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Summary

- Poor public health is a significant contributory factor in rising demand for healthcare services and the consequent financial and operational pressures on the NHS. This has led to commitments across the UK to focus on ill-health prevention; however, successive governments have not adequately prioritised an evidence-based approach to this.
- Although the role of the state intervening in public health is often contested, the BMA believes there is sufficient justification for government regulation to support improvements in population health.
- While evidence-based interventions and a strong regulatory framework have been well-utilised in some areas, such as action to reduce smoking rates, there has been an over-reliance on personal responsibility and voluntary industry action in other areas.
- Through limited changes in alcohol duty rates, the UK Government has not sufficiently used one of its key levers for reducing alcohol-related harm. There has also been an inconsistent approach across the devolved nations to introducing other evidence-based alcohol control measures; for example, unlike the rest of the UK, the Scottish Government has made public health a key criteria before granting licenses to sell and serve alcohol, has brought forward plans to implement a minimum unit price for the sale of alcohol, and has lowered its drink drive limit.
- While evidence reviews are often commissioned to support the development of government policies, they have not been consistently acted on in developing public health policies. For example, two of the key recommendations (to restrict price promotions and reduce advertising and marketing opportunities for high-sugar products) in the 2015 PHE (Public Health England) sugar reduction review did not feature in the subsequent 2016 childhood obesity strategy for England. There are also only vague or no commitments to action in these areas in Northern Ireland, Wales and Scotland. By contrast, after significant delays in deciding whether to introduce standard packaging for tobacco products, a 2014 independent review of the benefits of this measure was used to underpin its implementation throughout the UK in 2016.
- While the reasons for this inconsistent use of evidence are multifactorial – and include a lack of political will, differences in devolved powers across the UK and the competing interests of commercial companies – this approach is undermining the potential contribution of public health in the UK, and is counter to the established need to focus on prevention and early intervention.

Supporting and protecting the health of the public is one of the biggest challenges for any government. Doctors see first-hand the consequences of poor public health on a daily basis in their clinics, emergency departments and on hospital wards. Obesity rates remain stubbornly high across the UK,¹ nearly one in six adults still smoke,² and there are 7.8 million adults who binge drink.³ Other areas of public health can frequently go overlooked, including mental ill health, misuse of prescribed and illicit drugs, and dental problems.

Why is it important to focus on prevention?

Poor public health significantly increases the burden on health services. The UK population is ageing, and increasing numbers of people are suffering from multiple long-term conditions.⁴ Rising demand for services, alongside a decision by politicians not to invest, has resulted in unprecedented financial and operational pressures, and constraints on resources. For example, in England, NHS providers reported a record deficit of £1.85 billion in 2015-16; general practice is widely recognised to be in crisis; and mental health and community services are under significant strain.⁵ This has led to repeated calls for solutions to ease the pressure on the NHS.⁶ The Five Year Forward View for England calls for a '...radical upgrade in prevention and public health...', including the establishment of a preventative services programme that will '...expand evidence based action...'.⁷ This has also been a feature in the commitments in the STP (sustainability and transformation) plans being developed in England. The respective strategic plans for the health services in Scotland,⁸ Northern Ireland⁹ and Wales¹⁰ similarly emphasise the importance of prevention.

UK public health policies: are we utilising the best available evidence to improve health?

Despite commitments across the UK to focus on prevention, successive governments have not adequately prioritised an evidence-based approach to developing public health policies. In particular, there has often been an over-reliance in national policymaking on 'nudge'^a measures, personal responsibility and voluntary industry action, as these are generally less intrusive.

This is typified in England by the introduction of the 'Public Health Responsibility Deal' in 2011, which relied on a series of voluntary pledges with industry across a range of areas, including alcohol and diet.¹¹ The Scottish Government has also considered a similar approach.¹² This is despite strong evidence that voluntary approaches and self-regulation often fail to reflect the strongest evidence-based strategies for improving public health.^{13,14,15,16,17,18,19,20,21}

As the Nuffield Council on Bioethics highlights in its 'intervention ladder',^b there is a need to justify the use of measures that are more intrusive.²² In relation to the health risks of smoking, alcohol use and poor diet, the BMA believes there is sufficient justification for greater use of government regulation (see **Figure 1**). This briefing examines how well such measures have been used to reduce the impact of these particular health risks. It highlights the successful use of population-level interventions to reduce smoking rates in the UK, and considers the contrasting and inconsistent use of similar measures in relation to alcohol use and poor diet. While not covered in this briefing, it is worth noting that there are other issues – such as the need to promote regular physical activity – where the use of evidence-based measures is equally important.

a A 'nudge' is defined by Thaler and Sunstein as '...any aspect of the choice architecture that alters people's behaviour in a predictable way without forbidding any options or significantly changing their economic incentives.' (Thaler RH and Sunstein CR (2008) *Nudge*. London: Penguin Books Ltd).

b This sets out a range of different options for intervention, as well as the required ethical justification for doing so. Interventions that are higher up the ladder are more intrusive and therefore require a stronger justification.

Figure 1 – Behaviour change, public health and the role of the state

As a medical body, the BMA has a key role to play in providing and promoting evidence about the deleterious impact of unhealthy or risky lifestyle choices, and on the relative effectiveness of different interventions to address the problems they can cause. The scale of the problems associated with excessive alcohol consumption, poor diet or tobacco addiction, and the benefits of different interventions, present a compelling argument for the state to take concerted action to reduce the burden they place on individual health and on the NHS. However, evidence of harm or of the effectiveness of a particular measure alone is not sufficient to justify government intervention. While health is of maximum importance to a health body like the BMA, this can reasonably be traded against other goods.

Decisions about whether we smoke, how much alcohol we consume or what we eat are personal choices and the freedom to govern our own decisions in this personal sphere without undue intrusion is valued highly in liberal societies like the UK. Taken in moderation, the pleasures derived from food and drink can also form an important part of what it is to lead a good or fulfilled life for many people. Few doubt that the state has some role to play in health promotion, and it is widely accepted that restricting individual liberty can be justified to prevent harm to others. How far governments can legitimately interfere with the private choices of individuals for their own benefit, however, is controversial. As the BMA has discussed elsewhere,^{23,24} where the public good is in tension with personal autonomy, and in the absence of serious, direct harm to others, the government needs to balance these competing interests in deciding whether, and if so how, to intervene.

Weighing the different arguments for and against particular forms of intervention is not straightforward. Individual liberty is arguably more than simply a “negative” freedom from interference, it also has a positive aspect. Without the capabilities, including good health, to take advantage of free choice, it is of limited value by itself. People do not make choices in a vacuum, but within a complex nexus of social, economic and environmental factors. If healthy decision-making is frustrated or constrained by factors that are beyond the control of individuals to change, it can be argued that the state has greater licence to intervene and create conditions which, rather than restrict, enhance and promote individual autonomy.

Creating a healthier environment can be in tension with commercial freedoms, for example governments may wish to regulate how food and drink companies make or sell their products. Again, it is important to balance the positive contribution industry can make to public health and the economy, with the need to ensure that business practices do not undermine the healthy choices of individuals. Although the state has a duty to consider the impact of its policies on industry, the weight that these interests should be given is contested. Where there exists an irreconcilable conflict between commercial interests and public health, the government arguably has an ethical duty to prioritise ensuring the conditions necessary for healthy living.

Alcohol: the inconsistent use of evidence

Alcohol causes significant harm. It is causally linked to over 60 different medical conditions, including liver damage, brain damage, poisoning, stroke, abdominal disorders and certain cancers.²⁵ Drinking alcohol causes thousands of deaths every year, equating to 8,758 alcohol-related deaths in the UK in 2015.²⁶ There are also over a million hospital admissions related to alcohol consumption in the UK every year.^{27,28,29,30}

A large body of evidence – including reviews by the OECD (Organisation for Economic Co-operation and Development),³¹ WHO (World Health Organization),³² NICE (National Institute for Health and Care Excellence),³³ and most recently PHE³⁴ – highlight the effectiveness of a range of approaches to tackling the harm caused by alcohol. These include:

- raising alcohol duty above the rate of inflation
- introducing MUP (minimum unit pricing) for alcohol
- regulating alcohol mass media advertising, sponsorship, sales promotions and online advertising
- establishing public health as a licensing objective^c
- introducing a mandatory requirement for labelling on alcohol products, including health warnings
- lowering the drink driving blood alcohol content limit to 50mg/100ml
- providing early intervention and treatment for alcohol use problems.

One of the primary measures for reducing alcohol-related harm is to reduce its affordability, which has steadily increased in the UK since the 1980s. This has predominantly resulted from low alcohol duty rates, which remained relatively static between 1997 and 2007. While the introduction of the duty escalator saw annual increases of 2% above inflation between 2007 and 2014, the escalator has since been scrapped. Thus, the UK Government is no longer utilising one of its most important levers to reduce alcohol consumption.

There are also significant differences in the way this evidence has been used across the four UK nations.³⁵ For example, the Scottish Government has established public health as a licensing objective, and the Welsh Government has expressed support for this measure, although it does not have the devolved power to legislate. The UK Government and Northern Ireland Executive meanwhile have not publicly expressed full support for this policy.

There is good evidence that lowering the legal limit of alcohol, which it is considered safe to consume and drive, is an effective intervention at reducing road traffic casualties and deaths. In the UK, in 2014, there were an estimated 8,270 road traffic casualties as a result of drink driving, in which 1,070 were serious injuries and 240 were fatal.³⁶ The UK Government commissioned a review of the evidence – published in the North Report in 2010 – which recommended lowering the limit from a BAC (blood alcohol concentration) of 80mg/100 ml to 50mg/100ml, in order to save lives.³⁷ This finding was shared by a NICE review.³⁸ Despite this, the evidence has not had a significant influence on policy in England and Wales, where the limit remains 80mg/100ml. The Westminster Government has maintained the limit at 80mg/100ml. The Welsh Government has supported a reduction but does not currently have the legislative power to introduce this.³⁹ In contrast, the Scottish Government reduced the legal BAC limit from 80mg/100ml to 50mg/100ml in December 2014. The Northern Ireland Executive has also legislated to lower the limit to this level.⁴⁰

The introduction of MUP is another example which highlights inconsistency in the use of evidence. This measure tackles the cheap sale of alcohol in a way that alcohol taxation does not, by introducing a price floor below which alcohol cannot be sold. This would help end the sale of heavily discounted white ciders and spirits in the off-trade. For example, a recent

c Establishing the improvement and protection of public health as a licensing objective would ensure this aspect is formally considered in licensing applications.

survey found that it was possible to buy a 3 litre bottle of white cider for £3.49, which works out as 16p per unit of alcohol.⁴¹ This is particularly concerning as these drinks are favoured by heavy drinkers, children and young people, primarily due to their cheapness – for example, studies of white cider drinkers have indicated that between 75-85% favour it for its low price.⁴²

International evidence and robust domestic modelling data have demonstrated the potential effectiveness of MUP.^{43,44,45,46,47} It is projected that a minimum price of 50 pence per unit would lead to over 20,000 fewer deaths and nearly 40,000 fewer hospital admissions in the first 20 years following implementation.⁴⁵ The Scottish Government legislated to introduce MUP in 2012, but implementation has been delayed by legal challenges by the Scotch Whisky Association, with the UK Supreme Court set to consider the case in July 2017. The Northern Ireland Executive and Welsh Government have expressed support in principle. Yet the UK Government reversed a decision to introduce MUP in July 2013, following a public consultation, despite setting out their intention to introduce it just 16 months earlier.⁴⁸

The varied policy approach within the UK on drink driving limits and MUP provide examples of where, despite good evidence of effectiveness, UK Governments have not consistently acted on evidence in the same way. The Scottish Government has pursued these evidence-based interventions in spite of delays and mixed messaging in Westminster. The failure of the UK Government to prioritise the implementation of effective evidence-based intervention to reduce alcohol-related harm is ultimately to the detriment of public health.

Reducing smoking rates: a government success?

Tobacco control policies in the UK are among the most comprehensive in Europe,⁴⁹ and the UK has seen a long-term decline in overall smoking prevalence.² This decline has been supported by a range of regulatory tobacco control measures introduced in recent years (see **Figure 2**). These measures built upon previous tobacco legislation, starting in 1965 with the first ban on cigarette advertising, and the mandatory inclusion of health warnings on all cigarette packaging in 1971. Other notable legislative developments include the 2001 EU Tobacco Products Directive (updated in 2014),^d the 2002 Tobacco Advertising and Promotion Act,^e the 2005 WHO Framework Convention on Tobacco Control,^f and the Standardised Packaging of Tobacco Products Regulations 2015.^g

The implementation of these population-level measures demonstrates a welcome commitment from government to tackle a key public health concern in the UK. There is, however, a need to maintain this commitment as nearly one in six adults still smoke,² and it is estimated that over 200,000 children and adolescents (aged 11-15) take up smoking every year in the UK.⁵⁰

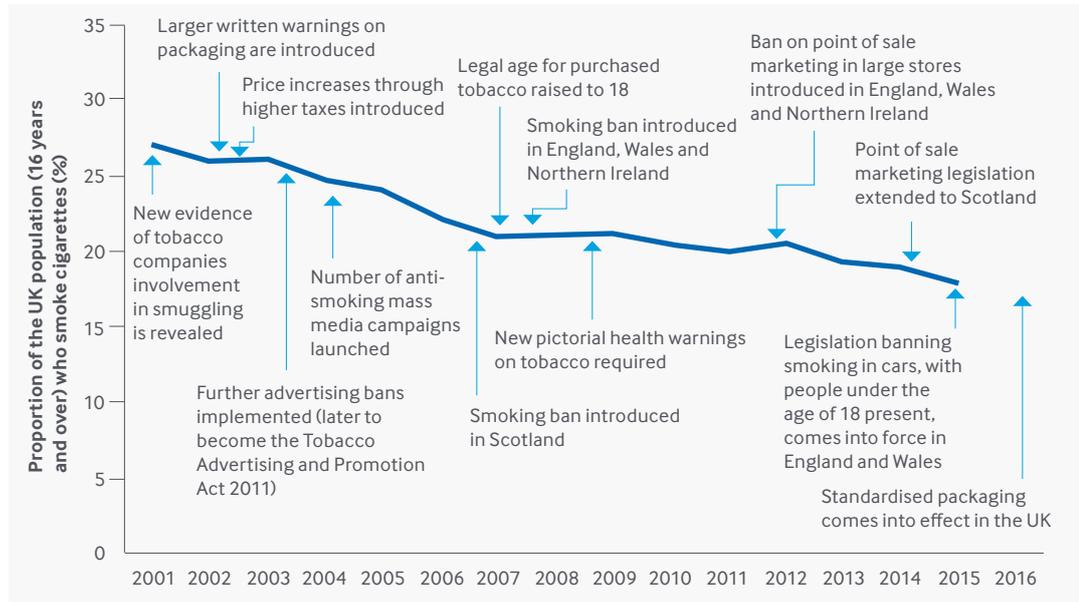
d The revised directive made comprehensive advancements in health warnings on tobacco packaging, stating that the warning must cover 65% of the front and back of packets, and that only the traditional cuboid packets are permitted.

e Various restrictions on tobacco advertising were incrementally introduced under this Act, including prohibiting print media and billboard advertising, direct marketing, sponsorship, and tobacco advertising at the point of sale.

f A global, legally-binding treaty requiring parties to implement evidence-based measures to reduce tobacco use and exposure to tobacco smoke. The UK has been a party to the treaty since 2004.

g The regulations introduced standardised packaging to tobacco products in the UK, ensuring all packaging has to have the promotional aspects of tobacco products removed and the appearance of all tobacco packs is standardised including the colour of the pack.

Figure 2 – Timeline of tobacco control policies/legislation compared to the proportion of the UK population (16 years and over) who smoke cigarettes, 2000-2014



Source: Action on Smoking and Health (2017) *Key dates in the history of anti-tobacco campaigning*. London: Action on Smoking and Health; Office for National Statistics (2017) *Opinions and lifestyle survey, adult smoking habits in Great Britain, 2015*. Newport: Office for National Statistics.

Smokefree public places: a positive impact on population health

The introduction of smokefree legislation across the UK demonstrates the positive impact government policy can have on public health. Legislation prohibiting smoking in workplaces and enclosed public places was introduced in Scotland in 2006, and in England, Northern Ireland and Wales in 2007. Despite robust evidence of the harm of secondhand smoke, the government was initially slow to act, and the tobacco industry has been implicated in delaying the implementation of this policy.^{51,52} There is now a significant body of evidence from the UK and internationally demonstrating that these regulations have been effective in reducing exposure to secondhand smoke.^{53,54} Analysis of Hospital Episode Statistics in England indicated a significant drop in hospital admissions for heart attacks following the introduction of smokefree legislation,⁵⁴ and it was also associated with reductions in emergency admissions for asthma. Further international evidence highlights the positive impact of smokefree legislation on a range of health outcomes, including reductions in morbidity from heart disease and improvements in respiratory function.⁵⁵ A decade on, 82% of adults now support smokefree public places.⁵⁶

The role of commissioned evidence reviews

In the context of assessing how well governments utilise available evidence, it is useful to look at the use of evidence reviews that they often commission to provide advice on implementing a particular policy decision. These reviews are therefore different to (but can take account of) systematic evidence reviews that summarise existing research on a particular issue. This section focuses on how this type of review was used to inform two recent policy decisions – action on childhood obesity in England, and the introduction of standardised packaging of tobacco products across the UK.

Childhood obesity

Childhood obesity is a major public health threat across the UK, with between a quarter and a third of children^h either overweight or obese.^{57,58,59,60} This increases the risk of developing a range of long-term conditions, including type 2 diabetes, hypertension, CHD (coronary heart disease) and stroke, and several types of cancer.⁶¹ It is also a significant cost to healthcare services; for example, it has been estimated that the NHS in England spent £5.1 billion on overweight and obesity-related ill health in 2014/15.⁶²

While a multitude of factors can contribute towards this, including physical inactivity, the recent focus on preventing obesity has been on reducing added sugar consumption, which significantly contributes to calorie intake among children (mainly through consumption of soft drinks, fruit juice, breakfast cereals, cakes and biscuits).⁶³ To support action in this area in England, PHE was commissioned⁶⁴ to provide recommendations to inform the government's future thinking on sugar in the diet. These were provided in a review⁶⁵ published in October 2015, with the following key recommendations:

- limit and rebalance the number and type of price promotions in all retail outlets and out of home settings, such as restaurants, cafes and takeaways
- reduce opportunities to market and advertise high sugar food and drink products to children and adults
- introduce a programme of gradual sugar reduction in everyday food and drink products, combined with reductions in portion size
- introduce price increases of a minimum of 10-20% on high sugar products through a tax or levy such as on soft drinks.

Following the publication of this review, the HM Treasury announced the introduction of a soft-drinks industry levy for the UK of 20% in the 2016 budget;⁶⁶ and the HM Government's action plan for childhood obesity in England set out plans for PHE to work with retailers, manufacturers and the out of home sector on a voluntary sugar reduction programme.⁶³ However, the action plan was widely criticised for failing to include any measures on price promotions or advertising and marketing activities, despite the clear recommendations in the PHE evidence review.^{67,68,69} Furthermore, action on marketing has since been identified as the number one policy priority by a group of health experts, ahead of a sugar tax.⁷⁰ There has also been limited action in other parts of the UK. For example, there is no specific obesity strategy in Wales, and the strategies in Northern Ireland⁷¹ (published in 2012) and Scotland⁷² (published in 2010) only have vague commitments to action on price promotions, advertising and marketing.

Standard tobacco packaging

Smoking has been reported to account for approximately 100,000 deaths a year in the UK,⁷³ and is estimated to cost the NHS in England between £2 billion⁷⁴ and £5.2 billion a year.⁷⁵ Tobacco companies use a range of marketing techniques to promote their products – of which product packaging is one key tool.⁷⁶ Doctors have consistently called for the introduction of standardised packaging in light of the well-established evidence base that it

^h Among children aged two to 15, 28% were either overweight or obese in England in 2015; 25% were either overweight or obese in Northern Ireland in 2015/16; and 28% were either overweight or obese in Scotland in 2015. In Wales, 26% of children aged 4 to 5 years were overweight or obese in 2014/15.

will protect young people from the impact of marketing and reduce uptake of smoking. Peer reviewed studies have shown that, compared to branded cigarettes, plain packaging is less attractive – particularly to young people – improves the effectiveness of health warnings, reduces mistaken beliefs that some brands are 'safer' than others, and is likely to reduce smoking uptake among children and young people.^{77,78}

In April 2012, a UK-wide public consultation was launched by the Department of Health in England (with the agreement of the devolved administrations) on whether to introduce standardised packaging. Despite widespread support for the intervention, the UK Government delayed legislating to implement the policy citing a lack of evidence.⁷⁹ After it appeared that the Government would lose a vote on amendments to the Children and Families Bill in the House of Commons, it tabled its own amendments to introduce standardised packaging, while also commissioning Sir Cyril Chantler to conduct a review of the existing evidence.⁸⁰ The Chantler Review concluded that '...it is highly likely standardised packaging would reduce the uptake of smoking, and implausible that it would increase the consumption of tobacco.'⁸⁰ In spite of this, the government commissioned a second public consultation to identify any further new evidence. Finally, after a number of delays, the government eventually announced in January 2015 that it would bring forward legislation to introduce standardised packaging, which came into force in May 2016.

Conclusion

Despite commitments to prioritise ill-health prevention across the UK, there is inconsistent use of evidence in the development of national-level public health policies; and thus, an inadequate focus on measures to improve public health. This is illustrated by the variable and inadequate approach to the introduction of effective measures to reduce alcohol-related harm and tackle obesity, which sits in contrast to the range of government regulations and interventions which have supported a decline in smoking rates. While the reasons for such inconsistency are multifactorial – and include a lack of political will, differences in devolved powers in the nations and the competing interests of commercial companies – this approach is undermining the potential contribution of public health in the UK, and is counter to the established need to focus on prevention and earlier intervention.

References

- 1 Baker C (2017) *Obesity statistics*. House of Commons Library Briefing Paper 3336. London: House of Commons Library.
- 2 Office for National Statistics (2017) *Adult smoking habits in the UK: 2015*. Newport: Office for National Statistics.
- 3 Office for National Statistics (2017) *Adult drinking habits in Great Britain: 2005 to 2016*. Newport: Office for National Statistics.
- 4 British Medical Association (2016) *Growing older in the UK: A series of expert-authored briefing papers on ageing and health*. London: British Medical Association
- 5 www.kingsfund.org.uk/publications/articles/nhs-agenda-for-action (last accessed 27.04.17).
- 6 British Medical Association (2016) *Report of the Special Representative Meeting*. London: British Medical Association.
- 7 NHS England (2014) *Five Year Forward View*. London: NHS England.
- 8 NHS Health Scotland (2012) *A Fairer Healthier Scotland: Our Strategy 2012-2017*. Edinburgh: NHS Health Scotland.
- 9 Department of Health, Social Services and Public Safety (2014) *Making life better: a whole system strategic framework for public health*. Belfast: Department of Health, Social Services and Public Safety.
- 10 Public Health Wales (2011) *Creating a healthier, happier and fairer Wales for everyone: Introducing the Public Health Wales strategic plan for 2015-18*. Cardiff: Public Health Wales.
- 11 <https://responsibilitydeal.dh.gov.uk/pledges/> (last accessed 27.04.17).
- 12 The Scottish Government (2014) *Supporting healthy choices: a framework for voluntary action. An invitation to the food industry to work in partnership with government in Scotland*. Edinburgh: The Scottish Government.
- 13 Knaia C, Petticrew M, Durand MA et al (2015) The public health responsibility deal: has a public-private partnership brought about action on alcohol reduction? *Addiction* **110**(8): 1217-25.
- 14 Moodie R, Stuckler D, Monteiro C et al (2013) Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. *The Lancet* **381**(9867): 670-9.
- 15 Sacks G, Swinburn B, Kraak V et al (2013) A proposed approach to monitor private-sector policies and practices related to food environments, obesity and non-communicable disease prevention. *Obesity Reviews* **14**(s1): 38-48.
- 16 Panjwani C & Caraher M (2013) The public health responsibility deal: brokering a deal for public health, but on whose terms? *Health Policy* **114**(2-3): 163-73.
- 17 Hawkes C (2005) Self-regulation of food advertising: what it can, could and cannot do to discourage unhealthy eating habits among children. *Nutrition Bulletin* **30**(4): 374-82.
- 18 Sharma L, Teret S & Brownell K (2010) The food industry and self-regulation: standards to promote success and to avoid public health failures. *American Journal of Public Health* **100**(2): 240-6.
- 19 Knaia C, Petticrew M, Durand MA et al (2015) Has a public-private partnership resulted in action on healthier diets in England? An analysis of the Public Health Responsibility Deal food pledges. *Food Policy* **54**: 1-10.
- 20 Bryden A, Petticrew M, Mays N et al (2013) Voluntary agreements between government and business – a scoping review of the literature with specific reference to the Public Health Responsibility Deal. *Health Policy* **110**(2-3): 186-197.
- 21 Gilmore AB, Savell E & Collin J (2011) Public health, corporations and the new responsibility deal: promoting partnerships with vectors of disease? *Journal of Public Health* **33**(1): 2-4.
- 22 Nuffield Council on Bioethics (2007) *Public health: ethical issues*. Cambridge: Cambridge Publishers Ltd.
- 23 British Medical Association (2012) *Behaviour change, public health and the role of the state – BMA position statement*. London: British Medical Association.

- 24 British Medical Association (2016) 'Fetal alcohol spectrum disorder – ethics, rights, duties' *Alcohol and pregnancy: preventing and managing fetal alcohol spectrum disorders (2016 update)*. London: British Medical Association.
- 25 Shield K, Parry C & Rehm J (2013) Measuring the burden: alcohol's evolving impact. *Alcohol Research: Current Reviews*. **35**(2): 122-7.
- 26 Office for National Statistics (2017) *Alcohol-related deaths in the UK: registered in 2015*. Newport: Office for National Statistics.
- 27 Health and Social Care Information Centre (2016) *Statistics on Alcohol: England 2016*. Leeds: Health and Social Care Information Centre.
- 28 NHS Scotland Statistics Service (2016) *Alcohol-related hospital statistics: Scotland 2015/16*. Edinburgh: NHS Scotland Statistics Service.
- 29 Public Health Agency Northern Ireland (2011) *Alcohol use and alcohol related harm in Northern Ireland*. Belfast: Public Health Agency Northern Ireland.
- 30 Public Health Wales Observatory (2014) *Alcohol and health in Wales 2014*. Cardiff: Public Health Wales Observatory.
- 31 Organisation for Economic Co-operation and Development (2015) *Tackling harmful alcohol use*. Paris, France: Organisation for Economic Co-operation and Development.
- 32 Andersen P (2010) *Alcohol and the workforce*. Geneva, Switzerland: World Health Organization.
- 33 National Institute for Health and Care Excellence (2010) *Alcohol use-disorders: prevention* [PH 24]. London: National Institute for Health and Care Excellence.
- 34 Public Health England (2016) *The public health burden of alcohol and the effectiveness of alcohol control policies*. London: Public Health England.
- 35 Fitzgerald N & Angus C (2015) *Four nations: How evidence-based are alcohol policies and programmes across the UK*. London: Alliance for Useful Evidence/Alcohol Health Alliance.
- 36 Department for Transport (2016) *Estimated number of reported drink drive accidents and casualties in Great Britain: 1979-2014*. London: Department for Transport.
- 37 North P (2010) *Report of the review of drink and driving law*. London: Department of Transport.
- 38 National Institute of Health and Clinical Excellence (2010) *Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths*. London: National Institute of Health and Clinical Excellence.
- 39 Welsh Government (2008) *Working together to reduce harm: the substance misuse strategy for Wales 2008-2018*. Cardiff: Welsh Government.
- 40 Northern Ireland Assembly (2015) *Road Traffic (Amendment) Bill*. Belfast: Northern Ireland Assembly.
- 41 Alcohol Concern (2015) *Alcohol brands consumed by young people in treatment, 2015*. London: Alcohol Concern.
- 42 Black H, Michalova L, Gill J et al (2014) White cider consumption and heavy drinkers: a low-cost option but an unknown price. *Alcohol and Alcoholism* **49**(6): 675–80.
- 43 Meier P, Holmes J, Angus C et al (2016) Estimated effects of different alcohol taxation and price policies on health inequalities: a mathematical modelling study. *Medicine* **13**(2): e1001963.
- 44 Brennan A, Meng Y, Holmes J et al (2014) Potential benefits of minimum unit pricing for alcohol versus a ban on below cost selling in England 2014: modelling study. *The BMJ* **349**: g5452
- 45 Angus C, Holmes J, Pryce R et al (2016) *Model-based appraisal of the comparative impact of minimum unit pricing and taxation policies in Scotland: An adaption of the Sheffield Alcohol Policy Model version 3*. Sheffield: University of Sheffield.
- 46 Meng Y, Sadler S, Gell L et al (2014) *Model-based appraisal of minimum unit pricing for alcohol in Wales: An adaptation of the Sheffield Alcohol Policy Model Version 3*. Sheffield: University of Sheffield.
- 47 Angus C, Meng Y, Ally A et al (2014) *Model-based appraisal of minimum unit pricing for alcohol in Northern Ireland: An adaptation of the Sheffield Alcohol Policy Model version 3*. Sheffield: University of Sheffield
- 48 Home Office (2012) *A consultation on delivering the Government's policies to cut alcohol fuelled crime and anti-social behaviour*. London: Home Office.

- 49 Joossens L & Raw M (2014) *The tobacco control scale 2013 in Europe*. Belgium: Association of European Cancer Leagues.
- 50 Hopkinson NS, Lester-George A, Ormiston-Smith N et al (2013) Child uptake of smoking by area across the UK. *Thorax* **69**(9): 873-5.
- 51 Britton J, McNeill A & Arnott D (2007) Tony Blair's 10 years of tobacco control. *The Lancet* **370** (9582): 110-112.
- 52 www.hazards.org/haz82/smokescreen.pdf (last accessed 27.04.17).
- 53 Bauld L (2011) *The impact of smokefree legislation in England: evidence review*. Bath: University of Bath.
- 54 <http://gov.wales/topics/health/improvement/smoking/legislation/ban/?lang=en> (last accessed 27.04.17).
- 55 www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/protection/improve_health/ (last accessed 27.04.17).
- 56 ASH/YouGov (2014) *Smokefree Britain Survey 2014*. London: YouGov.
- 57 NHS Digital (2016) *Health survey for England 2015*. Leeds: NHS Digital.
- 58 Scarlett M & Denvir J (2016) *Health survey (NI) first results 2015/16*. Belfast: Information Analysis Directorate, Department of Health.
- 59 Campbell-Jack D, Hinchliffe S & Rutherford L (2016) *The Scottish health survey 2015 edition, volume 1, main report*. Edinburgh: the Scottish Government.
- 60 Bailey L (2016) *Child measurement programme for Wales 2014/2015*. Cardiff: Public Health Wales NHS Trust.
- 61 Kopelman P (2007) Health risks associated with overweight and obesity. Short science review. Foresight tackling obesities: future choices. *Obesity Reviews* **8**(s1): 13-7.
- 62 HM Government (2016) *Childhood obesity: a plan for action*. London: Department of Health.
- 63 Bates B, Lennox A, Prentice A et al (2014) *National diet and nutrition survey. Results from years 1, 2, 3 and 4 (combined) of the rolling programme (2008/2009 – 2011/2012). A survey carried out on behalf of Public Health England and the Food Standards Agency*. London: Public Health England.
- 64 www.gov.uk/government/uploads/system/uploads/attachment_data/file/417629/Public_Health_England__Remit__Priorities_Letter__2015-16_Final__2_.pdf (last accessed 27.04.17).
- 65 Tedstone A, Targett V, Allen R et al (2015) *Sugar reduction: the evidence for action*. London: Public Health England.
- 66 HM Treasury (2016) *Budget 2016*. London: The Stationary Office
- 67 British Medical Association press release (18.8.16) *BMA response to the governments disappointing childhood obesity strategy*.
- 68 <http://obesityhealthalliance.org.uk/2016/08/22/letter-times-22-aug-experts-agree-obesity-plan-not-good-enough/> (last accessed 27.04.17).
- 69 Knai C, Petticrew M & Mays N (2016) The childhood obesity strategy. *The BMJ* **354**: i4613.
- 70 Food Foundation (2016) *Food environment policy index for England*. London: Food Foundation.
- 71 Department of Health, Social Services and Public Safety (2012) *A fitter future for all*. Belfast: Department of Health, Social Services and Public Safety.
- 72 The Scottish Government (2010) *Preventing overweight and obesity in Scotland. A route map towards healthy weight*. Edinburgh: The Scottish Government.
- 73 Action on Smoking and Health (2015) *Smoking statistics: January 2015*. London: Action on Smoking and Health.
- 74 Callum C, Boyle S & Sandford A (2011) Estimating the cost of smoking to the NHS in England and the impact of declining prevalence. *Health Economics, Policy and Law* **6**(4): 489-508.
- 75 Allender S, Balakrishnan R, Scarborough P et al (2009) The burden of smoking-related ill health in the United Kingdom. *British Medical Journal*. **18**(4): 262-267.
- 76 US Department of Health and Human Services (2012) *Preventing tobacco use among youth and young adults: a report of the surgeon general*. Atlanta, United States: US Department of Health and Human Services.
- 77 Quit Victoria (2011) *Plain packaging of tobacco products: a review of the evidence*. Victoria, Australia: Quit Victoria.

- 78 West R (2015) The growing evidence on standardised packaging of tobacco products (a collection of peer-reviewed research papers and commentaries reviewing the evidence base from 2008 to 2015) *Addiction* 110(2): 193-373.
- 79 House of Commons Library (2015) *Standardised (plain) packaging of tobacco products*. London: The Stationary Office.
- 80 Chantler C (2014) *Standardised packaging of tobacco: report by the independent review undertaken by Sir Cyril Chantler*. London: Kings College London.

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