Consultation: The UK National Planning Policy Framework (NPPF)

AHA Consultation response – September 2024

Question 70: How could national planning policy better support local authorities in (a) promoting healthy communities and (b) tackling childhood obesity?

The Alcohol Health Alliance (AHA) is an alliance of more than 60 non-governmental organisations working together to reduce alcohol-related harms.

As a significant cause of preventable death and ill-health, we believe there is more that can be done through the planning (and licensing) regulations to better limit the availability of alcohol through regulating the numbers of premises permitted to sell alcohol within designated locations; particularly in areas of high deprivation where local data demonstrates that the largest alcohol harms are felt and where these types of premises can be clustered.

We have a number of key points under this section (questions 70 and 71):

- Alcohol is a health-harming product which plays a causal role in over 200 illnesses and conditions (including 7 cancers) as well as links to obesity due to its high sugar content. It also impacts communities through anti-social behaviour, crime and disorder, and through costs to frontline policing and ambulance services, hospitals, and wider health services
- The higher densities of off-sales alcohol outlets, particularly in deprived communities, is a barrier to promoting healthy communities
- These harms are compounded by clustering of other health-impacting outlets in similar vicinities, such as concentrations of junk food, tobacco/vape and gambling outlets, many of which also sell alcohol and have long daily trading hours. New premises can obtain local authority approval even when the immediate locality is already being over-served by similar outlets
- The easy and almost constant availability of these health-harming products fuels addiction, making them more accessible within comminuities than more health-promoting alternatives. We believe it is time to make a change for the better.
- At present, local authorities are limited on how robustly they can refuse new premises applications on the grounds of health harms, and appeals are both expensive and time consuming for local authorities who are already fiscally challenged. In many instances they stand to lose the case because current licensing and planning frameworks are not explicit enough in supporting public health considerations and so applicants succeed even when local public sector partnerships are able to present robust evidence of chronic localised harms.
- Alcohol advertising (particularly in outdoor spaces frequented by children and young people) has a huge impact on consumption patterns, as well as on early uptake from young people
- Local authorities should be empowered to promote healthy communities by introducing ‘protecting and improving public health’ as a fifth licensing objective, as is the case in Scotland. We would also support Government action to tackle alcohol marketing, particularly marketing in public spaces.

(a) Promoting healthy communities

Alcohol consumption is the biggest risk factor for death, ill-health and disability among 15-49 year olds[1]. The most recent estimates put the total cost of alcohol harm in England alone at £27.44 billion per year.[2] Alcohol-specific deaths are at record-high levels, rising 32.8% between 2019 and 2022[3]. The World Health Organisation (WHO) has highlighted reducing availability of alcohol as one of the most cost-effective measures to tackling alcohol harm. [4]

Healthy communities are intrinsically linked to the planning and licensing systems. The availability of unhealthy products such as alcohol, tobacco and foods high in fat, salt and sugar (alongside how they are marketed and priced) determines what outlets fill our public spaces, thereby affecting consumption levels and local health outcomes. Consumers can make informed choices, but too often their choices are very restricted as to what is available to them locally and this is notably true within our more deprived communities.

Alcohol-related harm is both a determinant and an outcome of socioeconomic inequality.[5] In England, the death rate from alcohol in the most deprived decile is double that in the least deprived,[6] and combined deaths and hospital admission rates due to alcohol are over 60% higher in the most deprived groups than the least.[7] Premature death from alcohol-related liver disease is almost 5 times higher in the most deprived areas of England than the most affluent.[8] It is therefore imperative that public health authorities are given more powers through the planning and licensing systems to ensure decisions about where and when alcohol is sold are based on local alcohol harm data and that local health teams can use their formal role as Responsible Authorities more effectively, through a statutory Public Health Objective within both our spatial planning and licensing systems.

Alcohol availability

The greater availability of alcohol (more premises and/or longer opening hours) results in:[9]

- Easier access to shop-bought or delivered alcohol, making purchases more frequent, due to convenience, increasing consumption and alcohol-related ill-health;
- Continued late-night drinking increasing intoxication levels, accidents, violence, acute illness;
- Greater visibility of alcohol marketing and promotional deals, triggering impulse purchases, making it hard for people trying to cut down, and forming an important element of alcohol marketing to which children and adults are exposed;
- Downwards pressure on alcohol prices due to increased competition between retailers, exacerbated in England where minimum unit pricing is not in place.

Local authorities should be enabled to better control the total availability of alcohol in their local areas to protect the local populations by adding public health as an additional licensing objective, as has been done in Scotland.

---

[1] VizHub - GBD Results. (2019). Global Health Data Exchange, Institute for Health Metrics and Evaluation, University of Washington.
[2] Institute of Alcohol Studies, Economy (accessed 27 August 2024).
[3] Office for National Statistics (2024) Alcohol-specific deaths in the UK: registered in 2022.
[4] World Health Organisation (2017). Tackling NCDs: "best buys" and other recommended interventions for the prevention and control of noncommunicable diseases.
[5] IAS (2020). Alcohol and health inequalities.
[6] OHID (2021). Local Alcohol Profiles for England: short statistical commentary, December 2021
[7] Public Health England (accessed December 2020). Local alcohol profiles for England.
[8] Office for Health Improvement and Disparities (2022). Liver disease profiles
[9] O'Donnell R et al. (2023). Mechanisms of impact of alcohol availability interventions from the perspective of 63 diverse alcohol licensing stakeholders: a qualitative interview study. Drug Educ Prev Polic. 2023;31(3), 338–347.

In their 2012 Impact Assessment for including a health-related objective in the Licensing Act 2003, the Government stated that 'there is a good evidence base for the link between outlet density and alcohol-related harm and to suggest that a reduction in density would lead to a reduction in both alcohol-related health harm and crime and disorder.'[10] An evidence review by Public Health England in 2016 also concluded that 'Areas with more deprivation tend to have greater AOD [Alcohol Outlet Density]. Therefore, policies which seek to regulate the local availability of alcohol have the potential to reduce health inequalities, as they can be used when there is local concern about the impact of alcohol use in a community.'[11]

Support for a new Public Health Licensing Objective

In the UK, the availability of alcohol is mainly determined by local licensing authorities. However, the current licensing objectives in England are too narrow to enable proper consideration of the density of outlets, the different patterns of consumption seen in different groups of drinkers, and how the overall landscape of on and off-trade outlets can undermine public safety and enjoyment.

In their published response to the 2023 Government consultation on licensing easements, the Association for Directors of Public Health (ADPH) summarised key difficulties in the current system:

"Currently, the Licensing Act 2003 gives local authorities (LAs) the ability to assess the suitability of premises wishing to sell alcohol in their local area. In 2011, public health authorities were named as Responsible Authorities, meaning they are invited to comment on applications to sell alcohol. However, comments can only be made on the grounds of one of the four objectives in the Licensing Act: *the prevention of crime and disorder; public safety; the prevention of public nuisance; [and] the protection of children from harm*. A new public health objective should be introduced as part of the Licensing Act 2003. This could allow LAs to take public health impact into account in future licensing decisions. This would also serve as a legal requirement for businesses to think about public health issues, and LAs should be enabled to take action to support this."[12]

A 2016 survey found that 89% of Directors of Public Health in England who responded supported a public health licensing objective, highlighting that: "without this objective—objections were often unenforceable and evidence and insight from public health was not heard (despite local health data being used effectively by Public Health)."[13]

Furthermore, licensing applications for new alcohol sales outlets are almost invariably made once the applicants have already obtained Planning Permission for their new licensed premises. This means they have 'one foot through the door' before they reach licensing and can argue before a Licensing Commmittee that the local Planning Authority has already approved their intended use and their should be no grounds for impediment. It is imperative therefore that the Planning laws also recognise the local health evidence alongside consideration of other envirnomnental factors; notably that alcohol is 'no ordinary commodity' and therefore its impacts upon a proposed location need to be carefully considered when regulating the permitted uses, capacities and trading hours of new developments in Planning.

[10] UK Government (2012), Impact Assessment: Consultation on including a health objective in the Licensing Act 2003 related specifically to cumulative impact
[11] Public Health England (2016) The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An Evidence Review
[12] ADPH (2023), ADPH response to Licensing Act 2023 Regulatory Easements
[13] Local Government Association (2016) *LGA Survey: Public Health and the Licensing Process*

Enabling local authorities to hold firm on application decisions

Local authorities have been at the receiving end of large food and drink companies flexing their legal muscles to challenge planning decisions that are detrimental to public health. The lack of a fifth public health licensing objective means that challenging local authority decisions is currently easier for large companies with significant financial resources both to do and to win. Examples include KFC which has so far challenged at least 43 councils in England: in more than half of these cases, the decision was overturned, significantly undermining local authority efforts to champion public health and tackle childhood obesity.[14]

The experience in Scotland shows that, since the introduction of the public health licensing objective, the engagement and participation of public health partners in the licensing process has significantly increased. Moreover, health evidence has increasingly been used to inform licensing policies and subsequent decision making. Further information and a detailed discussion about the strengths and limitations of the public health objective in Scotland can be found in Alcohol Focus Scotland's 2016 report *Taking Stock*.[15]

(b) Tackling childhood obesity

Alcohol links to obesity

Research into obesity and alcohol consumption has found a 'supra-additive interaction' between the two, particularly in relation to liver disease.[16] A study led by Liverpool John Moores University found that, independent of total consumption, deprived drinkers were more likely to smoke, be overweight and report poor diet and exercise. The study concluded that higher rates of smoking, and lower levels of nutrition, were a significant factor in amplifying the harmful outcomes of drinking in poorer communities.[17] Therefore, tackling obesity through creating healthier spaces naturally requires a wider look at overlapping health harming products, such as alcohol and tobacco.

The UK has some of the worst rates of underage drinking in the world. A 2024 report from the World Health Organisation showed that a third of 11-year-olds and more than half of 13-year-olds in England have drunk alcohol - putting it top out of the 44 countries examined in the report.[18]

Alcohol is very energy dense, with a large glass of white wine having the equivalent calories as a slice of pizza,[19] and just two medium-sized glasses of the most calorific wines containing more calories than a McDonald's hamburger.[20] Research by the Alcohol Health Alliance found that a bottle of wine can contain anywhere between 0 to 15 teaspoons of sugar,[21] meaning it is possible to reach the recommended daily sugar intake by drinking just two medium-sized glasses of some of the most popular wines on the market.

---

[14] AHA, ASH and OHA (2024) Killer Tactics: How tobacco, alcohol and unhealthy food and drink industries hold back public health progress
[15] Alcohol Focus Scotland (2016/17) Taking Stock: Views and experiences of alcohol licensing in Scotland in 2016/17
[16] Hart, C. et al (2010). Effect of body mass index and alcohol consumption on liver disease: analysis of data from two prospective cohort studies. BMJ 340:1240.
[17] Bellis, M. et al (2016). The alcohol harm paradox: using a national survey to explore how alcohol may disproportionately impact health in deprived individuals. BMC Public Health, 16, 111.
[18] World Health Organisation (2024) A focus on adolescent substance use in Europe, central Asia and Canada. Health Behaviour in School-aged Children international report from the 2021/2022 survey.
[19] Royal Society for Public Health (accessed 22/03/24) Alcohol calorie labelling https://www.rsph.org.uk/our-work/policy/drugs/alcohol-calorie-labelling-.html
[20] Alcohol Health Alliance (2022), Sugar content in wine revealed: Health experts deem alcohol labelling 'woefully inadequate'
[21] Alcohol Health Alliance (2022), Sugar content in wine revealed: Health experts deem alcohol labelling 'woefully inadequate'

For those who drink, alcohol accounts for nearly 10% of daily calorie intake, with around 3.4 million adults consuming an additional day's worth of calories each week – totalling an additional two months of food each year.[22] What's more, higher calorie content is linked to higher strength drinks which are the most damaging to our health.[23]

Outdoor advertising of unhealthy food and drinks

As a legal but harmful product, the marketing of alcohol has far-reaching implications. Alcohol is heavily advertised, with evidence from the US illustrating that alcohol is marketed around three times as much as the average advertised product.[24] Furthermore, a recent study in Ireland found that 94% of the adult population could recall seeing alcohol marketing in the past month.[25]

Advertising is a significant driver of behaviour, and there is a wealth of evidence demonstrating the causal relationship between exposure to alcohol marketing and consumption, including higher-risk drinking.[26] Research has demonstrated that those who viewed alcohol advertisements consumed more alcohol than those who did not.[27] Taking action to tackle outdoor advertising would be beneficial to reducing consumption of health-harming products, particularly in more deprived areas.

In the joint Alcohol Health Alliance, Action on Smoking and Health and Obesity Health Alliance report 'Holding us Back', the report identified that elements of local environments can significantly affect and drive consumption in a number of ways: In the local area (clustering of fast-food shops, licensed alcohol premises, shops selling tobacco and advertisements); on public transport; via out of home advertising such as posters and billboards; and when buying groceries (for example with in-store multi-buy promotions and adverts).[28]

Despite being legally underage to buy alcohol, children encounter alcohol advertising on public transport and its infrastructure (such as in subway stations, on buses and at bus stops), due to these adverts being in public spaces that children use. There is evidence that children, particularly children living in more deprived areas, spend a substantial amount of time around bus stops and roads.[29]

A recent report from Adfree Cities showed that more than 4 in 5 outdoor billboard advertisements were in areas in the poorest half of England and Wales, and that there is 6 times more advertising in the most deprived decile of England than the least deprived.[30] Industry data also indicates that of the top 5 spenders on outdoor advertising in the UK, 3 of them were fast food companies.[31]

---

[22] Royal Society for Public Health (accessed 22/03/24) Alcohol calorie labelling https://www.rsph.org.uk/our-work/policy/drugs/alcohol-calorie-labelling-.html
[23] Alcohol Health Alliance (2022), Sugar content in wine revealed: Health experts deem alcohol labelling 'woefully inadequate'
[24] Saffer, H. (2020). Evaluating econometric studies of alcohol advertising. *Journal of Studies on Alcohol and Drugs*.
[25] Critchlow, N. et al. (2021). Awareness of alcohol marketing one year after initial implementation of Ireland's Public Health (Alcohol) Act and during the COVID-19 pandemic. *Journal of Public Health*.
[26] Sargent, J. D. et al. (2020). The relationship between exposure to alcohol marketing and underage drinking is causal. *Journal of Studies on Alcohol and Drugs*. Jernigan, D. et al. (2016). Alcohol Marketing and Youth Consumption: A Systematic Review of Longitudinal Studies Published Since 2008. *Addiction*. Anderson, P. et al. (2009). Impact of Alcohol Advertising and Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies. *Alcohol and Alcoholism*.
[27] Stautz, K. et al. (2016). Immediate effects of alcohol marketing communications and media portrayals on consumption and cognition: a systematic review and meta-analysis of experimental studies. *BMC Public Health*.
[28] AHA, ASH and OHA (2023) Holding Us Back: tobacco, alcohol, and unhealthy food and drink
[29] Olsen, J. R. et al. (2021). Exposure to unhealthy product advertising: Spatial proximity analysis to schools and socio-economic inequalities in daily exposure measured using Scottish Children's individual-level GPS data.
[30] Adfree Cities (2024) Unavoidable Impact: How outdoor advertising placement relates to health and wealth inequalities
[31] Outsmart (2023) 2021-2023 Out Of Home Advertising Spend Analysis

As well as demonstrating why outdoor advertising for these products in public spaces should be reviewed in terms of their impacts on community spaces, this also strengthens the argument for local authorities to have more powers to reject planning and licence applications for premises on public health grounds. This could be where local evidence suggests that a new alcohol supplying outlet is likely to further exacerbate existing health harms, widen health inequalities, or where there is already sufficient supply in that locality.

Question 71: Do you have any other suggestions relating to the proposals in this chapter?

The impact of marketing on health, including on children

Alcohol marketing directly influences alcohol consumption, including that of children and young people. There is substantial evidence that exposure to alcohol marketing leads children to start drinking earlier and more than they otherwise would.[32] We feel that more efforts to tackle alcohol marketing are needed alongside licensing and planning reforms to have wider impacts. This could include measures to tackle billboard and other outdoor advertising, particularly in public spaces often frequented by children or in deprived communities.

Research has further shown that existing self-regulatory codes are not working. Despite these codes, which are aimed to protect children from alcohol advertising, more than four in five children report seeing alcohol advertising in the last month.[33] Many brands have successfully established themselves with children. For example, almost seven in ten 11-17-year-olds are aware of the beer brand Guinness, including more than half of 11-12-year-olds.[34]

Further research has confirmed that alcohol advertising appeals to children: more than half of adolescents had overall positive reactions to adverts by Smirnoff (52%) and Fosters (53%) they were shown, and a third (34%) had a positive reaction to a Haig Club advert. Across all three adverts, positive reactions were associated with approximately 1.5 times increased odds of being susceptible to drink among never drinkers.[35]

The current system of advertising regulation for promotions targeting children is often slow and lacks enforcement power (measures such as substantial financial penalties for code breaches, if implemented and enforceable, could act as a deterrent). We would welcome further Government attention on this to protect children from alcohol advertising.

We emphasise that there is already significant public support on this: 76% want marketing restrictions to protect children.[36] The Government urgently need to align bold action on alcohol harm with that on unhealthy food and drinks, in line with the evidence and with public support for these population-wide measures.

---

[32] Anderson, P., et al. (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol and alcoholism*, *44*(3), 229-243; Smith, L. A., & Foxcroft, D. R. (2009). The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. *BMC Public Health*, *9*(1), 51; Booth, A., et al. (2008). Independent review of the effects of alcohol pricing and promotion. Part A: systematic reviews. In *Independent review of the effects of alcohol pricing and promotion. Part A: systematic reviews*. University of Sheffield.

[33] Alcohol Health Alliance UK (2021). No escape: how alcohol advertising preys on children and vulnerable people.

[34] Alcohol Health Alliance UK (2021). No escape: how alcohol advertising preys on children and vulnerable people.

[35] Boniface, S. et al (2022). Underage adolescents' reactions to adverts for beer and spirit brands and associations with higher risk drinking and susceptibility to drink: a cross-sectional study in the UK.

[36] Alcohol in England (2023). Annual findings.