

PHB 04

Bil Iechyd y Cyhoedd (Cymru)

Public Health (Wales) Bill

Ymateb gan: Iechyd Cyhoeddus Cymru

Response from: Public Health Wales

Public Health Wales NHS Trust Submission to the Health, Social Care and Sport Committee Call for Evidence: Public Health (Wales) Bill	
Date: 28 November 2016	Version: 1

This information should be read alongside the previous (updated) submission 'Public Health Wales NHS Trust, Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill', dated 4th September 2015 (Appendix 1).

Re- introduction of the Public Health Bill, November 2016

1. Public Health Wales welcomes the opportunity to further comment on the Public Health (Wales) Bill, and embraces this Bill alongside other complementary legislation such as the Well-being of Future Generations (Wales) Act, the Social Services and Well-being (Wales) Act, Environment (Wales) Act and the Active Travel (Wales) Act.
2. This Bill will help to ensure that the health and well-being of the population is considered and underpins the shared responsibility that all public bodies in Wales have for the health of the nation. The Public Health (Wales) Bill will add to the legislative framework for improving health and well-being, protecting health and reducing inequalities in Wales.

3. The following gives an update on relevant areas following our previous submission dated 4th September 2015 (Appendix 1) which should be read alongside this information.
4. In addition to the areas listed below, Public Health Wales strongly supports the re-introduction of the draft Public Health (Minimum Price for Alcohol) (Wales) Bill. Wales has the opportunity to follow Scotland's lead in taking forward this important agenda, to reduce the substantial harm associated with excess alcohol consumption in Wales. Our views on minimum unit pricing were previously articulated in some detail in our submission to the consultation on the White Paper. This is attached for information as Appendix 2.

Part 2: Tobacco and Nicotine Products

5. Public Health Wales strongly supports the proposed action to protect the Welsh population from harms associated with tobacco and nicotine products. We have updated our previous evidence in Appendix 1, and would further support the strengthening of proposals through:
 - Extending smoke free spaces into outdoor areas frequented by children and the margins of buildings.
 - Having a requirement for tobacco retailers to display information about quit smoking support.
 - Have a requirement for smoke free signs to include information on quit smoking support.

Part 3: Special Procedures

6. Minor amendments have been made to Appendix 1.

Part 4: Intimate Piercing

7. Minor amendments have been made to Appendix 1.

Part 5: Health Impact Assessment

8. We welcome the inclusion of Health Impact Assessment (HIA) within the Public Health (Wales) Bill as a statutory duty for public bodies in Wales in specific circumstances.
9. The inclusion of HIA provides an opportunity to strengthen and reinforce the commitment to Health in All Policies demonstrated in the Well-being of Future Generations (Wales) Act. Public Health Wales recommends that HIA should be a statutory requirement for key policies and in other specified circumstances, with due regard for proportionality, resource implications and cost. Legislating for HIA would consistently ensure that all public bodies consider the impact of their policies on health and well-being and inequalities and would more effectively deliver the intention of a 'Health in All Policies' approach. This would be a step change to the current approach, where health and well-being is considered in an inconsistent way.
10. HIA provides a systematic, objective, yet flexible and practical way of assessing potential positive and negative, or unintended, health and well-being impacts associated with a particular activity. It also provides an opportunity to suggest ways in which health risks can be minimized and health benefits and opportunities maximized. A major objective or purpose of an HIA is to inform and influence decision-making. HIA can provide a valuable source of evidence to be reviewed as part of any decision making process across a wide range of sectors.
11. As practised in Wales, HIA views 'health and well-being' in a holistic way which encompasses mental, physical and social well-being. Based on a social determinants framework, HIA recognizes that there are many, often interrelated factors that influence people's health, from personal attributes and individual lifestyle factors to socioeconomic, cultural and environmental considerations.
12. HIA includes both quantitative and qualitative data including, importantly, community participation and stakeholder knowledge.

13. HIAs generally take one of three forms in Wales – desktop, rapid participatory or comprehensive. A desktop HIA may take only a few hours or a day to execute, a rapid HIA may take a few days to a few months to complete, and a comprehensive HIA is more in-depth and time / resource intensive and can take many months or years to complete. The most appropriate type to conduct can be decided through a short scoping exercise, where timeframes, resources and levels of stakeholder involvement are reviewed. Comprehensive HIAs, whilst infrequent, can involve significant work but also provide significant value especially in respect of involving communities and private citizens. An illustration of such an approach can be seen with historical HIAs e.g. Margam open cast mining and more recently in the proposed Wylfa Newydd Nuclear Power Station in Anglesey.
14. A number of the governmental strategic levers and drivers currently exist and have been put in place to influence the use of HIA. In a wide range of areas, including road and rail transport¹, minerals², waste³ and land use planning⁴ and regeneration⁵ plans, HIAs are referred to in Welsh Government guidance. HIA is also a mandatory requirement within the NHS in respect of investment in infrastructure and capital build projects⁶.
15. It would therefore appear a logical next step as part of the Public Health (Wales) Bill to include provision for statutory HIAs in these existing circumstances and build on this body of HIA work and the requirements of the Well-being of Future Generations (Wales) Act. Other areas which would benefit from undertaking HIAs would be Public Services Board Well-being Plans; major Health Board or Local Authority service re-configuration; incorporating HIA into Environmental Impact Assessment requirements in Wales (thus avoiding duplication of resources); permitting new fast food outlets e.g. near schools; and for Welsh Government national policies or plans of significant impact. For example, the Wales Health Impact

¹ Welsh Transport Appraisal Guidance ([WeITAG](#)). Welsh Government 2008

² Minerals Technical Advice Note ([MTAN](#)) 2: Coal. Welsh Government, 2009

³ 'Construction, Infrastructure and Markets' Wales Waste Strategy Sector Plan . Welsh Government, 2012

⁴ Chapter 2: Development Plans, Planning Policy Wales (PPW), Edition 8, July 2016

⁵ 'Vibrant and Viable Places: A New Regeneration Framework'. Welsh Government, 2013

⁶ NHS Wales 'Infrastructure Investment Guidance' Welsh Government, 2015.

Assessment Support Unit (WHIASU), Public Health Wales has recently supported a HIA for the new Night Time Economy Framework. There could be a future role for WHIASU to support more of this type of work. WHIASU can best add value by providing expert advice on HIAs undertaken on national policies, large infrastructure projects or projects involving multiple agencies.

16. We believe that consideration needs to be given to capacity requirements of a wide range of organisations (including Public Health Wales) to develop systems, and ensure there is sufficient support and skills to undertake HIAs. Public Health Wales, and specifically WHIASU, has a clear role in supporting capacity development through training and the provision of support such as mentoring practitioners (and indeed much work has been successfully undertaken in this area to date). However, WHIASU currently consists of only 2.5 FTE posts and already provides wide ranging expert support. We believe that additional requirements for HIA would need to take into account current limited capacity within WHIASU and any additional resources needed to deliver the defined requirement(s) effectively and to a high standard.
17. Legislating for HIA will make a significant contribution to improving the future health and well-being of the Welsh population, lead to more effective policy making at the same time as enhancing Wales' reputation as a world leader in the application of Sustainable Development and public health policy.

Part 6: Pharmaceutical Services

18. We have no additional comments on pharmaceutical services.

Part 7: Provision of Toilets

19. We have no additional comments on the provision of toilets.

Finance

20. We have no additional comments on matters of finance.

Delegated Powers

21. We have no additional comments on delegated powers.

About Public Health Wales

22. We exist to protect and improve health and well-being and reduce health inequalities for people in Wales. We work locally, nationally and internationally with our partners and communities. Public Health Wales has four statutory functions. These are to:

- provide and manage a range of public health, health protection, healthcare improvement, health advisory, child protection and microbiological laboratory services and services relating to the surveillance, prevention and control of communicable diseases;
- develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters;
- undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales in particular including cancer incidence, mortality and survival; and prevalence of congenital anomalies; and
- provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health related matters.

Appendix 1 – *this paper has been updated where appropriate*



Public Health Wales NHS Trust Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill	
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1 Overview

Public Health Wales welcomes the opportunity to comment on the Public Health (Wales) Bill.

The Welsh Government has taken a number of steps in ensuring health is considered across Governmental agendas in respect of legislation such as the Active Travel (Wales) Act, Social Services and Well-being (Wales) Act and the Well-being of Future Generations (Wales) Act. The Public Health (Wales) Bill, although relatively narrow in scope adds to the legislative framework for health improvement and health protection.

Public Health Wales believes that the proposed actions in the Bill will have a positive impact on health and well-being in Wales and we look forward to working with the Welsh Government to progress the actions described.

Public Health Wales recognises that the Well-being of Future Generations Act includes within it provision for a ‘health in all policies’ approach which will raise the profile of public health in society and increase awareness and knowledge of public health issues across government departments (national and local) and among those who develop and implement policy. This approach in tackling the wider determinants of health is pivotal to achieving the types of improvement in health and well-being and the reduction in health inequalities that are required in Wales.

The Public Health (Wales) Bill provides an opportunity to reinforce Welsh Government’s commitment to Health in All Policies through inclusion of health impact assessment (HIA), which is not mandated in the Well-being of Future Generations Act. Public Health Wales recommends that HIA should be a statutory requirement for key policies and other specified circumstances, with due regard for proportionality, resource implications and cost.

In our response to the White Paper we identified the need to define ‘well-being’ and that it was not appropriate for the only definition and use of ‘well-being’ to be in the Social Services and Well-being (Wales) Act. The Public Health Bill must explicitly define well-being within its provisions and include reference to physical, mental and social well-being.

2 Part 2: Tobacco and Nicotine Products

Public Health Wales fully supports the proposals relating to tobacco and nicotine products contained in the Bill.

Extending restrictions on smoking in school grounds; playgrounds and hospital grounds.

Restrictions on the use of tobacco in public places serve two functions. The first is to restrict exposure to environmental tobacco smoke (ETS) to smokers and non-smokers. The second is to support the creation of an environment in which non-smoking is the norm, in which children in particular are exposed as infrequently as possible to adults smoking. The introduction of smoking restrictions in outdoor environments such as those listed above would support the second of these. While voluntary bans may have merit, we believe that the strong signal sent through legislation has more potential impact and supports local authorities, health boards and others in implementation – for example, we are aware of concerns from those who work in Public Health at a local level that voluntary smoking bans are

problematic to enforce. It also assists members of the public who can be certain as to whether or not they may smoke in a setting regardless of where in Wales they are.

We support proposals to prioritise the extension of current restrictions to playgrounds; the grounds of hospitals and schools. We would suggest that there would need to be a clear definition of ‘playground’ and that ‘schools’ should include early years educational settings such as nurseries (private and public). In the case of schools and playgrounds this should include the perimeter of these settings otherwise the intended impact of the restrictions is unlikely to be achieved i.e. if parents or other adults are permitted to smoke at the perimeter of a playground or at the school gates in clear view of children this will not impact on the intended goal of ‘denormalisation’ (reduce smoking being modelled to children as normal behaviour). We would also propose that the restrictions should not be limited to hospitals but should include the grounds of premises used predominately for the delivery of healthcare to include community health facilities and primary care.

We would also suggest that consideration is given to extending the requirement to include signage indicating that the premises or outdoor area is non-smoking to including information on signs (either a website or telephone number) on access to smoking cessation support.

Any additional legislation will need to be accompanied by enforcement powers such as Fixed Penalty Notice, although there will need to be consideration of the enforcement approach as currently enforcement is against the “person in control of premises” which may be less applicable for playgrounds

Establishing a national register of retailers of tobacco and nicotine products

Public Health Wales strongly supports this action, which is in line with Welsh Government and local Tobacco Control Action Plans to reduce smoking prevalence through prevention of uptake of smoking in young people.

The introduction of a register in Scotland has enabled the availability and trends in availability of tobacco to be monitored effectively.

In addition to a register of retailers, we support the view of the Wales Heads of Environmental Health Group that the register should also cover all those that manufacture, distribute and sell tobacco products. This would ensure that the register covers other parts of the tobacco chain. To support this, an offence should

be created where tobacco products can only be sold, distributed, etc to those registered. However there is need to be mindful that the aforementioned would appear to be covered by the recent HMRC consultation ‘Tobacco Illicit Trade Protocol – licensing of equipment and the supply chain’. Although this consultation has closed consideration should be given to including this provision should the proposal to introduce the licensing system not progress.

We are concerned about the use of the phrase “reasonable excuse” in section 35(5) ‘*A registered person who fails, without reasonable excuse, to comply with section 30 (duty to notify certain changes) commits an offence*’. This term is not defined in the legislation and may lead to evasion of enforcement action.

Establishment of a register to protect under 18s from accessing tobacco and nicotine products

Enforcement of underage sales is a key component of a strategy to prevent smoking uptake. Supporting enforcement, in this case through a register, would strongly enhance current measures. It is likely that the measure will also support enforcement of display regulations. Identifying locations where the sale of tobacco is permitted may help with the identification of premises where tobacco is sold illicitly.

We also believe that the measure contributes to the denormalising of tobacco as a product i.e. it is not the same as other consumer products and should not be available for sale in the same way. The introduction of registration re-enforces this position. We also believe that over time it may be possible to use a register to monitor systematically trends in illegal sales to young people – the current important enforcement and intelligence based approach used by local authorities does not enable Government or public health agencies to understand whether there is a declining trend in likelihood of non-compliance which would be a key goal of tobacco control policy. We also believe that it would offer potential to consider density of tobacco control outlets and their control by local authorities as a public health measure in future.

Strengthened Restricted Premises Order regime, with a national register, to aid local authorities in enforcing tobacco and nicotine offences

Public Health Wales would support the proposal to enable Welsh Ministers to extend the tobacco offences that may be counted toward the application for a RPO.

Public Health Wales remains concerned that the current enforcement programme and resources available mean that it is highly unlikely that any premises will be found to have infringed the regulations on three occasions in a three year period and that in practice prohibition is therefore unlikely. Anecdotal evidence from the current enforcement of illegal sales legislation suggests that magistrates are reluctant to impose the maximum fines even when cases are brought to court. We would suggest that in the unlikely event of an application for prohibition being brought the minimum restriction on sales should be 12 months.

Our review of the international evidence in this field supports the view that while the introduction of legislation is important it will only be effective if accompanied by active enforcement and a meaningful deterrent. We remain concerned that this is not the case in Wales at the current time.

Creating a new offence for knowingly handing over tobacco and nicotine products to a person under 18, which the is legal age of sale in Wales

The growth of online shopping would suggest the need to revisit all age restricted sales in this way. The introduction of this new offence is supported by Public Health Wales to ensure that all tobacco products are requested and received only by an adult.

Any additional tobacco control measures which should be considered for inclusion in the Bill

Wales is currently well placed according to international comparisons in the implementation of policy and legislation to minimise harm from tobacco use. The main area for future development would relate to hypothecated taxes or a levy on cigarette purchase or profits. Work has been done that has demonstrated that the normal competitive market forces do not operate for tobacco products, with the tobacco market being dominated by a few large multinational tobacco corporations. In addition, most notably in California, a levy on every pack of cigarettes sold has funded public health action; they now have among the lowest smoking rates in the world. We recognise however, that these measures may not be within the current legislative competence of the National Assembly for Wales.

We would support early implementation of the extension of the smoking ban in enclosed public places to outdoor environments with a priority given to hospital grounds; school grounds; playing fields and outdoor leisure facilities; beaches and National Parks.

3 Part 3: Special Procedures

These proposals will certainly improve the protection of public health. Recent experience within Wales relating to a 'look back' exercise conducted by Aneurin Bevan University Health Board in relation to potential infection risk in Tattoo and body piercing parlours in the area has highlighted the potential risk to Public Health from these procedures. The proposals will mean that basic conditions must be met prior to any special procedures being undertaken. This, together with the strengthened local authority powers to deal with non-compliance, will contribute to protecting public health in Wales.

Creating a compulsory, national licensing system for practitioners of specified special procedures in Wales, and the approval of premises or vehicle from which the practitioners operate

Public Health Wales supports the proposal for a National Special Procedures Register to ensure the provision of consistent standards in respect of infection control, cleanliness and hygiene for all practitioners and businesses operating any of the listed special procedures.

There is some older evidence that procedures such as piercing are a risk factor for hepatitis, though actual occurrences may be rare. A recent review suggests there is a significant risk of transmission through piercing and tattooing procedures which are not done under sterile conditions, such as at home or in prison. However, in our view, the risk of transmission is the same in commercial parlours where sterile conditions and infection control measures are not in place. Scarring from complications following such procedures can also have long-term psychological impacts. Anecdotal evidence suggests that individuals with localised infections associated with such procedures often present in GP practices and Accident and Emergency departments, particularly following tongue piercings. All of the nine cases identified in the look back exercise in Newport self-presented to healthcare, often multiple times.

The current legislation does not adequately protect the public and these procedures have the potential to cause harm if not carried out safely. In the recent look back

exercise in Wales⁷, nine people were identified as needing hospital admission due to severe *Pseudomonas aureaginosa* infection, eight of whom required surgical intervention (including incision, drainage, reconstruction and stitching), following body piercing at a tattoo and body piercing premises. The individuals needed weeks of hospital treatment and follow-up care, and some are permanently disfigured. More minor problems for other clients included swelling and trauma around the site, scarring, local skin infections, and allergic reactions which were more prevalent. A lack of good hygiene and infection control can lead to severe skin infections, blood poisoning (sepsis) or transmission of blood-borne infections through contaminated equipment, such as Hepatitis B, Hepatitis C or HIV.

The Register should also consider requiring practitioners of special procedures to have received a course of Hepatitis B vaccinations and routine testing for blood borne viruses.

Types of special procedures defined in the Bill

Public Health Wales agrees with the types of procedures included within the Bill and the acknowledgement that this is a changing field and the need to include provision to amend the regulations accordingly. In our initial response we had identified other procedures that might be included within the scope of the Bill which have not been included e.g. injections or fillers. This Bill also presents an opportunity to regulate the administration of the following procedures: body modification (to include stretching, scarification, sub-dermal implantation/3D implants, branding and tongue splitting), injection of any liquid into the body e.g. Botox or dermal fillers, dental jewellery, chemical peels, and laser treatments such as used for tattoo removal or in hair removal.

We note that these have not been included within the Bill, it is possible that this will be encompassed within specific requirements for cosmetic procedures in line with those proposed by the UK Government for England following the Keogh Review in 2013⁸

Provision for Welsh Ministers to amend the list of special procedures through secondary legislation

⁷ The report is available at:

<http://www.wales.nhs.uk/sitesplus/documents/866/Exercise%20SerenLookback%20Technical%20ReportFinal%20email%20version%20complete%201%208%2016.pdf>

⁸

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf

Public Health Wales is of the opinion that the ability to amend the list of special procedures to enable the inclusion and removal of specific procedures would enable the Welsh Government to adapt and change legislation in accordance with new trends and patterns in body modification.

Professions that are exempt from needing a licence to practice special procedures

The exemptions proposed include all of the registered health professions. Further consideration would be required as to whether all of the professions included within the scope of this definition would have the necessary competence by virtue of their professional registration to undertake these procedures.

Impact of enforcing the licensing system on local authorities

We support the view of the Wales Heads of Environmental Health Group that the proposed licensing system will enable local authorities to carry out their public protection duties more effectively. The ability to recover costs will provide local authorities with the finance to undertake their enhanced role.

Health risks associated with electrolysis and acupuncture

The addendum addresses this matter. It is informed by a review of the scientific literature since 2000 and by an analysis of the findings from the look back exercise undertaken recently in Newport, Gwent following concerns about skin infections identified in clients who had used a piercing and tattoo studio.

Other comments

Section 75 (5) of the Bill (Special procedure licence: licence holder remedial action notices) should be clarified so as to ensure that where there is a risk to public health, there is the provision to stop an individual undertaking procedures with immediate effect.

Public Health Wales believes that the Bill should place a duty on practitioners to check the age of those presenting for a special procedure, as we do not believe it is sufficient to solely ask for a client's age. We would also advocate that the level of fine for non compliance should be increased from level 3 to level 5.

We have already highlighted other procedures that we believe need to be regulated (body modification, injection of any liquid into the body, laser treatments). Whilst these may be under review as part of specific requirements for cosmetic procedures,

we believe this situation needs to be monitored closely to ensure that these procedures are covered by a legislative framework.

4 Part 4: Intimate Piercing

Prohibiting intimate piercing of anyone under the age of 16 in Wales

Public Health Wales supports these proposals.

Intimate body parts defined in the Bill

We would also propose that the risks posed by piercing of the lip also offer significant risks to the health of children and that the scope of the proposed regulations should be extended to include this area of the body.

Placing a duty on local authorities to enforce the provisions, and to provide local authorities with the power to enter premises, as set out in the Bill

Public Health Wales agrees with these proposals.

The role of proposals relating to intimate piercing in contributing to improving public health in Wales

Public Health Wales agrees that these proposals will strengthen the protection of public health in Wales by protecting some of the most vulnerable in our population.

Implementing a minimum age restriction for all body piercings

Public Health Wales recognises that ear piercing in young children is culturally accepted in some populations in Wales.

Current evidence indicates that if there is parental consent and support for ear piercing and if sterile piercing equipment is used in a sterile and appropriate environment and the correct aftercare is provided, then there is no evidence of increased risk of infection in children.

As such, we do not believe there is sufficient evidence to challenge current practice.

5 Part 6: Pharmaceutical Services

Delivery of additional pharmaceutical services at community pharmacies can increase NHS capacity and improve access (location, extended opening hours and availability of some services without an appointment). The proposed changes mean

that Health Boards will be better able to identify which additional pharmaceutical services they wish to commission, where, and at what times to meet the needs of their populations.

Pharmaceutical services are more likely to be considered as part of wider health service planning and will be offered where there are advantages to the population and Health Board. The proposed legislation will also enable Health Boards to undertake service redesign.

Overall, Public Health Wales is fully supportive of the proposals outlined with the Bill in relation to Pharmaceutical Services.

Improving the planning and delivery of pharmaceutical services in Wales

Public Health Wales agrees that the proposals will improve the planning and delivery of pharmaceutical services.

By undertaking a Pharmaceutical Needs Assessment (PNA) and aligning the PNA with other needs assessment and planning processes, Health Board planning of pharmaceutical services is more likely to be integrated and aligned with wider health needs assessment and health service planning, rather than being undertaken in isolation.

Encouraging existing pharmacies to adapt and expand their services in response to local needs

Under the proposals, existing pharmacies will be encouraged to respond to commissioner requests to deliver additional pharmaceutical services to meet identified needs listed in the PNA. If the contractor does not provide the services requested, they face the risk of another contractor making a successful application to join the pharmaceutical list in their area. Not only would the new contractor provide the additional pharmaceutical services, but they would also compete for NHS prescriptions and over-the-counter sales, which are important sources of income for community pharmacy contractors, thus leading to a potential loss of income for the existing pharmacy.

Other comments

Public Health Wales believes that it is crucial that the development of PNAs is aligned with wider Health Board planning and commissioning.

6 Part 7: Provision of Toilets

Local authority duty to prepare and publish a local toilets strategy for its area

Public Health Wales is in no doubt that the provision of toilets for public use should be regarded as an important public health issue. We fully recognise the challenges of safeguarding the existing provision or improving provision in the current economic climate. Whilst the preparation of a strategy that considers the need for and plans for the future provision of toilets for public use would provide clarity at the local level (for elected members, officers and the public) the real issue of making resources available to address this issue remains. The writing of a strategy alone will not automatically improve provision.

Public Health Wales recognises that access to toilet facilities when away from home is an important public health issue, but precise quantitative evidence of need is often lacking. Publicly accessible toilets are a necessity to maintain population health for everyone, but some groups have specific needs. These groups include people with disability, parents with babies and young children, pregnant women, older people and those with specific conditions including incontinence, inflammatory bowel disease, irritable bowel syndrome, multiple sclerosis, and people who have been prescribed diuretics. If toilet provision is inadequate, people can become afraid or reluctant to go leave their home for periods of time, leading to poor mobility, isolation and depression.

Impact of a local toilet strategy on improved provision of public toilets

Public Health Wales is cognisant of the financial pressures experienced by local authorities at this time. Local authorities are best placed to comment on their ability to safeguard existing provision and to promote new facilities. A requirement to undertake health impact assessment of changes to service provision and policy decisions would inform the consideration of the adequacy of public toilet provision in an area.

Ensuring appropriate engagement with communities to guarantee the views of local people are taken into account in the development of local toilet strategies

Section 112 (1) of the Bill refers not only to communities but includes “any person it considers likely to be interested in the provision of toilets in its area”. This should include not only local communities but also, for example, those representing specific age groups, people with disabilities or impairments or those with medical problems. Consultation should also include the needs of homeless people, mobile workers and visitors to the area. It is essential that toilet provision should be adequate at transport hubs and in city centres where local communities will be a minority of potential users.

The impact of Welsh Ministers’ ability to issue guidance on the development of strategies

Guidance on the development of strategies is likely to lead to a more consistent approach across local authorities.

Toilet facilities within settings in receipt of public funding

It would be useful if toilet facilities could be made accessible to the public in settings such as leisure centres, libraries, subsidised theatres, arts centres, galleries and museums. This is already the case in some of these venues but may not be widely known by some members of the public. However, this would not be a complete answer to provision for public use due to restricted opening hours.

Including changing facilities for babies and for disabled people within the term ‘toilets’ to ensure that the needs of all groups are taken into account

Including changing facilities for babies and for disabled people within the term ‘toilets’ is insufficient to ensure that the needs of all groups are taken into account in the development of local toilet strategies. Publicly accessible toilets are a necessity to maintain population health for everyone, but some groups have specific needs. These groups also include parents with young children, pregnant women, older people and those with specific conditions including incontinence, inflammatory bowel disease, irritable bowel syndrome, multiple sclerosis, and people who have been prescribed diuretics.

The contribution of toilet provision to improving public health

Provision of more toilets for public use should contribute to improving public health, but only if they are well designed and appropriately located with high standards of maintenance and cleaning. Different categories of user and their specific needs should be considered when making provision, as set out above.

7 Finance questions

Costs and benefits of implementing the Bill

We have noted the costs and benefits of implementing the Bill in the Regulatory Impact Assessment. Most of the additional costs of implementing the Bill are borne by local authorities, Welsh Government, businesses and local health boards.

The economic downturn has resulted in strain being placed on public bodies, including the NHS and local authorities. Any additional duties mean that there is an opportunity cost around what can be provided with limited resource available. As the proposed legislation places significant additional duties on local authorities, we believe that they should be sufficiently funded to enable them to meet these requirements e.g. through cost recovery.

Public Health Wales believes that the Bill will help to improve and protect the health of the population of Wales and that the costs are proportionate.

Accuracy and completeness of the estimates of costs and benefits identified in the Regulatory Impact Assessment

The Regulatory Impact Assessment provides detailed estimates of cost and benefit.

Public Health Wales is unable to comment on the accuracy of the costs to other organisations.

Overall, most costs and benefits appear to have been considered in the Assessment, including costs to the health sector and health benefits.

Financial impact of the Bill on Public Health Wales

The areas that may have a financial impact on Public Health Wales are:

- Special Procedures

We welcome the proposal to include Public Health Wales in the development of guidance in relation to special procedures, to assist practitioners and businesses in their understanding of the legislation and its requirements. This is likely to have opportunity costs for Public Health Wales. We will address this through realigning our priorities in order to meet this need.

- Pharmaceutical services – Pharmaceutical Needs Assessment

Public Health Wales has been identified as a stakeholder in the task and finish group to oversee and develop guidance to support local health boards in undertaking a PNA and overseeing market exit. We note that the anticipated resource implications for Public Health Wales are three people attending up to half day meetings, costed at £2,800. We anticipate that representation at these stakeholder meetings will be from Pharmaceutical Public Health and Public Health Wales Observatory. We agree with the proposed costings for this.

We have also identified that the Pharmaceutical Public Health Team, the Primary Community and Integrated Care Team and the Public Health Wales Observatory and potentially the IM&T Team are likely to need to support local health boards with the content of the PNA, as well as with stakeholder and public engagement. This may require the development of webpages to achieve this.

Public Health Wales, via its Integrated Medium Term Plan 2016–19, has committed to supporting local health boards with the development of PNAs and will be looking to prioritise work to ensure that it is able to deliver this.

Additional costs of the Bill's proposals to businesses, local authorities, community councils and local health boards

As mentioned previously, most of the costs will be borne by organisations other than Public Health Wales.

Overall, we consider that the additional costs are reasonable and proportionate.

8 Delegated powers

Balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance

We agree that the Bill does contain a reasonable balance between what is included in the Bill itself and what is included in subordinate legislation.

We have already commented on the need for subordinate regulation for modifying the list of special procedures included in the Bill.

Addendum – Health risks associated with electrolysis and acupuncture

a) Summary of evidence on Acupuncture, Electrolysis, Tattooing and Piercing

A review of evidence in scientific literature since 2000 examined the reported impacts of the four special procedures outlined in the draft Public Health Bill. This review identified 206 published articles from across the world and reviewed them to draw out key themes. The key points from this review were:

1 – Range and severity of potential adverse consequences is consistent across the four procedures.

Infections were the most commonly reported adverse consequences in case reports for all procedures identified. The causative agents for these infections were a wide range of bacteria, including *Haemophilus parainfluenzae*, *Staphylococcus aureus*, *Listeria monocytogenes*, *Pseudomonas* species, Non-tuberculous *Mycobacterium* and *Enterococcus faecalis*, and viruses (e.g. Hepatitis).

In interpreting these findings it is important to note that the nature of the complications reported are different depending on the nature of the study reporting them. Cohort studies involving practitioner reporting of complications generally show high levels of minor consequences (e.g. minor bleeding, itching). This is a different picture to the case reports published by medical professionals which describe more unusual or severe outcomes and outbreaks. This makes estimation of the prevalence of infections following the procedures difficult.

Outbreaks of infectious disease have been reported in the academic literature for all of the special procedures listed. Similar causative agents (e.g. Non-tuberculous *Mycobacterium species* or hepatitis virus) are seen across these outbreaks.

The numbers of studies or reported cases are not necessarily the same, but this may reflect differences in prevalence of the procedure or management and reporting of cases. This is exemplified by electrolysis where only one study was identified within the time period and one older outbreak was subsequently identified. This may reflect a lower risk or a lower prevalence of the procedure being used – there is not sufficient evidence to say which of these applies.

As all procedures proposed in the legislation involve piercing the skin with a needle and the skin is the body's first line of defence against infection there is a *prima facie* case that the risks of infection posed by the procedures are similar. This is apparent in the evidence identified and for most procedures the organisms reported to be

causing infection are similar. It is therefore important to ensure that standards of infection control and awareness of infections are similar across the procedures.

2 - Risk of severe outcome is dependent on type and location of procedure and patient characteristics

With many of the infectious adverse events the consequences range from minor localised infection to fatal or life changing outcomes for the case. There is evidence that there are a number of factors which contribute to the severity of the outcome for patients. These factors include susceptibility of the client to serious infection and the body site where the procedure is carried out.

It is clear that diabetes and congenital heart conditions feature regularly in the case reports of severe and fatal outcomes. It is also clear that in some cases the client was aware of the condition but not that it carried an increased risk for the procedure. The outcomes including invasive group A streptococcus infection and infective endocarditis carry large costs for health services (e.g. heart valve transplant) and risks to the patient. Some evidence suggests that risks can be reduced in these vulnerable cases by good infection control or measures such as antibiotic prophylaxis.

For some special procedures specific locations and practices have been associated with increased risk. In piercing there is evidence that some piercing sites (high ear, tongue) carry substantially higher risks of complications and subsequent infection than others. This evidence of location specific risk does not exist for other special procedures. It is clear that tongue piercing in particular carries an especially high risk of complication for individuals, including bacterial endocarditis, aspiration of jewellery and dental issues, compared to other sites. Additionally, high ear piercing was associated with a larger number of outbreaks (mostly pseudomonas species) compared to other piercing sites. Similarly dilution of black ink to create grey during tattooing has been associated with a number of outbreaks of Non-tuberculous mycobacterium in the UK and worldwide.

It is therefore important that practitioners are equipped with sufficient knowledge of the risks to vulnerable patients and the increased risks associated with certain locations and practices in order to minimise the risk for patients and the population. Studies of practitioner knowledge in the UK suggest that this is not currently the case and minimum standards of training have been advocated.

Conclusion

Measures proposed by the Public Health (Wales) Bill requiring minimum standards for knowledge and practice for all special procedures to be set and enforced are proportionate to reduce the risks faced and necessary to protect public health. All

four special procedures share the same risk factor, a needle is used to pierce the skin. Although each has technical differences, which alter the likelihood of infection transmission and the severity of infection if acquired, the similarity between the basic technique means that all should be regulated in the same way. The case in Wales supporting these conclusions has been reinforced by the findings from a recent health protection incident in Newport, Gwent, as described in the next section.

b) Newport look back

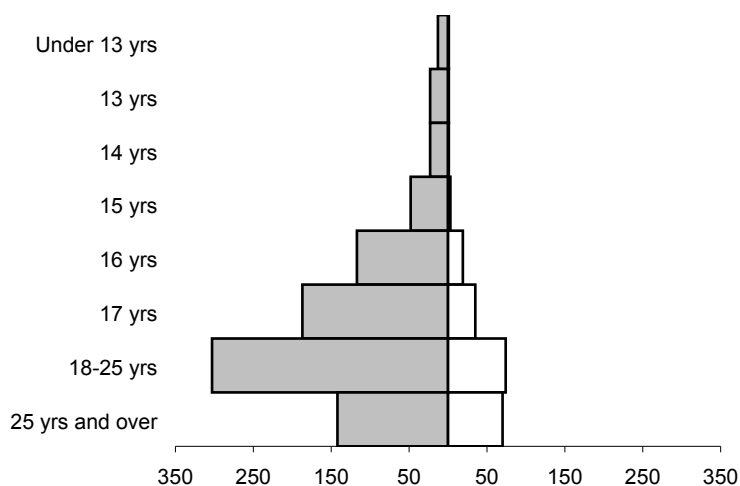
A cohort of people at risk of infection following a body piercing or tattoo at a premises under investigation (termed 'at-risk cohort') was identified. This 'at-risk cohort' was identified from client lists held at the premises and from people who self-presented following media reports of the incident, either through a Public Health Wales helpline or by directly attending a clinic session for a blood borne virus screen. The cohort represents only those who were known to the Health Board, and is unlikely to include all those who attended the premises under investigation.

In total 1069 people were included in this 'at risk cohort'; 680 from client lists, 337 from people contacting the Public Health Wales helpline and considered to be at risk, and 44 who self presented at a clinic session. Source of referral was not recorded for 8 people.

Age of cohort

Figure 1 illustrates the age profile of those identified in the look back exercise. The largest proportion are aged less than 18 years with many under 16 years.

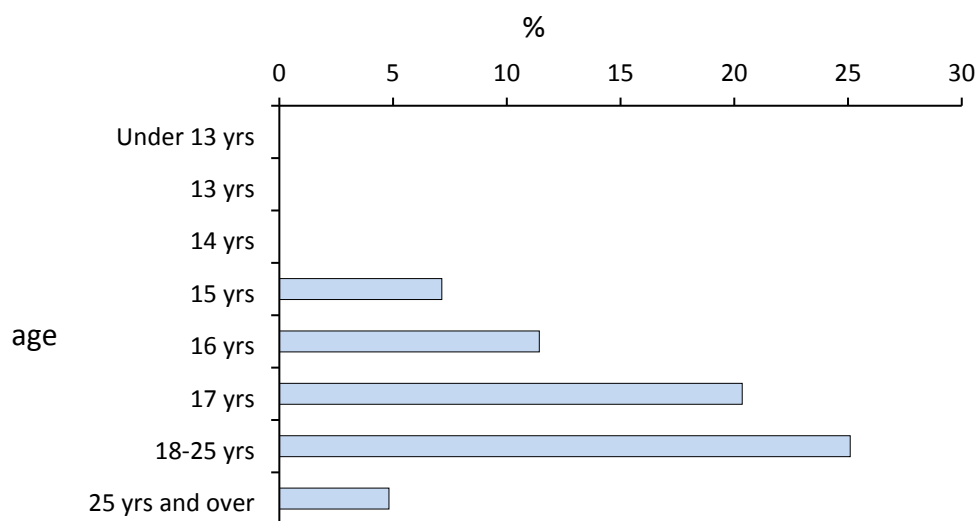
Figure 1. Age¹ and sex distribution of cohort of people considered to be at risk of infection following a piercing or tattoo at the premises under investigation ('at-risk cohort')



¹ Age as at May 2015

Figure 2 illustrates those identified who reported having 'intimate' piercings. It is of note that almost 1 in 15 are under 16 years of age. There are many more under the age of 18.

Figure 2. Proportion of individuals attending for a blood borne virus screen reporting a body piercing at an intimate site (nipples and/or genitals) by age group¹



¹ Age as at May 2015

Evidence of harm

Of the 628 who reported having had a piercing in the previous two years, 215 (34%) reported having had a skin infection following the piercing. Infections were reported across all age groups. Forty-one of the 215 people (19%) reporting a skin infection stated that they had contacted a health service about the infection. Ten reported attending hospital. Twenty-nine percent (28/96 individuals) of those aged less than 16 years reported an infection, compared to 35% of those 16 years or older (187/532).

Proof of age

From table 1 it can be seen that clients under the age of 18, and under 16 in particular, are adding years to their true age to pass themselves off as older. Requiring the practitioner to check proof of age is necessary to overcome this issue.

Table 1: Difference in self- reported age¹ and true age² in 387 clients attending a piercing/tattoo studio under investigation in Exercise Seren by age at time of procedure³

	Reported age greater than true age			Exact age match	Reported age less than true age		
	>2 years	1-2 years	<1 year		<1 year	1-2 years	> 2 years
<13	0%	6%	38%	56%	0%	0%	0%
13	10%	10%	10%	70%	0%	0%	0%
14	13%	33%	8%	38%	4%	0%	4%
15	6%	15%	48%	29%	2%	0%	0%

Public Health Wales				Response to the consultation on the Public Health (Wales) Bill			
16	8%	6%	12%	73%	1%	0%	0%
17	0%	29%	16%	52%	0%	3%	0%
18–25	1%	0%	3%	96%	0%	0%	0%
>25	0%	0%	0%	97%	0%	0%	3%
Total	4%	12%	17%	65%	1%	1%	1%

¹ Age calculated by subtracting client date of birth from date of procedure. Both dates obtained from piercing studio client records

² Age calculated from dates of birth obtained by checking client's details against Welsh Demographics Service

³ First known visit for piercing and/or tattoo. (Clients reported more than one visit and multiple procedures on same visit)

Appendix 2 – Minimum Unit Pricing Alcohol

Additional Material from Public Health Wales NHS Trust Response to the Consultation on the Public Health White Paper – Listening to You Your Health Matters

Public Health Wales shares the Welsh Government’s concerns regarding the levels of alcohol related harm in Wales. We support the view that the consideration of public health should be one of the statutory licensing objectives under the Licensing Act 2003 and that all other available controls should be maximised at the local level. Most notably, the opportunities of the local development planning process should be promoted to ensure that health impacts are taken into account during local decision making. The Public Health Wales evidence based position on the issue of Minimum Unit Price is reproduced in full in our response, for completeness and accuracy, recognising that there is a notable overlap with the evidence presented in the White Paper.

Minimum Unit Pricing

Given the evidence base and public health considerations, do you agree that the Welsh Government should introduce a Minimum Unit Price for alcohol?

There is compelling evidence that introducing a minimum unit price in Wales would lead to significant improvements in health and well-being. Recent decades have seen increases in alcohol consumption and health harms associated with alcohol across Wales. These increases are linked with real terms reductions in the cost of alcohol. A minimum unit price is a targeted measure that will impact beneficially on the heaviest drinkers and other groups particularly at risk from alcohol related harms – such as young people. Moderate drinkers will experience relatively little change in the amount they have to pay for alcohol. The evidence for this is presented below and as a result of this compelling evidence Public Health Wales strongly supports implementation of the minimum unit price for alcohol in Wales.

Minimum Unit Price (MUP) sets a floor price for a unit of alcohol⁹, meaning that alcohol could not legally be sold below that price. This would not increase the price of every drink, only those that are sold below the minimum price; for example very cheap spirits, beer and wine. MUP is based on two fundamental principles that are widely supported by scientific evidence:^{10,11,12}

⁹ 25ml spirit (40%) is one unit, 175ml of wine (13%) 2.3 units, a pint of cider (4.5%) 2.6 units, a pint of beer (4%) 2.3 units;

¹⁰ Stockwell and Thomas, (2013) Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol. Institute of Alcohol Studies Report

¹¹ Wagenaar AC, Salois MJ, and Komro KA (2009) Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction*, 104, 179-90

- When the price of alcohol increases consumption by most drinkers goes down including, critically, consumption by hazardous and harmful drinkers (i.e. heavier drinkers)
- When alcohol consumption in a population declines, rates of alcohol-related harms also decline

Drinking alcohol increases the risk of developing over 60 different health problems¹³ including a range of cancers, liver disease, high blood pressure, injuries and a variety of mental health conditions. It also increases the risk of causing harms to the health of others.

UK Government guidelines for the consumption of alcohol recommend that to limit the harms from alcohol to their health: men should not regularly (every day or most days of the week) drink more than the lower risk guidelines of 3–4 units of alcohol (equivalent to a pint and a half of 4 per cent alcohol by volume [ABV] beer) and women more than 2–3 units (equivalent to a 175 ml glass of wine)¹⁴.

The 2011 General Lifestyle Survey (GLS¹⁵) showed that the percentage of persons that drank more than 3–4 units on at least one day in Wales (28 per cent) was similar to Scotland (31 per cent) and England (31 per cent). Those drinking more than 6–8 units on at least one day was the same in Wales (15 per cent) as in England (15 per cent) and similar to Scotland (16 per cent). Residents of England and Wales (13 per cent and 12 per cent respectively) were more likely than men in Scotland (7 per cent) to have had an alcoholic drink on at least five days in that week.

The Welsh Health Survey¹⁶ (2012) reported that around two in five (42 per cent) adults reported drinking above the recommended guidelines on at least one day in the past week, including 26 per cent who reported binge drinking (drinking more than twice the daily guidelines). Men were more likely than women to report drinking above the recommended guidelines on at least one day in the past week (48 per cent of men compared with 36 per cent of women) and to report binge drinking (31 per cent of men, 21 per cent of women).

¹² Wagenaar, A., Tobler, A. and Komro, K. (2010) Effects of alcohol tax and price policies on morbidity and mortality: A systematic review. *American Journal of Public Health*, published online September 23, 2010 at: <http://ajph.aphapublications.org/cgi/content/abstract/AJPH.2009.186007v1>

¹³ World Health Organisation (2009) Harmful Use of Alcohol http://www.who.int/nmh/publications/fact_sheet_alcohol_en.pdf

¹⁴ The UK CMOs' Alcohol Guidelines Review (2016) is for both men and women to not drink more than 14 units per week and to spread this over 3 days or more.

¹⁵ Office for National Statistics, (2011) 'General Lifestyle Survey' [online] Available at: <http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/index.html>

¹⁶ Welsh Government (2012) 'Welsh Health Survey' [online] Available at: <http://wales.gov.uk/statistics-and-research/welsh-health-survey/?lang=en> WHO. Alcohol policy in the WHO European Region: current status and the way forward.

Importantly, social surveys consistently record lower levels of consumption than would be expected from data on alcohol sales, partly because people often underestimate how much alcohol they consume.

Although alcohol sales data are not available for Wales, 2012 sales data for the UK show that consumption was estimated at 22 units per person per week. This is a much greater level than recorded in surveys and suggests that more people exceed weekly guidelines than surveys would suggest.

The past four decades have seen a rise in alcohol consumption and although the reasons behind this are complex and multi-factorial, affordability is a key factor. It has been reported that alcohol is 45 per cent more affordable than in 1980 and the increase in affordability of alcohol has been linked with increased alcohol consumption and related health harms^{17,18,19,20}.

Men and women in the UK can now exceed recommended daily limits for about £1 if they purchase inexpensive alcohol from supermarkets or other off-trade outlets²¹.

A 2005 review by the World Health Organisation (WHO)²² of 32 European alcohol strategies found that the most effective measures to curb alcohol related health harms include changes to price and availability.

By comparison other measures (public service campaigns, education initiatives, and voluntary self regulation preferred by the alcohol industry) have more limited impacts on drinking patterns and problems.

This evidence has led several countries to consider MUP policy²³.

¹⁷ Institute for Social Marketing: University of Stirling (2013) '*Health First: An evidence-based strategy for the UK*' [online] Available at: <http://www.stir.ac.uk/management/about/social-marketing/>

¹⁸ Home Office (2012) *A minimum unit price for alcohol: impact assessment 1A*. Home Office, London, UK.

¹⁹ Anderson, P., Chisholm, D. and Fuhr, D. (2009) Alcohol and Global Health 2: Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet*, 373, 2234–46.

²⁰ Gallet, C.A. (2007) The demand for alcohol: a meta-analysis of elasticities. *Australian Journal of Agriculture and Resource Economics*, 51, 121–35.

²¹ Institute for Social Marketing: University of Stirling (2013) '*Health First: An evidence-based strategy for the UK*' [online] Available at: <http://www.stir.ac.uk/management/about/social-marketing/>

²² WHO fact sheet. 2005. www.parpa.pl/download/fs1005e2.pdf.

²³ Holmes, J., Meng, Y., Meier, P.S., Brennan, A., Angus, C., Campbell-Burton, A., Guo, Y., Hill-McManus, D. and Purshouse, R.C. (2014) Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. *Lancet*, 383, 1655–1664

Do you agree that a level of 50 pence per unit is appropriate? If not, what level do you think would be appropriate?

Based on the evidence provided here, Public Health Wales regards a level of 50 pence per unit MUP as an appropriate level at which to initially establish a MUP. Sufficient modelling has already been undertaken in England and elsewhere to estimate the benefits that a 50 pence MUP would have on alcohol consumption and related health harms. However, this is based on current levels of affordability of alcohol (2014), and we consider that MUP should be linked to an inflationary measure to ensure it remains an effective measure to reduce alcohol health harms. Should the introduction of MUP be delayed the initial MUP should be adjusted from 50p to account for inflationary trends up to the point of its introduction.

Both US and UK data show that the heaviest drinkers gravitate towards the cheapest alcohol^{24,25}. As a result MUP affects heavy drinkers' consumption much more than light or moderate drinkers. Consequently, MUP is a targeted measure which primarily impacts heavy drinkers.

In England, modelling suggests that a 50 pence MUP would result in:

- a harmful drinker drinking 368 fewer units per year
- a moderate drinker drinking 11 fewer units per year
- an annual reduction in alcohol related deaths of 12.3 per cent and in alcohol related hospital admissions of 10.3 per cent

Concerns around the possibility of a hard-hitting impact on those with low incomes have been a critical consideration of MUP debate,^{26,27} however, for the majority of people on low incomes who are abstainers, light or moderate drinkers, the financial impacts of MUP are very small.

While a moderate drinker may see a small increase in costs of alcohol per year with a MUP of 50 pence (around £43.17– £55.57²⁸, however, this figure is based on the average drinker per annum), this should be seen in the context of national costs from alcohol related harms (health, social, economic and criminal justice) being

²⁴ Kerr, W. C. and T. K. Greenfield (2007). "Distribution of alcohol consumption and expenditures and the impact of improved measurement on coverage of alcohol sales in the 2000 National Alcohol Survey." *Alcoholism: Clinical and Experimental Research*, 31, 1714-1722.

²⁵ Meier, P., Brennan, A., Purhouse, R., Taylor, K., Raffia, R., Booth, A., O'Reilly, D., Stockwell, T., Sutton, A., Wilkinson, A. and Wong, R. (2008) *Independent review of the effects of alcohol pricing and promotion, Part B. Modelling the Potential Impact of Pricing and Promotion Policies for Alcohol in England: Results from the Sheffield Alcohol Policy Model, Version 2008(1-1)*. University of Sheffield, Sheffield, UK. Report commissioned by the UK Department of Health.

²⁶ Hansard. House of Commons Debate 14 March 2013. *Hansard* 2013; **560**: 451–91.

²⁷ Duffy, J.C. and Snowdon, C. (2012) The minimal evidence for minimum pricing: the fatal flaws in the Sheffield alcohol policy model. <http://www.adamsmith.org/blog/liberty-justice/the-minimal-evidence-for-minimum-pricing> (accessed July 2, 2013).

²⁸ Purhouse, R., Brennan, A., Latimer, N., Meng, Y., Rafia, R., Jackson, R. and Meier, P. (2009) Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0) <http://www.nice.org.uk/nicemedia/live/11828/45668/45668.pdf>

equivalent to around £900 per family. These harm-related costs could be substantially reduced if a MUP was introduced.

Work in Scotland suggests that an MUP of 50 pence per unit would reduce alcohol-related hospital admissions in Scotland by 8,900 annually and would reduce alcohol related criminal offences by 4,200, with a total value of an estimated saving of £1.3 billion over 10 years.²⁹

The inclusion of impacts of MUP on crime is an important health and well-being consideration. Therefore, as well as harm to the individual who is drinking, alcohol consumption can also impact the well-being of wider society through reducing alcohol-related crime, including those relating to violent, anti-social and disorderly behaviour, acquisitive crime and criminal damage.

The Crime Survey for England and Wales reports that within the year 2011/12 there was 917,000 violent incidents where the victim believed the offender(s) to be under the influence of alcohol, accounting for 47 per cent of violent offences that year. Alcohol routinely accounts for over 40 per cent of all violent crimes committed³⁰ and, as well as youth violence, is strongly associated with domestic violence, child abuse and self-directed violence (e.g. suicide)³¹.

In Scotland 50 per cent of people reported one or more harms as a result of someone else's drinking in the last year³².

Modelling undertaken for England and Scotland suggest a MUP of 50 pence would reduce alcohol related violence.

A MUP of 50 pence would not impact the cost of alcohol in licensed settings (e.g. pubs) but would increase the cost of the cheapest alcohol sold in off-licences settings (e.g. supermarkets). This is an important affect as the difference in costs between the two settings is driving health harming behaviours such as pre-loading with alcohol especially in young people, before going out for a night³³.

²⁹ School of Health and Related Research, University of Sheffield. Model-based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland. www.shef.ac.uk/polopoly_fs/1.956081/file/scottishadaptation.pdf.

³⁰ British Crime Survey, ONS;

<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Crime+in+England+and+Wales>

³¹ World Health Organisation (2006) Interpersonal violence and alcohol.

http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/pb_violencealcohol.pdf

³² Alcohol Focus Scotland (2013) Unrecognised and under-reported: the impact of alcohol on people other than the drinker in Scotland. <http://www.alcohol-focus-scotland.org.uk/alcohol-harm-to-others>

³³ Barton, A. and Husk, K. (2012) Controlling pre-loaders: alcohol related violence in an English night time economy, *Drugs and Alcohol Today*, 12, 89-97.

Do you agree that enforcing Minimum Unit Pricing for alcohol would support the reduction in alcohol related harms? Please provide evidence to support your answer, if available.

Public Health Wales agrees that enforcing a MUP for alcohol would reduce alcohol related harms. We have presented much of the evidence to support this position in the above sections. We have provided some additional information below.

MUP in Canada has proved a successful measure for reducing alcohol-related harms; including reducing alcohol-related deaths.³⁴

In British Columbia with a population of 4.6million, a 10 per cent increase in the average minimum price of all alcoholic beverages was associated with a 9 per cent decrease in acute alcohol-attributable admissions and a 9 per cent reduction in chronic alcohol-attributable admissions two years later³⁵. It was estimated from this that a 10 cent (approximately 6 pence) increase in average minimum price was associated with 2 per cent (166) fewer acute admissions in the first year and 3 per cent (275) fewer chronic admissions two years later. Canada is one of six countries that have introduced some form of MUP and in every case the observed impacts on reducing consumption (and consequently preventing related harms) have been larger than those estimated.

The estimated costs to the health service in Wales of alcohol-related harm are between £70 and £85 million each year.³⁶ These costs have increased since the 1970s, as alcohol has become more affordable and alcohol-related deaths and disease have risen. Therefore, Wales appears to be price sensitive to alcohol with harms increasing as alcohol becomes more affordable.

Thus, the number of alcohol-related deaths³⁷ for males in Wales from alcohol increased from 236 in 2002 to 311 in 2012. The corresponding increase for females was 34 per cent from 127 to 193 deaths. The number over the last five

³⁴ Zhao, J., Stockwell, T., Martin, G., Macdonald, S., Vallance, K., Treno, A., Ponicki, W., Tu, A. and Buxton, J. 2013. The relationship between changes to minimum alcohol price, outlet densities and alcohol-related death in British Columbia, 2002-2009. *Addiction*. URL:<http://onlinelibrary.wiley.com/doi/10.1111/add.12139/pdf>.

³⁵ Stockwell, T., Zhao, J., Martin, G., Macdonald, S., Vallance, K., Treno, A., Ponicki, W., Tu, A. And Buxton, J. (2013) Minimum alcohol prices and outlet densities in British Columbia, Canada: estimated impacts on alcohol-attributable hospital admissions. *American Journal of Public Health, 103*, 2014-20.

³⁶ Welsh Assembly Government (2008) 'Working Together to Reduce Harm, The Substance Misuse Strategy for Wales 2008-2018'.

³⁷ 'Alcohol-related deaths' follow the Office for National Statistics (ONS) definition of alcohol-related deaths (which includes causes regarded as most directly due to alcohol consumption). ONS has agreed with the GROS and NISRA that this definition will be used to report alcohol-related deaths for the UK. In January 2011, the software used by the Office for National Statistics (ONS) for cause of death coding was updated from the ICD-10 v2001.2 to v2010. The main changes in ICD-10 v2010 are amendments to the modification tables and selection rules, which are used to ascertain a causal sequence and consistently assign underlying cause of death from the conditions recorded on the death certificate. Overall, the impact of these changes is small although some cause groups are affected more than others. Please refer to [Results of the ICD-10 v2010 bridge coding study, England and Wales - 2009](#). Please note that these mortality figures have NOT been adjusted in any way to compensate for these changes.

years has declined slightly from 541 in 2008 to 504 in 2012 but actually rose again between 2011 and 2012.³⁸

Wales's (episode-based) rates for hospital admissions caused solely by alcohol (e.g. alcoholic liver disease or alcohol poisoning) has increased consistently from 2001/02 to 2011/12. Among females, alcohol-specific admissions per 100,000 population increased from 2001/02 (274.4) to 2011/12 (335.5), with a comparable increase among males (537.5 in 2001/02 to 675.5 in 2011/12).

When considering alcohol specific conditions plus alcohol related conditions (those that are caused by alcohol in some, but not in all cases; e.g. stomach cancer and unintentional injury) in the past 10 years, the overall rate in Wales has increased (1,280.9 in 2001/02 to 1,643.7 in 2011/12). This increase has been observed among females (951.6 to 1,185.4) and males (1,650.5 to 2,158.0).

Many of the health harms associated with alcohol fall disproportionately on the most deprived communities, with levels of alcohol related deaths across Wales increasing from the most affluent to the most deprived quintile. Consequently, tackling alcohol related ill health is an important element in reducing inequalities in health³⁹.

Based on evidence from Canada and elsewhere, MUP would help substantially in reversing these health harming trends relating to alcohol consumption in Wales.

As the Welsh Government cannot legislate on the licensing of the sale and supply of alcohol, what enforcement and/or penalty arrangements do you think should be in place to introduce Minimum Unit Pricing for alcohol in Wales?

Public Health Wales is not currently in a position to provide specialist legal advice on the implementation of a Minimum Unit Price for alcohol across Wales. However, we would suggest the points below are taken into consideration:

- We are aware the issue of compatibility between European law and MUP has been raised as an issue. We understand that certain articles prohibit quantitative restrictions between Member States on the Union's founding principle that goods must be able to move freely between Member States
- Opponents to MUP argue that if goods are subjected to minimum prices in one Member State this could act as a barrier to the free movement of such goods

³⁸ PEDW; NWIS

<https://www.healthmapswales.wales.nhs.uk/IAS/dataviews/report/multiple?reportId=60&viewId=117&geoTypeId=7,2>

³⁹ A Profile of alcohol and health in Wales (2009)

[http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/85c50756737f79ac80256f2700534ea3/0400558233b1c95c802576ea00407a33/\\$FILE/Alcohol%20and%20health%20in%20Wales_WebFinal_E.pdf](http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/85c50756737f79ac80256f2700534ea3/0400558233b1c95c802576ea00407a33/$FILE/Alcohol%20and%20health%20in%20Wales_WebFinal_E.pdf)

- However, European law stipulates that such articles do not preclude consideration of public morality, public policy or the protection of health and the lives of humans. In other words measures such as MUP could be introduced when the public health case is sufficiently strong
- Any measures implemented on the basis of Public Health must be proportionate. In other words it is important to demonstrate that public health benefits sought justify the measures implemented and that the same outcome would not be achievable by a less intrusive measure
- Public Health Wales believes that there is a strong case across Wales that MUP is a measure proportionate to expected reductions in health harms and numbers of lives saved
- Further, we understand that when raised by the Association of Greater Manchester Authorities, their legal advice refuted the claim that minimum pricing imposed at the sole instigation of a public authority would be an infringement of national and EU competition law
- As the measure that is likely to at least involve consideration of law changes and how they would impact public health, Public Health Wales is keen to work with Welsh Government on the possible options to implement MUP
- Public Health Wales would suggest the implementation of bye laws across Wales be explored alongside the use of existing licensing legislation that allows conditions to be attached to alcohol licenses
- As well as legislative measures, it may also be worth considering opportunities to allow additional freedoms and incentives to those who operate a MUP policy on the basis that they are not contributing to the costs resulting from sales of cheap alcohol that fall on health, criminal justice, education systems and the broader economy
- A number of local authorities in England and Wales have taken steps towards implementing MUP. Wales would be well placed to bring these players together to share learning and provide leadership for authorities wishing to tackle alcohol related harms to health through MUP. Public Health Wales would be keen to support such a forum with the support of the Welsh Government

Do you think there are other measures that should be pursued in order to reduce the harms associated with excessive alcohol consumption?

Public Health Wales recommends a range of other evidence based measures should be considered in order to reduce the harms caused by alcohol to Welsh citizens. None of these require MUP so are not dependent on MUP being in place but would work in synergy to reduce alcohol harms to health. Not all of these measures can be unilaterally implemented in Wales as devolved powers do not allow their

introduction. However, we believe Wales can still act as a powerful advocate for creating a culture where people are better informed about the harms associated with alcohol consumption and the real costs of alcohol are reflected in the price at which it is sold. Further work is required to identify the best way of delivering these through action and advocacy within existing devolved powers. While provision of evidence to support all the actions suggested below would be inappropriate in this consultation we believe there is sufficient evidence already available to support⁷:

- Public health and community safety should be given priority in all public policy-making about alcohol
- At least one third of every alcohol product label is an evidence based health warning from an independent regulatory body
- Sales in shops should be restricted to specific times of the day and designated areas with no promotion outside these areas
- Tax on alcohol products should be proportionate to volume of alcohol to incentivise sales of lower strength products
- Licensing authorities should be empowered to tackle alcohol-related harm by controlling total availability in their area
- Alcohol advertising should be strictly limited to newspapers and other adult press while its content should be limited to factual information
- There should be an independent body to regulate alcohol promotion, including product and packaging design for public health and community safety
- The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml.
- Graduated driver licensing should be introduced, restricting the circumstances in which young and novice drivers can drive
- All health and social care professionals should be trained to provide early identification and brief alcohol advice
- People who need support for alcohol problems should be routinely referred to specialist alcohol services for assessment and treatment
- Existing laws to prohibit the sale of alcohol to individuals who are already heavily intoxicated should be enforced in order to reduce acute and long term harms to their health and that of the individuals around them.