard of measuring alcohol consumption in units. A purpose of the Know Your Limits campaign is to raise the numbers motivated to keep a check on the units they drink and it seems most drinkers can already estimate units in particular drinks. In 2009 this was supported by unit content on 67% of alcoholic drink labels.
8. 75% had heard of lower-risk guidelines and but only 44% of these could roughly state the correct lower-risk guidelines for men and women.
9. There is clearly potential to increase knowledge of units in drinks and knowledge and understanding of the lower-risk guidelines. The fact that substantial numbers of consumers have noticed unit labelling on alcoholic drinks, with the current partial coverage, suggests there is potential for labelling of alcoholic drinks to play a bigger part in supporting national campaigns. Greater awareness should help reduce alcohol harm.

## Background

10. The UK alcohol industry (a range of trade associations and organisations) launched its Social Responsibility Standards document on 18 November 2005. In this document, it committed them to including a lower-risk drinking message on packaging, advertising and at point of sale. This followed on from a commitment in the Government's 2004 Alcohol Harm Reduction Strategy for England.
11. The then Minister of State for Public Health, Caroline Flint MP, asked that a small group of alcohol industry representatives work with Department of Health officials to develop a range of lower-risk drinking messages and unit information that could be displayed on alcoholic drinks labels. She asked that the group consider the standardisation of such messages.
12. The Government is committed to improving information on alcohol product labels and the Government and the alcohol industry first agreed that alcohol unit content should be included on all alcohol drinks labels in 1998. In May 2007, the Department of Health reached a UK wide voluntary agreement with the alcohol industry to include alcohol unit and health information on labels of alcoholic drinks. Government expected the majority of labels to comply with agreement by the end of 2008.
13. The following are the unit and health information elements of the voluntary agreement
  - (i) the drink's unit content, to the nearest decimal point; unit content must always be shown per container; for wine and spirits, this may be shown in addition per 125ml wine glass or per 25ml spirits glass
  - (ii) the recommended Government lower-risk drinking guidelines: "UK Chief Medical Officers recommend men do not regularly exceed 3-4 units daily and women, 2-3 units daily"

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<sup>6</sup> Office for National Statistics (2009) *Drinking: adults' behaviour and knowledge in 2008*. See <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=6990>

- (iii) the website address of the independent charity, the Drinkaware Trust – [www.drinkaware.co.uk](http://www.drinkaware.co.uk), or alternatively, [www.drinkaware.com](http://www.drinkaware.com) – detailing lower-risk drinking messages; as a further alternative, the Drinkaware logo as set out at Annex C (iii) of the attached consultation document may be shown
- (iv) “Know Your Limits” or “Enjoy Responsibly” or ‘Drink Responsibly’ as heading
- (v) the short version of the reworded alcohol in pregnancy message as agreed by the four Chief Medical Officers of the United Kingdom:  
*“Avoid alcohol if pregnant or trying to conceive”.*

In addition, it was agreed that labels might, as an alternative to the above text, carry a circular logo, (‘the logo used in France’) showing the silhouette of a pregnant woman holding a wine glass, with a line struck across it.

There is a strong preference for the agreed pregnancy text to be used on labels, rather than the logo; and industry has been encouraged by Government to implement this, but is not bound by the voluntary agreement to do so.

- 15. The Government expects the industry to produce labels that consumers can easily read and take in. Visibility, legibility and intelligibility are key measures of effectiveness and the Food Standards Agency guidance on label clarity<sup>7</sup> is used to support the assessment of this.
- 16. The Government is conscious of the need to ensure that regulation of the industry is targeted towards preventing harm, is proportionate and does not impact unfairly on responsible consumers, manufacturers and retailers.

## Rationale for unit and health labelling

- 17. This section sets out an illustration of the levels of drinking above lower-risk guidelines and its implications, alongside an illustration of how alcohol labelling may help reduce alcohol harm.

### Levels of drinking above lower-risk guidelines

- 18. It is clear that a significant proportion of the population is regularly drinking above lower-risk guidelines (the lower-risk guidelines are that men should not regularly drink more than 3–4 units per day; women should not regularly drink more than 2–3 units per day). The risk of harm from drinking above lower-risk guidelines increases the more alcohol people drink and the more often people drink above lower-risk guidelines and can result in harm to the drinker’s health; drunkenness is, of course, also associated with crime, reduced productivity and other harm.
- 19. Over a quarter of the adult population (9 million adults) in England drink above the Government guidelines. These 9 million adults drink three quarters of all the alcohol consumed in England.
- 20. The number of adults drinking more than twice the recommended limits on the heaviest drinking day in the last week is a proxy for ‘binge drinking’. Young people aged 16–24 years are among the most likely to have been drinking at this level out of all age groups (30% of men and 24% of women for this age group)<sup>8 9</sup>. Binge drinking at any age carries

<sup>7</sup> <http://www.food.gov.uk/foodindustry/guidancenotes/labelregsguidance/clearfoodlabelling>

<sup>8</sup> Office for National Statistics (2010) *Smoking and Drinking Among Adults*, General Household Survey, 2008.

<sup>9</sup> More men aged 25-34 have drunk at these levels on their heaviest drinking day in some recent years; they are nevertheless less likely to be involved in anti-social behaviour or alcohol related crime than men aged 16-24.

a risk of acute harm to individuals and their families and is associated with crime, nuisance and disorder.

## The implications of alcohol misuse

21. Given the above findings, it is instructive to consider the external cost to the economy through NHS costs, lost productivity, crime and disorder and so on. These costs are described below, alongside the number of hospital admissions and data on alcohol-related mortality.
22. Economic cost of alcohol misuse:
  - a) A 2003 Cabinet Office paper<sup>10</sup> calculated the external cost of alcohol misuse at £18.5 billion to £20 billion per annum in 2001 prices, including NHS costs, costs of crime and lost productivity.
  - b) The NHS cost and crime cost estimates have since been updated by the Department of Health (2008) and the Home Office (2003), using the newest available data and 2006–07 prices. Merging these with the original results (and uprating those results using the GDP deflator, as discussed in the Technical Appendix to this impact assessment), a newer estimate ranges from £17.7 billion to £25 billion in 2006–07 prices can be obtained.<sup>11</sup>
23. Alcohol-related deaths:
  - a) Data from the Office for National Statistics<sup>12</sup> reports that the alcohol-related death rate in the UK did not increase in 2007, but had still risen significantly since 1991, rising from 6.9 deaths per 100,000 population in 1991 to 13.6 in 2008. The number of alcohol-related deaths more than doubled from 4,144 in 1991 to 9,031 in 2008. These statistics are based primarily on deaths specifically attributable to alcohol.
  - b) If deaths caused directly by alcohol are added to deaths caused partly by alcohol (Alcohol Attributable Fractions), there were around 16,000 deaths both directly and partly caused by alcohol in 2007/8 in England. (North West Public Health Observatory)
24. Alcohol-related hospital admissions:
  - a) The most recent analysis of alcohol-related hospital admissions<sup>13</sup> indicates an 85% increase between 2002/3 and 2008/9.
  - b) Specifically, 945,223 hospital admissions were attributable to alcohol in 2008/9, compared with 510,200 in 2002/3.

## The links between labelling, consumption and harm

26. If consumers are given advice about the level of, and health implications of, their alcohol consumption by health professionals, evidence shows that one in eight individuals will choose to reduce their consumption to within lower-risk levels. Moyer, A., Finney, J.,

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<sup>10</sup> Cabinet Office (2003) *Alcohol misuse: How much does it cost?* See [http://www.cabinetoffice.gov.uk/strategy/work\\_areas/alcohol\\_misuse/background.aspx](http://www.cabinetoffice.gov.uk/strategy/work_areas/alcohol_misuse/background.aspx)

<sup>11</sup> Department of Health (2008) *The Cost of Alcohol Harm to the NHS in England*.

<sup>12</sup> See <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14496>

<sup>13</sup> North West Public Health Observatory (2008), 'Local Alcohol Profiles for England'. See <http://www.nwph.net/alcohol/lape/>

Swearingen, C. and Vergun, P. (2002) Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment -seeking and non-treatment seeking populations, *Addiction*, 97, 279-292. However, without unit information on product labels, it is much harder for people to monitor their consumption.

27. There is clearly scope for improving consumer knowledge of alcohol units and alcohol harm. Specifically, an Office for National Statistics publication<sup>14</sup> notes that around a quarter of frequent beer drinkers and around a third of frequent wine drinkers had either not heard of units or could not say what a unit was. Although other measures (such as a social marketing campaign) are being used to address this, a multifaceted approach will likely deliver greater benefits.
28. Concerning the link between health messages and reduced consumption, evidence shows that one in eight people will reduce their consumption to lower-risk levels<sup>15</sup> on the receipt of brief advice provided by non-specialist staff, to help anyone assess how much they are drinking, what their potential health risks are, how their drinking compare with others and some simple approaches they could use to reduce their drinking to recommended lower risk levels, a rate comparable to the delivery of smoking advice (when used with nicotine replacement therapy).<sup>16</sup>
29. Even if a direct link between labelling and consumption has not been researched, it should be noted that a small effect would not be detectable in most analyses. It is shown later on in this impact assessment that only a very small reduction in consumption is needed to generate a net benefit. The proposed label format may also be more effective than those considered by existing studies (e.g. the US warning), given its focus on providing information with a content of alcohol units and health messages rather than 'warnings'. *The Review of the evidence base around effective alcohol harm reduction communications* (COI 2005) concluded that when used in conjunction with a mass media campaign or other health promotion tools, information labels can help to reinforce specific messages, such as regular daily unit guidelines. Unit and health information on labels is not seen as a stand alone measure. Although labelling alone will provide the consumer with the information needed to make healthier and responsible choices, we know that a combination of interventions including campaigns and social marketing create a greater impact.
30. The Technical Appendices of this impact assessment set out the estimated links between per capita alcohol consumption and harm. Reduced population consumption is likely to be associated with reduced harm.

## Developments in the EU

31. The EU Commission's proposal for Regulation on the provision of Food to Consumers (COM(2008)40 final) is currently under discussion in the European Parliament and the Council of Ministers. The proposal requires, in principle, information to be given on ingredients of alcoholic beverages, along with nutrition information, but grants a 5 year exemption to wine, spirit, and beer. Discussions within the Council indicate that there is some support for an earlier introduction of a requirement for calorie content on labels of all alcoholic beverages. The United Kingdom strongly supports this requirement and

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<sup>14</sup> Office for National Statistics (2009) *Drinking: adults' behaviour and knowledge in 2008*. See <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=6990>

<sup>15</sup> Moyer, A., Finney, J., Swearingen, C. and Vergun, P. (2002) Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment -seeking and non-treatment seeking populations, *Addiction*, 97, 279-292.

<sup>16</sup> Moyer, A. et al. (2002) 'Brief interventions for alcohol problems', *Addiction* 97(3): 279-292.

has argued for earlier introduction. Provided that support can be achieved within the Council for a common position on nutrition information, then the earliest that such a requirement could come into force would be from 2011.

## Recent research into the implementation of the alcohol labelling voluntary agreement

32. The Government's alcohol strategy, *Safe. Sensible. Social. – the next steps in the National Alcohol Strategy* (June 2007)<sup>17</sup>, included a commitment by Government to monitor the extent to which the elements of the voluntary labelling agreement (as set out in 10 above), along with the pregnancy message, have been implemented; and to consult on legislative options should insufficient progress have been made.
33. To meet this commitment the Department of Health commissioned an independent monitoring survey from Campden & Chorleywood Food Research Association (CCFRA) to establish a baseline for assessing the breadth and depth of implementation of the voluntary agreement across the UK that took place in March 2008.
34. The full research findings from CCFRA's stage 1 survey were published in July 2008, *Monitoring Implementation of Alcohol Labelling regime (including advice to women on alcohol and pregnancy)*. The report is available on the Department of Health's website at: [http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH\\_086412](http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_086412)
35. From this survey to establish a baseline, it is perhaps not surprising that CCFRA concluded that lower-risk drinking information on labels of alcoholic drinks was only being used to a limited extent and that there was wide variety in the elements included on the labels and how they were portrayed.
36. *Safe.Sensible.Social – Consultation on further action* was launched by the Department of Health on 22 July 2008, ended on 14 October 2008 and asked the question:

*If there continues to be slow progress in implementing a voluntary labelling scheme, should the Government take the next steps to make it a legal requirement to include health and unit information on all bottles and cans?*

37. Most respondents to the consultation strongly supported the idea of introducing a regulatory requirement on labelling, if the voluntary agreement is not implemented as expected.
38. The Department of Health commissioned a second independent monitoring survey from Campden BRI (formerly CCFRA) earlier this year to assess the current breadth and depth of implementation of the voluntary agreement across the UK and progress since the first monitoring survey.
39. Campden BRI have concluded that the main conclusion of the stage 1 report that lower-risk drinking information on labels of alcohol products was only being used to a limited extent and that there was wide variety in the elements included on the labels and how they were portrayed remained valid. Campden BRI's full stage 2 monitoring report was published on 15 February 2010 and can be found at [http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH\\_112472](http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_112472)

<sup>17</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH\\_075218](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_075218)

## Legal powers to make unit and health information mandatory on alcoholic drinks labels

40. Powers already exist to regulate alcoholic drinks labelling.
41. The principal power to make regulations that require warnings or advice on labels of alcoholic drinks is in Section 16 of the Food Safety Act 1990. The power is exercised by the Secretary of State – in practice the Secretary of State for Health having had regard to relevant advice given by the Food Standards Agency.
42. Section 16(1)(e) provides that the Secretary of State may by regulations impose requirements or prohibitions as to, or otherwise regulate, the labelling, marking, presenting or advertising of food, and the descriptions that may be applied to food.

## Policy options considered in this impact assessment

43. The policy options are as follows:
  - i) (Option 1) Continue with current voluntary agreement as set out in 2007 MoU
  - ii) (Option 2) A renewed and strengthened agreement with industry to improve coverage and consistency of unit and health information on labels. To include specific commitments by individual major producers and retailers with specific agreed timescales.
  - iii) (Option 3) A mandatory requirement through regulations made under the Food Safety Act 1990.

## Benefits and costs of Option 1

### Continue with current voluntary agreement as set out in 2007 MoU

44. Given the progress so far of industry in complying with the voluntary labelling agreement and the opposition of some major producers, there is no clear, early prospect that the majority of products on the market will carry all five elements and it seems unlikely that compliance would progress much beyond 35%-40% coverage in the short to medium term. Unless there is a credible expression of determination by all alcohol producers and 'own label' retailers to implement a renewed voluntary agreement, there must be doubt on how far Option 1 would contribute to the Government's policy of informing and supporting people to make healthier and more responsible choices in the near future.
45. As described in the findings of the second stage monitoring, information on labels 'in the pipeline' suggests that 19% will be 'acceptable' by mid-2010. Diageo's decision to support the voluntary agreement would raise this by about 9%. Other producers and supermarkets currently partly compliant may become fully compliant by the end of 2010 or later, which should raise the 'acceptable' level towards 35%-40% by the end of 2011 or early 2012. However, without some further commitment, government has no assurance that adequate standards of clarity and legibility will be delivered – this has been a problem for a substantial minority of labels.
46. Using the estimates for 100% coverage, as outlined under option 3, and in the technical appendices (Appendix 2 and associated tables), we would expect additional costs and benefits to be at a maximum of around 21% (using the current 19% compliance as a starting point) of those detailed there (paragraphs 53-55, below), with similarly reduced net benefits(as set out for option 3 in paragraphs 56-58).

## Benefits and costs of Option 2

**A renewed and strengthened agreement with the alcohol industry to improve the coverage and consistency of unit and health information on labels. To include specific commitments by individual major producers and retailers with specific timescales.**

47. The UK Government has undertaken an assessment of the potential for market coverage if around 40 major companies complied. It is estimated that nearly 60% off-trade market coverage could be achieved if the five major beer producers, seven major spirits producers, five major wine producers, and three cider and perry producers not implementing the 2007 agreement in full at April 2009, when samples were taken for monitoring by Campden BRI, would be willing to change their stance. The UK Government believes this is a realistic assessment of potential delivery in the near term (taken to be 2012). At February 2010, of these, one beer producer, three spirits producers, one wine producer, and one cider producer have all indicated their intention to support the 2007 agreement.
48. Using the estimates for 100% coverage, as outlined under option 3, and in the technical appendices (Appendix 2 and associated tables), we would expect costs and benefits to be at a maximum of around 60% of those detailed there (paragraphs 53-55, below), with similarly reduced net benefits(as set out for option 3 in paragraphs 56-58).
49. It is not thought that this policy option would result in a significant administrative burden to business, as the main change is staff becoming familiar with the new guidance/regulations. While those producing labels would need to be aware of the guidelines, recurrent costs would not necessarily be incurred. This is in line with the findings of Impact Assessments conducted by the Food Standards Agency that looking at food labelling in general, which includes labelling of alcoholic drinks<sup>18</sup>.

## Benefits and costs of Option 3

**A mandatory requirement through regulations made under the Food Safety Act 1990**

### Beneficial links to other policy areas

50. A legal requirement to include unit and health information on labels may help to increase the effectiveness or practicality of other potential policies. For example, government health marketing campaigns, or health messaging at point of display, could highlight the availability of unit and health information on alcohol labels. Such interventions would reinforce each another.
51. For example, in December 2002, the New Zealand government introduced compulsory standard drinks information on alcoholic beverage labels. In response to this, the Alcohol Advisory Council of New Zealand (ALAC) and a number of partners from the hospitality, retail and liquor industries agreed to work together to deliver programmes to educate New Zealanders on what a standard drink is. The campaign combined mass-media initiatives such as TV and press advertising advising people to look at the label to find out how many standard drinks there are in the container. Importantly though, ALAC felt that the overall community and media campaign were the key to changing behaviour, with the labels themselves acting as just one component that helped to reinforce the message.

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<sup>18</sup> See <http://www.food.gov.uk/consultations/ukwideconsults/2008/infoprovision>

## Benefits of option 3

52. As noted above, the benefits of option 3 would take the form of life-years saved and reduced external harm. These benefits would be the result of reduced population alcohol consumption; the Technical Appendices set out the estimated links between population alcohol consumption and these harms. Saved life-years are currently monetised by the Department of Health at £50,000 each.
53. It has not been possible to identify the marginal reduction in consumption that would result from unit and health labelling. However, given current imperfect knowledge of alcohol units and lower-risk guidelines, and evidence on the effectiveness of brief interventions in primary care (see earlier), it is likely that some consumers at least would reduce consumption.
54. As an illustration, consumption reduction scenarios of 0.02%, 0.1% and 1% would result in annual external harm reductions, including crime and employment effects, and saved monetised life-years (combined) of £9.73 million, £49.0 million and £492 million, once the consumption reduction has been sustained over 10 years. These results are derived from the Technical Appendix, which sets out the reduction in external harm and the number of discounted life-years saved taken from the Sheffield Alcohol Policy Model<sup>19</sup>.
55. The pregnancy advice may also contribute to a reduced incidence of foetal alcohol spectrum disorder (FASD), which will bring with it an economic benefit.
  - a) In England, data is available on foetal alcohol syndrome (FAS), but not the full spectrum of FASD. Hospital episode statistics data state that there were 128 cases of FAS in 2002/03.<sup>20</sup>
  - b) Research by the Foetal Alcohol Spectrum Disorders Centre for Excellence (ultimately part of the US Department for Health and Human Services) discusses the lifetime cost of each case of FASD.<sup>21</sup> The cost per case estimates cited in the article imply a lifetime cost in the hundreds of thousands (if not millions) of dollars, though estimates of course vary depending on the severity of the case, the structure of the healthcare system and so on.

## Costs

### Costs of option 3

56. Cost of altering labels:
  - a) In a legal requirement to implement unit and health labelling, a cost is incurred for the redesign of labels and the reconfiguration of printing machines. Because this cost will be incurred for each stock keeping unit (SKU) that requires a label change, the total cost must equal the number of SKUs sold in England multiplied by a cost per SKU.

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<sup>19</sup> See Appendix 3 for a more detailed discussion. The full report can be found at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_091364.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_091364.pdf)

<sup>20</sup> British Medical Association (2007) *Fetal Alcohol Spectrum Disorders – a guide for healthcare professionals*. See [http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFFetalalcohol/\\$FILE/FetalAlcoholSpectrumDisorders.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFFetalalcohol/$FILE/FetalAlcoholSpectrumDisorders.pdf)

<sup>21</sup> See <http://www.fasdcenter.samhsa.gov/publications/cost.cfm>

- b) Previous regulatory impact assessments performed by the Food Standards Agency have used a cost of £1,000 per SKU that requires a labelling change. A study by the US Food and Drug Administration (FDA) on labelling of Trans Fatty Acids (TFAs) found an average lower cost of US\$1,100 and an average higher cost of US\$2,600 per SKU affected, which is compatible with a figure of £1,000 per SKU. This impact assessment therefore proposes a cost of £1,000 per SKU.
- c) It is assumed that the marginal cost of printing each label is unaffected by the regulation. It is also assumed that the policy would only apply to newly printed labels; products that have already been manufactured and labelled would not need to be altered due to a two years transitional period for implementation.
- d) The total one-off additional cost of altering labels is not likely to be significant for most producers<sup>22</sup>. We would expect that most labels that comply fully with the voluntary labelling agreement, which has been in place for over 2 years, should not need to be changed significantly. Additionally, labels are often routinely changed to accommodate promotions or design changes, especially for high-sales SKUs. The unit and health labelling changes can be incorporated into label redesigns that would have occurred anyway, thus reducing the cost. A lead-in time of two years for the proposed regulations would therefore have the potential to minimise this one-off cost. A lower end to the range of total one-off costs, possible if the labels of all SKUs would normally be redesigned within a three year period, would be a figure approaching zero. This is consistent with methods used previous impact assessments performed by the Food Standards Agency<sup>23</sup>. If relabelling cycles are normally longer than two years, for example for small producers, we would welcome evidence and examples of this. Similarly, we would wish to know of any continuing costs, if there are examples of producers who do not currently operate separate labelling for the UK market.

57. Costs to alcohol producers and retailers due to reduced sales:

- a) The Technical Appendix sets out the estimated impact of reductions in consumption based upon a review and model produced by the University of Sheffield School of Health and Related Research. The results of the model inform this impact assessment. A more detailed description of the model and its results can be found in Appendix 3.
- b) Nonetheless, considering possible consumption reductions of 0.02%, 0.1% and 1% and using the results of the Technical Appendix, it can be shown that these scenarios would result in reduced annual alcohol producer and retailer revenue of £5.76 million, £21.2 million and £194 million respectively.

58. Costs in terms of reduced duty revenue:

- (a) The same issue applies to the estimated reduction in duty revenue – again, there is likely to be an effect but this cannot be precisely identified. Nonetheless, using the results and methods presented in the Technical Appendix, it can be shown that consumption reduction scenarios of 0.02%, 0.1% and 1% would result in reduced annual duty revenues of £3.36 million, £15.8 million and £156 million respectively.

## Net benefits

<sup>22</sup> See <http://www.food.gov.uk/consultations/ukwideconsults/2008/infoprovision>

<sup>23</sup> See <http://www.food.gov.uk/consultations/ukwideconsults/2008/infoprovision>

59. As explained, the net benefit of option 3 is not known due to insufficient data on the impact of labelling changes on consumption. However, it is clear from the Technical Appendices that there are substantial net benefits from reduced alcohol consumption; for a 1% reduction in consumption, the reduction in external harms, including life years saved of £3.21 billion discounted over 10 years offset lost tax revenue of £648 million and lost alcohol producer and retailer profit of £1.62 billion discounted over 10 years.
60. For any labelling change to be cost-beneficial, the net benefits described above would also need to offset the one-off cost of altering alcohol labels for those labels that need to be altered.
61. Only a very small effect on consumption is needed to make the policy cost-beneficial. This is partly driven by the fact that the consumption benefits would be annually recurrent, whereas the labelling costs are a one-off. Such a small effect would likely be achieved, especially given the evidence set out earlier in relation to the effectiveness of brief advice. Small effects may also be hard to detect in statistical analysis.

## Note: administrative burdens

62. It is not thought that the policy option would result in a significant administrative burden to business as the main change is staff becoming familiar with the new guidance/regulations. While those producing labels would need to be aware of the regulations, recurrent costs would not necessarily be incurred. This is in line with the findings of Impact Assessments conducted by the Food Standards Agency that looking at food labelling in general, which includes labelling of alcoholic drinks<sup>24</sup>.

## Note: enforcement

63. Alcohol labelling is currently enforced by trading standards departments, on behalf of the relevant local authority. Amongst other requirements, trading standards already monitor whether labels carry information on the ABV%, and the quantity of liquid in the container. We envisage that trading standards departments would also enforce any new alcohol labelling rules.
64. It is not envisaged that assessing compliance with a new labelling scheme, including information on alcohol units and health information, would entail additional work or costs. Local Authorities are already responsible for enforcement of labelling legislation in the UK, including that for alcoholic drinks. However, small one-off costs might be incurred from training and guidance, while inspection would take place alongside current enforcement practices and should not result in substantive further costs.
65. Previous impact assessments by the Food Standards Agency (FSA) have noted that Local Authorities Coordinators of Regulatory Services (LACORS) consider that enforcement costs could indeed reduce if a single labelling approach were to be used as enforcement officers would only need to be familiar with a single set of criteria.
66. Currently, as unit and health labelling is voluntary, producers of alcoholic drinks have to ensure that the labels are compliant. Under Option 3, trading standards officers will be tasked with enforcement of compliance. This shift of responsibility from producers to trading standards will therefore reduce costs for those producers who currently print labels voluntarily.

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<sup>24</sup> See <http://www.food.gov.uk/consultations/ukwideconsults/2008/infoprovision>

## Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

**Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.**

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
<b>Competition Assessment</b>	<b>No</b>	<b>Yes</b>
<b>Small Firms Impact Test</b>	<b>No</b>	<b>Yes</b>
<b>Legal Aid</b>	<b>No</b>	<b>No</b>
<b>Sustainable Development</b>	<b>No</b>	<b>No</b>
<b>Carbon Assessment</b>	<b>No</b>	<b>No</b>
<b>Other Environment</b>	<b>No</b>	<b>No</b>
<b>Health Impact Assessment</b>	<b>No</b>	<b>Yes</b>
<b>Race Equality</b>	<b>No</b>	<b>Yes</b>
<b>Disability Equality</b>	<b>No</b>	<b>Yes</b>
<b>Gender Equality</b>	<b>No</b>	<b>Yes</b>
<b>Human Rights</b>	<b>No</b>	<b>Yes</b>
<b>Rural Proofing</b>	<b>No</b>	<b>No</b>

### Appendix 1: Specific impact tests

#### Competition assessment

1. All Policy options would not directly limit the number or range of suppliers.
2. All Policy options may indirectly limit the number, or range, of suppliers. Because the regulations would apply to all alcohol producers, the proposal does not significantly raise the cost of some existing producers relative to others. However, the proposal may marginally increase the cost of entering the market for alcoholic drink, to the extent that the correct labelling would need to be researched and correctly implemented.
3. All Policy options are unlikely to have an impact on competition.
4. All Policy options would not limit the incentive for suppliers to compete vigorously.

#### Small firms impact test

5. A legal requirement for labelling has implications for domestic and overseas production of alcoholic beverages intended for sale in the UK. The proportion of SMEs involved in alcohol production varies between sectors, but is high overall.
6. Achieving consistent and widespread improvements in alcohol labelling will depend upon uptake by the large number of small firms involved in alcohol production. Enforcement of food labelling is conducted in the UK by local authorities, through their trading standards or environmental health units and is actioned against the producer/manufacturer rather than the seller. Having a different implementation date for smaller businesses would create a number of enforcement issues because in many cases the enforcement officer on the ground will have no way of knowing, from the label, the size of the company that produced the product and finding out this information before being able to take a decision about whether action is necessary will be time consuming and impractical. For these reasons, government does not propose exempting small firms from the scheme as a whole.
7. Conversely, the same firms will incur the costs of complying with new legal requirement for alcohol labelling, and economies of scale suggest that these costs might be more burdensome to small firms than to larger operations. During development of the voluntary agreement between government and the alcohol industry, the government discussed the implications for industry, including small firms, with bodies such as the British Beer and Pub Association and the British Retail Consortium (BRC) who indicated that some flexibility might be warranted to avoid imposing disproportionate burdens.
8. During the *Safe Sensible Social consultation on further action* (July – October 2008), the views of small firms and representative trades bodies was sought on the principle of whether government should introduce a legal requirement for alcohol labelling if the voluntary agreement was not implemented as expected. The responses received from industry suggested that they were concerned that the prospect of a legislative requirement would discourage producers from taking up

the voluntary scheme and that there should be sufficient transitional periods to allow for non-compliant products and stocks of labels to be sold.

## Health

9. The key health benefits of all policy options would arise from reductions in alcohol consumption among groups drinking at increasing-risk or higher-risk levels.
10. Against the standard checks, we have assessed that alcohol labelling as described in all policy options is likely to have the following impacts:
  - a) No direct impact on individual financial security; although industry costs could be passed on to members of the workforce.
  - b) No impact on the safety services, workplaces and dwellings. The policy is expected to contribute to the consumption of alcohol at lower-risk levels.
  - c) No impact on environmental factors. Allowing sufficient implementation times will prevent wastage that might otherwise occur with a requirement to change labels and packaging.
  - d) No impact on access to transport, services or facilities.
  - e) No impact on housing conditions.
  - f) No impact on opportunities for education and training, although the policy is intended to improve public understanding of alcohol and health.
  - g) No direct impact on access to healthy, affordable food, but the policy will improve public knowledge of alcohol and health.
  - h) The policy is intended to reduce alcohol consumption among groups drinking at increasing-risk or higher-risk levels.
  - i) Alcoholic drinks provide on average 7% of total energy intake, which is comparable to that provided by potatoes and savoury snacks (9%), therefore reductions in consumption may also contribute to reducing obesity levels if the individual does not increase caloric intake elsewhere.
  - j) No impact on stress at home or work.
  - k) No impact on community cohesion and social inclusion.
  - l) No impact on discrimination; equality impacts are set out separately.
11. Our assessment is that the policy will produce net benefits arising from improved public understanding of alcohol and health, and reduced levels of alcohol consumption among groups drinking at increasing-risk and higher-risk levels.
12. The Technical Appendices describe the effects upon external harms of reductions in consumption.
13. It is desirable that, where appropriate, groups drinking alcohol at increasing-risk or

higher-risk levels should consult their GP.

14. There are not likely to be public or community concerns about the potential health impacts of this policy change.

## Equality impact assessment

15. A limited Equality Impact Assessment was produced prior to publication of *Safe. Sensible. Social: next steps in the national alcohol strategy*. This may be found at: [www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse](http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse)
16. This recommended that any consultation on alcohol promotion should draw its consultees from a range of target groups, to identify any risks of adverse impacts as well as potential for narrowing inequality and good community relations. The consultation process will implement this recommendation.
17. Subsequent to consultation, as government develops the detailed content of future policy on alcohol promotion, we will continue to consult with target groups to ensure that the policy is sensitive to the potential impacts upon different groups and will update the Equality Impact Assessment to reflect our findings.

## Age

18. The proposed policy does not differentiate between age groups and is a population-wide policy. Labels should be equally meaningful to groups of all ages.
19. However, the policy is likely to yield valuable benefits for young people:
  - a) The policy may help parents to be better informed, influence young people's drinking habits at an earlier stage and so alter their drinking habits as they move into adulthood; preventing the longer-term harm that is associated with regularly exceeding lower-risk guidelines.
  - b) Drinking more than twice the number of recommended units on a single occasion, a proxy for binge drinking, is more common among young people. For this age group, levels now stand at 32% of men and 24% of women aged 16-24, higher than any other age group<sup>25</sup>.

## Race

20. The policy is a population-wide policy that does not differentiate on grounds of race or ethnicity.
21. We have considered whether labelling is likely to pose significant difficulties for those whose first language is not English. The current voluntary scheme does not pose significant difficulties, since the labels are, largely, pictorial or numerical and self-explanatory.
22. When developing the detailed content of alcohol labels, we have carefully consider whether format and content would present significant difficulties to any group.

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<sup>25</sup> Office for National Statistics (2009) *Smoking and Drinking Among Adults*, General Household Survey, 2007.

23. There is good reason to expect that the benefits of a legally required labelling scheme would affect certain populations more. For example:
- a) According to the 2005 Health Survey for England, Irish men and women were more likely than any other ethnic group to have drunk more than four or three units respectively on the heaviest drinking day in the last week.
  - b) Over half of Irish men (56%) and a third of women (36%) drank in excess of these levels. All other ethnic minority groups were much less likely than the general population to be drinking above these levels.
  - c) After Irish men and women, Black Caribbean men and women were most likely to drink above the guidelines. Some 28% of Black Caribbean men and 18% of Black Caribbean women did so.
  - d) Less than 5% of men or women from the Pakistani and Bangladeshi groups drank more than these amounts. Very few Black African and Indian women exceeded the guidelines (7% and 8% respectively) but 17% and 22% of Black African and Indian men drank above this level.<sup>26</sup>

## Gender

24. The policy recognises the differences in health advice for men and women. The required labelling would carry specific advice aimed at men, specific advice aimed at women, and specific advice aimed at women who are pregnant or trying to conceive.
25. This advice is based on the Government's lower-risk drinking guidelines, which advise that adult women should not regularly drink more than 2–3 units of alcohol a day, and that adult men should not regularly drink more than 3–4 units of alcohol a day. Women who are pregnant or trying to conceive are advised to avoid alcohol altogether. If they do choose to drink, to protect the baby they should not drink more than 1–2 units of alcohol once or twice a week and should not get drunk.
26. The sensible drinking message is based on scientific evidence from studies in the population as a whole in the UK and others about long-term health harm for broadly average, healthy adults. The limits are lower for women because their bodies are less effective than men's at breaking down alcohol, putting them at higher risk of harm.
27. Legally required labelling would not otherwise differentiate on the grounds of gender. Health benefits are likely to accrue to both men and women as they become increasingly aware of how much alcohol they are consuming and lower their consumption to within lower-risk levels.

## Disability, transgender, religion or belief and sexual orientation

28. The policy will not impact differently on people on grounds of their disability, transgender, religion or belief and sexual orientation. The policy is a population-

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<sup>26</sup> HSE (1999) *The Health of Minority Ethnic Groups*, DH.

wide policy that will affect all people who buy or consume alcohol equally and does not differentiate on the grounds of disability, transgender, religion or belief and sexual orientation.

## Discrimination, harassment and community relations

29. The policy will not influence unjustifiable discrimination. The policy is purely in relation to labelling alcohol products and therefore should have no causal association with discrimination.
30. The policy will not influence harassment. The policy is purely in relation to alcohol labelling and should have no causal association with harassment.
31. The policy will not influence relations between people of different groups. The policy is purely in relation to alcohol labelling and should have no causal association with community relations.

## Human Rights

32. The policy will not discriminate or impact unduly on individuals' or companies' human rights. We do not expect there to be any significant negative human rights impacts. On the contrary, the policy will help ensure the provision of important information to which individuals should have a right as consumers, making it easier for them to exercise healthier choices. The policy is intended to be part of a population-wide comprehensive strategy to tackle alcohol harms, including alcohol related harms to health, alcohol-related crime, and harms to children and young people. This policy should in particular help individuals to play their part in protecting their own health by making informed choices about what, how much and how often they drink. The way in which information is provided on labels will be subject to the existing legislation with regard to legibility and intelligibility, as currently set out in the Food Labelling Regulations 1996, as amended. The policy seeks to ensure that alcohol producers fulfil their responsibility to provide essential information for consumers.

## Appendix 2: Technical Appendix

1. This appendix provides details to the methods used in the cost-benefit analysis in this Impact Assessment. This is based on phase 2 of the review into the pricing and promotion of alcohol by the School of Health and Related Research (ScHARR)<sup>27</sup> at Sheffield University. The phase 2 modelling considers the benefits and some of the costs for a number of interventions, including the range of consumption decreases presented in this Impact Assessment.
2. The phase 2 report contains the full technical details of the modelling, but a short summary is provided below. The model is divided into two parts. The first part considers the effect of an intervention on the distribution of alcohol consumption; the second part considers the effect of these consumption changes on a wide variety of harms, such as mortality, morbidity, NHS costs, crime costs and unemployment/absence costs.

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<sup>27</sup> The full report can be found at

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_091364.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_091364.pdf)

*The first part of the model: identifying the impact of the policy on consumption*

3. The model begins with the alcohol consumption of the cohort for the 2006 General Household Survey, which covers 9,731 households (22,924 individual interviews) in Great Britain. The aim of the first part of the model is to simulate a 'new General Household Survey' (i.e. a new distribution of consumption) for both baseline and intervention pricing and promotion policies.
  - a. In the context of changes in alcohol consumption, four types of drink are considered (beer, wine, spirits and RTDs) at both low and high prices and for both the on- and off-trades; this yields sixteen categories in total.
  - b. Running the model for both thus yields the baseline and intervention consumption scenarios. As well as feeding into the second part of the model to calculate the change in harms, the two consumption scenarios can be compared in order to work out the change in sales revenue and tax receipts.

*The second part of the model: identifying the effect of a consumption change on alcohol harms*

4. The second part of the model aims to calculate new levels of alcohol harm for both the baseline and intervention consumption distributions. These can then be compared to estimate the changes in harm that are brought about by the intervention. For a given consumption distribution, the total harm is calculated as follows.
  - a. Firstly, risk functions are set for each type of harm, which relate the risk of harm to the amount of alcohol that an individual consumes. These risk functions are used to assess the overall risk associated with the consumption distribution in question for a number of different population groups (various combinations of age group, gender and consumption level). New harm totals are then calculated and aggregated based on the new risks.
  - b. The reduction of acute harms is modelled to be immediate, as these are related to the amount of alcohol consumed at a single point in time. (For example, if an individual has consumed less alcohol in an evening, they will be less intoxicated and will therefore be immediately less susceptible to some acute harms). By contrast, reduction of chronic health harms is modelled to occur gradually (based on medical evidence for a number of specific conditions), with 10% of the full chronic harm reduction feeding through in each year after a consumption change.
  - c. The model's main results tables state policy benefits for the first year after the reduction (T=1), the tenth year after the reduction (T=10), and for the total across these 10 years (discounted appropriately). The difference in benefits between T=1 and T=10 is driven by the gradual pass-through of chronic harm reductions, as explained above.
  - d. All harm reductions are costed and discounted appropriately, arriving at an overall monetary benefit figure. Specifically, Quality Adjusted Life-Years (QALYs) saved are valued at £81,000 if due to reduced crime (following the appropriate Home Office appraisal value for victims of crime); all other QALYs saved are valued at the Department of Health appraisal value of £50,000. Future life-years saved are discounted at 1.5%, which is derived from the standard Green Book rate of 3.5%. (Part of the 3.5% figure is comprised of an assumed long-term real economic growth rate of 2%; because the value per life-year saved can also be expected to

grow in line with this growth rate, the effects cancel out (regardless of the growth rate's actual value), leaving a 1.5% discount rate). The unadjusted 3.5% Green Book discount rate is used for all other benefits.

## Cost-Benefit Analysis

5. This Impact Assessment draws upon the findings of the Sheffield Alcohol Policy Model by taking the results from consumption reductions of 0.02%, 0.1% and 1%. The results are presented in tables A3.1, A3.2 and A3.3 below. These tables correct for under-reporting in the General Household Survey, on which the model is based.

### *Differences between published SchARR report and analysis in this Impact Assessment*

6. The following paragraphs detail how the use of the model with regards to this Impact Assessment differs from the published report. The results from the model are therefore adjusted accordingly. The two areas of change are:

- Improved estimates for duty and retail sales losses
- Correction for under-reporting inherent in the General Household Survey, the basis of the model.

### *Improved duty estimates*

7. The reported duty and retail sales losses are slightly different from the published SchARR report; the retail sales figures use the Budget 2007 duty rates<sup>28</sup> (for complete consistency with the 2007 price data used by SchARR) whereas the duty loss figures use the latest duty rates (as announced in the Budget 2009, including the subsequent adjustment to spirits duty)<sup>29</sup>. These changes are both conservative (in that they increase the estimated costs) as well as being most theoretically valid. The Budget 2008 duty rates<sup>30</sup> are also used at one point, again for consistency reasons. VAT losses are not included in the results tables, as it is later argued that these will be offset by increased VAT receipts elsewhere.
8. The model requires duty rates to be specified in terms of the duty per unit of alcohol for beer, wine, spirits and RTDs. Because beer, spirits and RTDs are effectively taxed per litre of pure alcohol equivalent, the duty rates can be directly converted into a rate per unit<sup>31</sup> without making any assumptions. Wine duty is instead defined per hectolitre of product, although the duty rate is also determined by ABV bands, whether the wine is still or sparkling and so on. The duty on still wine with an ABV between 5.5% and 15% is used in the model, as the majority of wine falls into this category. An average wine ABV of 12.5% is used (which is consistent with the ABV rates used in the SchARR modelling) to calculate the wine duty rate per alcohol unit<sup>32</sup>. The following table presents the calculated duty rates that are used in the cost-benefit analysis.

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<sup>28</sup> See <http://www.hmrc.gov.uk/budget2007/bn71.htm>

<sup>29</sup> See <http://www.hmrc.gov.uk/budget2009/bn86.htm>

<sup>30</sup> See <http://www.hmrc.gov.uk/budget2008/bn91.pdf>

<sup>31</sup> One unit of alcohol is defined as 10ml of pure alcohol equivalent. There are therefore 100 units in a litre of pure alcohol equivalent, so dividing the stated duty rate (which is effectively defined per litre of pure alcohol equivalent) by 100 yields the duty on a single alcohol unit.

<sup>32</sup> One hectolitre of 12.5% ABV contains 12.5 litres of pure alcohol equivalent. Since one alcohol unit is defined as 10ml of pure alcohol equivalent, this is equivalent to 1250 units. Dividing the stated duty rate (which is defined per hectolitre of product) by 1250 therefore yields the duty on a single alcohol unit.

	Budget 2007 (£ duty per alcohol unit)	Budget 2008 (£ duty per alcohol unit)	Budget 2009 (£ duty per alcohol unit)
Beer	0.137	0.150	0.165
Wine	0.142	0.155	0.171
Spirits	0.196	0.214	0.226
RTD	0.196	0.214	0.226

Source: Department of Health calculations based on HMRC duty rates

9. The adjustments relating to the under-reporting inherent in the General Household Survey affect both the benefit and cost calculations. They are approached here separately.

## Benefits

10. The benefits analysis begins with the results tables set out later in this Appendix (tables A3.1, A3.2 and A3.3). The SchARR analysis is based on the General Household Survey, which provides detailed demographic and other distributional information on consumption. However, the GHS also under-reports consumption because of the self-reported nature of its data; reliable aggregate data (such as HMRC duty clearances or Nielsen sales estimates) implies notably higher alcohol consumption per head. The downward bias from the GHS under-reporting will feed through into the absolute (though not the percentage) consumption reductions, and would therefore feed into the benefits.
11. Only some of the SchARR benefit categories need adjustment for under-reporting; others are not affected, and no adjustment to these is required. Specifically, those conditions that will suffer from under-reporting are:
- Partly attributable chronic NHS cost reductions
  - Partly attributable chronic QALY benefits
  - Unemployment costs

The remaining categories do not need adjustment for under-reporting:

- Wholly attributable chronic NHS cost reductions
- Wholly attributable chronic QALY benefits
- Acute NHS cost reductions
- Crime costs
- Absenteeism costs.

The reasoning behind this split is as follows. The categories that need adjustment are all based on existing relative risk functions from the literature; the under-reported consumption baseline has therefore fed through into underestimated (absolute) consumption falls, which in turn feed into underestimated reductions in risk and therefore underestimated benefits. For all other conditions, adjustment would overstate the benefits.

12. This Impact Assessment therefore corrects for the under-reporting. The ScHARR baseline implies an annual consumption figure of 242,321,860 litres of pure alcohol equivalent in England. By contrast, Nielsen data (for England and Wales, 2007; compiled for the Scottish Government, 2008) implies annual consumption of 439,642,000 litres of pure alcohol equivalent. ONS mid-2006 population data implies that the latter figure should be scaled by a factor of 0.945, yielding an England-only estimate of 415,373,187 litres, which is a factor of 1.7141 larger than the ScHARR baseline estimate. It is acknowledged that there is a slight mismatch between the year of the GHS data (2006) and the Nielsen data (2007) used to calculate this factor, though this should not have a significant quantitative effect.
13. The ScHARR benefits highlighted above are therefore uprated by a factor of 1.7141. This is conservative in that HMRC duty clearances data<sup>33</sup> imply a higher total consumption than do the Nielsen data; the Nielsen data has been chosen for consistency with the scaling factor that is applied to lost sales revenue. The adjusted benefits for each scenario are set out in full in the tables below.

## Costs

### *Reduced duty revenue*

14. In the context of reduced alcohol consumption, reduced alcohol duty revenue is an economic cost in that there is not any offsetting benefit to the consumer or to the Exchequer. Consider a consumer who is planning to spend £5 on alcohol, from which they will derive a certain level of utility. If they are then better made aware of the dangers of excessive alcohol consumption, some consumers will switch part of their spending to other goods or services. Because they have switched part of their spending, they must derive more utility at the margin from these alternative goods and services than they would now derive from marginal purchases of alcohol (given their improved knowledge about the risks). The consumer has not lost any utility, but the duty revenue has been lost; this loss has not been offset by any related gain to the consumer or to the Exchequer.
15. By contrast, note that the lost VAT revenue is not an economic cost. It is likely that the alternative goods and services chosen by the consumer will be VAT-rated; the consumer's total spend on VAT-rated goods and services will therefore not change. Since VAT is equal to 17.5% (temporarily 15%) of this total spend, the amount of VAT payable will not change either. Essentially, the lost VAT from alcohol products is offset by additional VAT revenue elsewhere.
16. As with the benefit estimates, the duty cost estimates begin with the three results tables set out below; uprating for non-response is then necessary.
17. When set with the Budget 2008 duty rates given above, the ScHARR model calculates a total duty revenue baseline of £3.93 billion per annum for England alone. 2008/9 HMRC forecasts (which are also based on Budget 2008 duty rates, hence their use in the previous calculation) estimate a total revenue of £8.66 billion per annum for the whole United Kingdom. Again, the difference is driven by the fact that ScHARR is based on data that gives downwardly biased total consumption estimates, although the HMRC figure also relates to a larger population (the UK rather than England). The HMRC estimate equals £7.26 billion when scaled to England-only terms using ONS mid-2006

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<sup>33</sup> See <http://www.uktradeinfo.com/index.cfm?task=factalcohol> . UK Trade Info is an HMRC website.

population data (a scaling factor of 0.84). A factor of 1.845 therefore scales the SchARR baseline figure up to match the HMRC figure.

18. The SchARR duty loss costs are therefore scaled upwards by a factor of 1.845; the adjusted results are presented in Appendix 3.
19. Note that when calculating the net benefit figure, the above duty loss costs to the Exchequer are doubled. This technique is used in a number of new Department of Health Impact Assessments, although it was not used in the original consultation-stage Impact Assessment of the alcohol counter-advertising proposal. The rationale is that the NHS budget is limited to around £20,000 to £30,000 per life year at the margin, whereas a review of the relevant literature suggests that individuals place a higher value of £50,000 on each life-year (at average incomes). Each £1 of NHS spending is therefore able to buy £2 of monetised benefit at the margin; each £1 of NHS spending lost from reduced Exchequer tax receipts is equal to a £2 loss in monetised benefit.

#### *Cost to the alcohol and related industries*

20. The results in this appendix display the loss in alcohol revenue at retail (after duty and VAT) associated with the central consumption reduction, alongside the reduction for the upper and lower scenarios. These also have been scaled so that the SchARR baseline figures match accepted aggregate market data.
21. To calculate the loss in alcohol revenue at retail, the SchARR model is set up with Budget 2007 duty rates. This ensures that the calculations are consistent with the 2007 retail prices used in the model. Specifically, the model identifies total sales of £17.36 billion at baseline. Nielsen data (for England and Wales, 2007; compiled for the Scottish Government, 2008) identifies total sales of £30.11 billion. Scaling the Nielsen figures to an England-only basis (using ONS mid-2006 population data) yields an estimate of £28.45 billion; the scaling factor used is 0.945. Ultimately, the Nielsen figure is estimated to be a factor of 1.64 greater than the SchARR baseline when both are expressed in England-only terms.
22. The SchARR results are adjusted by a factor of 1.64, and are presented later in this Appendix
23. The previous Impact Assessment noted, “to the extent that there is a supernormal component to the profit that could not be earned elsewhere, the profit impact (before tax) is indicative of the economic cost associated with the reduction in sales”. The ultimate target is to identify the pre-tax<sup>34</sup> loss associated with reduced capital in the alcohol industry (including on-trade and off-trade retail, and the supply chain) when accompanied by increased capital elsewhere, to the extent that the capital in various parts of the industry has a higher return than average. This Impact Assessment uses additional data to arrive at a more accurate approximation of this cost. A recent report by Deloitte (2008)<sup>35</sup> presents data on various financial parameters for the world’s top 250 consumer products companies<sup>36</sup>; specifically, it finds an average net margin of

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<sup>34</sup> If capital has a higher return in the alcohol industry, the lost tax forms part of the loss from reallocating that capital elsewhere.

<sup>35</sup> Deloitte (2008), ‘Global powers of the consumer products industry’. Download at <http://www.deloitte.com/dtt/article/0,1002,cid%3D184046,00.html?theme=FB1>

<sup>36</sup> Alcohol will compete with such products for a share of consumer expenditure.

6.1%. By contrast, financial data from Morningstar<sup>37</sup> suggests an alcohol industry average net margin of 13.42%, i.e. an excess of 7.32 percentage points. It is also necessary to capture the excess for alcohol retail and the alcohol supply chain, which will likely be lower due to their different market structure. The excess is therefore scaled up by 50% to approximate for this, yielding an excess of 11 percentage points. Lastly, it is noted that the net margin figures exclude tax; this should be included, as the revenue forms part of the economic cost. As with lost alcohol duty revenue, the economic cost to the government needs to be taken into account. Given that an extra £1 of NHS spending lost is equal to a £2 loss of monetised benefit at the margin, the 11-percentage-point estimate is scaled up by the UK rate of corporation tax (28%) and multiplied by 2 to account for this. This yields a total approximation factor of 17.16 percentage points.

24. A consequence of the reduction in revenue and profit will be reduced employment in the alcohol and related industries. Increased spending on other goods and services will create additional employment and profits in those areas, including in related industries. Aside from the cost set out above, the long run effect is a reallocation of economic resources rather than a reduction in economic capacity. It should be noted that 'Employment' harm reductions presented in tables A3.1, A3.2 and A3.3 related to unemployment related to drinking and alcoholism rather than unemployment in the alcohol and related industries.

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<sup>37</sup> Morningstar is an investment research company. The following page relates to Diageo but also contains industry-wide averages, and it is these that are used in the cost-benefit analysis. (Accessed 02/12/2008)  
<http://quicktake.morningstar.com/StockNet/Diagnostics.aspx?Country=USA&Symbol=DEO>

## Result Tables

25. The following tables show the results from the Sheffield Alcohol Policy Model of the impact of reductions in consumption of 0.02%, 0.1% and 1%. These tables inform the costs and benefits in the main body of the IA.

**Table A3.1**

Sales and duty impacts:		0.02% Consumption Reduction	
			<b>England</b>
Change in sales revenue excl. duty and VAT (£)	Off-trade		-156,615
	On-trade		-5,599,162
Change in duty (£):	Off-trade		-232,559
	On-trade		-1,449,258

Harm reduction impacts:		0.02% Consumption Reduction		
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			England Total		
			T+1	T+10	10 yr Cumul
Health	Deaths	Chronic	-1	-11	-43
		Acute	-1	-1	-7
	Sick	Chronic	-14	-169	-690
		Acute	-45	-46	-376
	Admissions	Chronic	-28	-348	-1,412
		Acute	-51	-52	-430
	Costs (£)	Chronic	-78,060	-941,576	-3,847,276
		Acute	-255,507	-260,745	-2,150,338
QALYs			19	87	439
Value of 'saved' QALYs		£	957,609	4,338,486	21,925,824
Crime	Volume	Violent	-137	-137	-1,137
		Criminal damage	-244	-244	-2,033
		Other	-169	-169	-1,405
	Cost (£)	Violent	-386,134	-386,134	-3,211,325
		Criminal damage	-96,565	-96,565	-803,096
		Other	-116,345	-116,345	-967,599
QALYs	Violent	7	7	67	
	Criminal damage	1	1	13	
	Other	2	2	16	
Total Value of 'saved' QALYs			10	10	97
			848,420	848,420	7,824,281
Employment	Volume	Absenteeism	-2,770	-2,770	-23,038
		Unemployment	-97	-97	-804
	Cost	Absenteeism	-258,193	-258,193	-2,147,289
		Unemployment	-	-	-
			2,279,177	2,279,177	-18,955,014
Total of Health Crime and Employment Costs (£)			3,610,415	4,489,329	-33,294,606
Total of Health Crime and Employment Costs +QALY saved (£)			5,492,228	9,730,013	-63,512,999

Table A3.2

**Sales and duty impacts: 0.1% Consumption Reduction**

		<b>England</b>	
Change in sales revenue excl. duty and VAT (£)	Off-trade	-4,898,373	
	On-trade	-16,260,567	
Change in duty (£):	Off-trade	-4,034,150	
	On-trade	-3,869,847	

**Harm reduction impacts: 0.1% Consumption Reduction**

			<b>England Total</b>		
			<b>T+1</b>	<b>T+10</b>	<b>10 yr Cumul</b>
<b>Health</b>	<b>Deaths</b>	<b>Chronic</b>	-4	-54	-216
		<b>Acute</b>	-4	-4	-36
	<b>Sick</b>	<b>Chronic</b>	-69	-846	-3,445
		<b>Acute</b>	-224	-228	-1,882
	<b>Admissions</b>	<b>Chronic</b>	-141	-1,736	-7,051
		<b>Acute</b>	-256	-260	-2,149
	<b>Costs (£)</b>	<b>Chronic</b>	-389,377	-4,698,614	-19,196,027
		<b>Acute</b>	-1,277,265	-1,303,516	-10,749,717
<b>QALYs</b>			96	435	2,198
<b>Value of 'saved' QALYs</b>		<b>£</b>	4,775,576	21,762,355	109,914,778
<b>Crime</b>	<b>Volume</b>	<b>Violent</b>	-686	-686	-5,704
		<b>Criminal damage</b>	-1,219	-1,219	-10,138
		<b>Other</b>	-862	-862	-7,165
	<b>Cost (£)</b>	<b>Violent</b>	-1,947,664	-1,947,664	-16,197,951
		<b>Criminal damage</b>	-481,495	-481,495	-4,004,400
		<b>Other</b>	-586,311	-586,311	-4,876,113
<b>QALYs</b>	<b>Violent</b>	37	37	339	
	<b>Criminal damage</b>	7	7	66	
	<b>Other</b>	9	9	81	
<b>Total Value of 'saved' QALYs</b>			53	53	486
			4,268,296	4,268,296	39,363,016
<b>Employment</b>	<b>Volume</b>	<b>Absenteeism</b>	-13,847	-13,847	-115,158
		<b>Unemployment</b>	-491	-491	-4,082
	<b>Cost</b>	<b>Absenteeism</b>	-1,286,069	-1,286,069	-10,695,725
		<b>Unemployment</b>	-	-	-97,026,461
<b>Total of Health Crime and Employment Costs (£)</b>			<b>18,302,174</b>	<b>22,696,324</b>	<b>168,553,021</b>
<b>Total of Health Crime and Employment Costs +QALY saved (£)</b>			<b>27,704,567</b>	<b>48,991,313</b>	<b>320,093,304</b>

**Table A3.3**

**Sales and duty impacts: 1% Consumption Reduction**

		<b>England</b>	
Change in sales revenue excl. duty and VAT (£)	Off-trade	-58,243,148	
	On-trade	-136,201,382	
Change in duty (£):	Off-trade	-46,802,042	
	On-trade	-31,101,472	

**Harm reduction impacts: 1% Consumption Reduction**

		<b>England Total</b>			
		<b>T+1</b>	<b>T+10</b>	<b>10 yr Cumul</b>	
<b>Health</b>	<b>Deaths</b>	<b>Chronic</b>	-43	-551	-2,209
		<b>Acute</b>	-43	-44	-359
	<b>Sick</b>	<b>Chronic</b>	-694	-8,456	-34,447
		<b>Acute</b>	-2,236	-2,282	-18,818
	<b>Admissions</b>	<b>Chronic</b>	-1,411	-17,316	-70,388
		<b>Acute</b>	-2,560	-2,598	-21,488
	<b>Costs (£)</b>	<b>Chronic</b>	-3,903,965	-46,999,012	-192,147,400
		<b>Acute</b>	-12,773,310	-13,036,215	-107,503,760
	<b>QALYs</b>		957	4,392	22,143
<b>Value of 'saved' QALYs</b>		£ 47,864,659	219,624,332	1,107,145,507	
<b>Crime</b>	<b>Volume</b>	<b>Violent</b>	-6,865	-6,865	-57,096
		<b>Criminal damage</b>	-12,208	-12,208	-101,529
		<b>Other</b>	-8,569	-8,569	-71,269
	<b>Cost (£)</b>	<b>Violent</b>	-19,513,344	-19,513,344	-162,284,784
		<b>Criminal damage</b>	-4,822,158	-4,822,158	-40,103,982
		<b>Other</b>	-5,848,736	-5,848,736	-48,641,633
	<b>QALYs</b>	<b>Violent</b>	369	369	3,400
		<b>Criminal damage</b>	71	71	656
		<b>Other</b>	88	88	811
<b>Total</b>		528	528	4,867	
<b>Value of 'saved' QALYs</b>		42,744,602	42,744,602	394,198,607	
<b>Employment</b>	<b>Volume</b>	<b>Absenteeism</b>	-138,796	-138,796	-1,154,309
		<b>Unemployment</b>	-4,881	-4,881	-40,590
	<b>Cost</b>	<b>Absenteeism</b>	-12,903,046	-12,903,046	-107,309,544
		<b>Unemployment</b>	-	-	-
		116,179,685	116,179,685	-966,220,586	
<b>Total of Health Crime and Employment Costs (£)</b>		182,724,486	226,660,676	1,683,115,994	
<b>Total of Health Crime and Employment Costs +QALY saved (£)</b>		276,990,033	491,705,145	3,207,639,917	

## Quantifying the cost of alcohol harm in England

26. Cabinet Office (2003)<sup>38</sup> calculated the external cost of alcohol harm in England as £18.5bn to £20bn in 2001 prices, considering healthcare costs, lost productivity and the cost of crime. The complete results are presented below; the original paper presents the detail on the methods and data sources used.

*The annual cost of alcohol harm in England (Cabinet Office (2003), in 2001 prices).*

	First Estimate (£m)	Second Estimate (£m)
<b>Healthcare costs</b>		
Hospital inpatient & day visits		
Directly attributable to alcohol misuse	126	126
Partly attributable to alcohol misuse	344	400
Hospital outpatient visits	223	446
Accident and emergency visits	305	305
Ambulance services	205	205
Practice nurse consultations	19	19
NHS GP consultations	28	49
Laboratory tests	N/A	N/A
Dependency prescribed drugs	2	2
Other health care costs	35	35
Specialist treatment services	96	96
<b>Workplace and wider economy costs</b>		
Lost output due to absenteeism	1,214	1,786
Lost output due to reduced employment	1,726	2,154
Lost output due to reduced employment efficiency	N/A	N/A
Lost output due to premature death	2,254	2,482
<b>Costs of alcohol-specific and alcohol-related crime</b>		
Criminal Justice System (CJS) costs		
Alcohol-specific offences	30	30
Alcohol-related offences	1,720	1,720
Property/health and victim services	2,521	2,521
Costs in anticipation of crime	1,495	1,495
Lost productive output of victims	970	970
Emotional impact costs for victims of crime	4,679	4,679
Drink driving		
Criminal Justice System (CJS) costs	77	77
Cost of drink driving casualties		
Lost output		
Serious casualties	34	34
Slight casualties	26	26
Medical and ambulance costs		
Serious casualties	21	21
Slight casualties	11	11
Human costs		
Serious casualties	233	233
Slight casualties	124	124
<b>TOTAL COSTS</b>	<b>18,517</b>	<b>20,044</b>

Notes: Inpatient and day visits that are 'directly attributable to alcohol misuse' only cover the medical conditions that are 100% related to excessive alcohol consumption (such as alcoholic gastritis). Those that are 'partly related to alcohol misuse' only include the medical conditions for which some (but not all) cases are alcohol-related. For more information, see Cabinet Office (2003).

<sup>38</sup> Cabinet Office (2003), 'Alcohol misuse: how much does it cost?'. See [http://www.cabinetoffice.gov.uk/strategy/work\\_areas/alcohol\\_misuse/background.aspx](http://www.cabinetoffice.gov.uk/strategy/work_areas/alcohol_misuse/background.aspx)

27. The healthcare costs and crime costs have since been updated by the Department of Health ('The cost of alcohol harm to the NHS in England', 2008) and the Home Office ('Interim Impact Assessment of responsible alcohol sales', 2008) respectively to take account of the latest data. Further detail is presented in the respective papers. Other costs are converted into 2006/7 prices using the HM Treasury GDP Deflator<sup>39</sup>. The new total estimate ranges from £17.7bn to £25bn.

*The annual cost of alcohol harm in England (Department of Health (2008), Home Office (2008) and Cabinet Office (2003), in 2006/7 prices):*

	First Estimate (£m)	Second Estimate (£m)
<b>Healthcare costs</b>		
Hospital inpatient & day visits		
Directly attributable to alcohol misuse	168	168
Partly attributable to alcohol misuse	1,023	1,023
Hospital outpatient visits	272	272
Accident and emergency visits	646	646
Ambulance services	372	372
Practice nurse consultations	10	10
NHS GP consultations	102	102
Laboratory tests	N/A	N/A
Dependency prescribed drugs	2	2
Other health care costs	54	54
Specialist treatment services	117	117
<b>Workplace and wider economy costs</b>		
Lost output due to absenteeism	1,389	2,044
Lost output due to reduced employment	1,976	2,465
Lost output due to reduced employment efficiency	N/A	N/A
Lost output due to premature death	2,580	2,841
<b>Costs of alcohol-specific and alcohol-related crime</b>		
Total costs	9,000	15,000
<b>TOTAL COSTS</b>	<b>17,711</b>	<b>25,115</b>

Note: Inpatient and day visits that are 'directly attributable to alcohol misuse' only cover the medical conditions that are 100% related to excessive alcohol consumption (such as alcoholic gastritis). Those that are 'partly related to alcohol misuse' only include the medical conditions for which some (but not all) cases are alcohol-related. For more information, see Department of Health (2008), 'The cost of alcohol harm to the NHS in England'.

<sup>39</sup> See [http://www.hm-treasury.gov.uk/economic\\_data\\_and\\_tools/gdp\\_deflators/data\\_gdp\\_index.cfm](http://www.hm-treasury.gov.uk/economic_data_and_tools/gdp_deflators/data_gdp_index.cfm)

# Standard Consultation Information

## The Consultation Process

### Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- HM Government Code of Practice on Consultation states that consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible<sup>40</sup>.
- be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

[Link to consultation Code of Practice](#)

### Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please:

**contact**      Consultations Coordinator  
Department of Health  
3E48, Quarry House  
Leeds  
LS2 7UE

**e-mail**      [consultations.co-ordinator@dh.gsi.gov.uk](mailto:consultations.co-ordinator@dh.gsi.gov.uk)

**Please do not send consultation responses to this address.**

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<sup>40</sup> A consultation on whether inadequate delivery of the voluntary agreement should mean moving to legislation took place between July and October 2008.

Consultation on options for improving information on the labels of alcoholic drinks to support consumers to make healthier choices.

## Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's [Information Charter](#).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

## Summary of the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at <http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm>

The consultation document has been made available to a wide range of stakeholders, including health organisations, the NHS, local government, young people's organisations, retail organisations and the alcohol industry. Nevertheless, any group or member of the public with an interest in the issues presented within the document is welcome to provide feedback. The Department of Health requests that, wherever possible, responses are accompanied by references to research or other evidence.

## How to and when to respond to the consultation

The consultation will be open to responses for 12 weeks. Responses to this consultation must be received by 9 May 2010. Responses can be submitted online to:

Responses relating only to England: [Englandalcohollabelling@dh.gsi.gov.uk](mailto:Englandalcohollabelling@dh.gsi.gov.uk)

Responses relating only to Wales: [Walesalcohollabelling@dh.gsi.gov.uk](mailto:Walesalcohollabelling@dh.gsi.gov.uk)

Responses relating only to Scotland: [Scotlandalcohollabelling@dh.gsi.gov.uk](mailto:Scotlandalcohollabelling@dh.gsi.gov.uk)

Responses relating to Northern Ireland: [NorthernIrelandalcohollabelling@dh.gsi.gov.uk](mailto:NorthernIrelandalcohollabelling@dh.gsi.gov.uk)

Responses relating equally to the whole UK: [UKalcohollabelling@dh.gsi.gov.uk](mailto:UKalcohollabelling@dh.gsi.gov.uk)

Consultation on options for improving information on the labels of alcoholic drinks to support consumers to make healthier choices.

Postal replies should clearly state which territory they apply to and be sent to: Alcohol Labelling Consultation, 628 Wellington House, 133-155 Waterloo Rd, SE1 8UG]