Alcohol etc. (Scotland) Bill

British Medical Association Scotland

Introduction

The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 doctors representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 13,400 doctors.

BMA Scotland welcomes the opportunity to provide the Health & Sport Committee with written evidence outlining its reasons for supporting the Alcohol Etc (Scotland) Bill. Alcohol is the third leading cause of disease burden in Europe and this burden weighs heavy on the NHS in Scotland. A new study, by the University of York, has found that the cost of premature deaths and healthcare related costs are £1.46 billion and £268.8 million respectively. This is a significant increase in previously quoted figures and, if this trend continues, then the NHS will struggle to cope with the additional demand caused by alcohol misuse.

Alcohol misuse is consistently highlighted as an area of public health concern by the BMA membership and has frequently been debated at our Annual Representatives’ Meeting, the policy making body of the Association. In 2006, BMA Scotland surveyed more than 600 members on the issue of alcohol misuse as part of a wider survey of health priorities in Scotland. Around 70% of doctors who took part in this survey supported a strategy to increase the price of alcohol to discourage excessive drinking. 96% of doctors believed that licencees (both on and off sales) must be made to take their legal and social responsibilities seriously with appropriate penalties for those found guilty of selling alcohol to under-age people and more than eight out of ten doctors believed that alcoholic drinks manufacturers should be compelled to clearly label their products.

The results of this survey demonstrate clearly the medical profession’s support for enforcing existing legislation, improving education and awareness and creating further legislation to address the pricing and availability of alcohol which encourages drinking to excess.

The BMA’s views on tackling alcohol misuse have been widely publicised and are detailed in a range of policy documents, most recently Alcohol Misuse: tackling the UK epidemic (2008); Under the Influence (2009); The Human Cost of Alcohol Misuse: doctors speak out (2009). Some of the key policy recommendations highlighted in these publications are reflected in the Scottish Government’s strategic approach to tackling alcohol misuse.
Alcohol misuse and health: the facts

Alcohol is related to more than 60 types of disease, disability and injury\textsuperscript{2}. In 2007/08 there were 42,430 alcohol related discharges from general hospitals in Scotland\textsuperscript{3}. Over the last 30 years, UK liver cirrhosis mortality has risen over 450\% across the population\textsuperscript{4}, with a 52\% increase in alcoholic liver disease between 1998 and 2002\textsuperscript{5}. Scotland now has one of the highest cirrhosis mortality rates in Western Europe.

Regular heavy alcohol consumption and binge drinking are associated with physical problems, antisocial behaviour, violence, accidents, suicide, injuries and road traffic crashes. Among adolescents, they can also affect school performance and crime. Alcohol misuse is associated with a range of mental disorders and can exacerbate existing mental health problems. Adolescents report having more risky sex when they are under the influence of alcohol; they may be less likely to use contraception and more likely to have sex early or have sex they later regret\textsuperscript{6}. The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) study 2002 showed that 14\% of 15 year olds reported having unprotected sex as a result of drinking alcohol. Drinking too much on a regular basis increases the risk of damaging one’s health, including liver damage, mouth and throat cancers and raised blood pressure\textsuperscript{7}. Unhealthy patterns of drinking by adolescents may lead to an increased level of addiction and dependence on alcohol in adulthood.

Scotland is currently ranked 8\textsuperscript{th} in the world for alcohol consumption per head of population. Although men and women in England drink more frequently than those in Scotland, Scots are more likely to exceed daily limits: 1 in 3 men and 1 in 4 women exceed recommended daily limits\textsuperscript{8}. More than a million people in Scotland are drinking hazardously or harmfully.

Alcohol misuse affects all age groups. A recent report on Alcohol and Aging published by Alcohol Focus Scotland reports that levels of alcohol consumption within the older population have been rising steadily over the past 20 years\textsuperscript{9}. Meanwhile surveys of children find that 13 and 15 year olds who report drinking, consumed 16 units and 18 units respectively in a week on average\textsuperscript{10}.

Alcohol-related ill health and mortality is linked to socio economic status, with the most deprived experiencing between a three and five fold increase in death rates\textsuperscript{11} compared to the most privileged. For any level of drinking, lower income groups suffer more. Despite the fact that professional groups drink more than lower income groups, lower income groups suffer far more from liver disease\textsuperscript{12}. Alcohol related death rates are highest in the most deprived areas of the West of Scotland. Almost two-thirds of all alcohol related deaths in Scotland in 2007 were amongst the most deprived members of society\textsuperscript{13}.

In 2009, researchers conducted detailed analysis of alcohol statistics for 2003\textsuperscript{14}. This study reported that one in 20 deaths in Scotland was estimated to be attributable to alcohol. It also found that deaths were proportionately
higher in younger age groups with 1 in 4 men and 1 in 5 women aged between 35 and 44 dying an alcohol attributable death. While older people are more likely to die from a chronic condition, younger people are more likely to die from an acute consequence (e.g. accident or injury), one in 10 of all deaths in this age group were due to alcoholic liver disease.

The report concluded that almost half of all deaths could have been prevented by lower alcohol consumption – mainly deaths from coronary heart disease in older age groups. However drinking at lower levels still also carries a risk for some conditions such as cancers.

The Committee requests views on seven key elements included in the Bill. The views of the BMA are detailed below:

**The advantages/disadvantages of establishing minimum alcohol sales price based on a unit of alcohol**

Access to alcohol is an important determinant of alcohol use and misuse. This incorporates the implementation of policies that regulate the affordability of alcohol as well as the introduction and enforcement of strict controls on availability of alcohol to adults and young people. In the UK, the affordability of alcohol has increased by 69% between 1980 and 2007. Over the corresponding time, per capita alcohol consumption has increased. This increase is against the backdrop of falling (or levelling) consumption trends over the last 10-15 years in most of the EU. It is widely accepted that price is linked to consumption therefore it is essential that policies are introduced to address pricing as a central part of a wider alcohol strategy.

Competition between sellers of alcohol has driven down the price of alcoholic drinks through extended promotions, buy-one-get-one-free offers, deep discounting and below cost selling. These promotions are introduced to attract people into the stores and increase overall sales\(^ {15}\). A minimum price per unit of alcohol would prevent the sale of alcohol at a level below a certain price per unit. This will prevent the loss leading practices of supermarkets and will not enable the supermarkets to absorb price increases as they currently do with increases in duty via taxation.

The pricing practices of supermarkets are an important factor in addressing overall alcohol consumption because of their dominance in the off-trade alcohol market, selling more than 70% of the volume of alcohol sold\(^ {16}\).

It is especially galling to note that supermarkets that sell alcohol at less than cost can recover some of their losses from the taxpayer through the VAT recovery scheme. Thus all taxpayers are supporting their irresponsible pricing policy on alcohol.
The level at which such a proposed minimum price should be set and the justification for that level

An independent study conducted by researchers at Sheffield University (Model-based appraisal of alcohol minimum pricing and off-license trade discount bans in Scotland) states that “as the minimum price threshold increases, healthcare costs are reduced”. The BMA does not have a view on the appropriate minimum price per unit of alcohol, but as a general principle we believe it should be set at the point at which a minimum price has a significant and positive impact on health outcomes (i.e. reduced hospital admissions and decrease in death rates).

The BMA does agree that a minimum price should be set via regulations that are subject to an affirmative legislative process. This would enable the minimum price to be regularly reviewed without the requirement to amend primary legislation.

The rational behind the use of minimum pricing as an effective tool to address all types of problem drinking

There is strong and consistent evidence that increases in price have the effect of reducing consumption levels and the rates of alcohol problems including alcohol related violence and crime, deaths from liver cirrhosis and drink driving deaths. Increases in the price of alcohol not only affect consumption at a population level but there is evidence that particular types of consumers (e.g. heavy drinkers and young drinkers) are especially responsive to price. Studies have also reported that price increases have the effect of reducing rates of alcohol problems including alcohol related violence and crime. Conversely lowering the price of alcohol is associated with an increase in alcohol related mortality\(^17\).

The Sheffield study examining the effect of a range of minimum price levels of health and social harm in Scotland estimated that minimum pricing would have the greatest impact on consumption by harmful drinkers\(^18\). Evidence shows that harmful drinkers tend to choose cheaper alcohol, so if the price of the cheapest alcohol increases, consumption will fall as these drinkers cannot afford to buy as much alcohol.

It has been observed that when the price of alcohol goes up, population consumption falls and when population consumption falls, so do rates of chronic alcohol related disease such as liver cirrhosis\(^19\). This indicates that changes in population consumption reflect changes in drinking habits of harmful drinkers, not just moderate drinkers. If price changes only influenced the consumption of moderate drinkers, then trend changes in rates of chronic alcohol related diseases would not be expected.

The Sheffield study considered the impact of minimum pricing on sub-groups of the population and estimated that, with a minimum price of 40p in combination with an off-trade discount ban, the extra spending per week
would be: 21p for moderate drinkers, £1.12 for hazardous drinkers and £2.63 for harmful drinkers.

Possible alternatives to the introduction of a minimum alcohol sales price as an effective means of addressing the public health issues surrounding levels of alcohol consumption in Scotland

Price is an important factor in alcohol misuse and therefore controlling price should be a central part of an alcohol strategy. The BMA would support a system that does not unreasonably penalise the careful, sensible drinker, but acts as a disincentive especially to young and heavy drinkers.

The BMA has not seen any compelling evidence to suggest that an alternative mechanism is available (banning below cost selling/minimum profit mark-up, banning the sale of alcohol below the amount of duty and VAT payable) that would have as significant an impact on consumption and health when compared to the evidence presented in the Sheffield study on minimum pricing.

A comparison of the benefits of minimum pricing for alcohol with a ban on the sale of alcohol below the cost of duty and VAT found that the price for products such as supermarket own brand vodka (currently selling for around £7 for 700mls or 26p per unit) would increase to £10.50 under a minimum price of 40p but under a ban on selling below duty and VAT the price would remain the same and could even decrease\(^\text{20}\).

It is also evident that the implementation and enforcement of a minimum price for alcohol would be straightforward as the calculations can be made on the spot.

To date BMA Scotland has not been presented with any evidence that another pricing mechanism would be more effective than minimum pricing in providing both targeted and population wide reductions in consumption and subsequent benefits to health.

The advantages and disadvantages of introducing a social responsibility levy on pubs and clubs in Scotland

In our 2009 report Under the influence: the damaging effect of alcohol marketing on young people the BMA recommended the introduction of a compulsory levy on the alcohol industry with which to fund an independent health body to oversee alcohol-related research, health promotion and policy advice. The Committee should consider whether this social responsibility levy could be extended to include supermarkets and other large off-sales organisations based on alcohol sales.
The justification for empowering licensing boards to raise the legal alcohol purchase age in their area to 21

The BMA does not have policy on the issue of increasing the age of purchase of alcohol to 21 however we do acknowledge that it may have an impact by reducing availability of alcohol to young people. Current age limits are not enforced adequately and the BMA would certainly support tougher enforcement of existing legislation. The BMA therefore welcomes the inclusion of a requirement for an age verification policy under Section 5 of the Bill.

The role of promotional offers and promotional material in encouraging people to purchase more alcohol than they intended

The tendency to drink quickly and to excess is frequently facilitated by heavily discounted alcohol prices and the use of price promotions such as two-for-one offers. Irresponsible promotional activities are common in off licenses (including supermarkets and convenience stores) throughout Scotland. There is evidence that excessively cheap promotions are particularly likely to fuel heavy drinking and alcohol related crime and disorder. BMA policy supports legislation to prohibit irresponsible promotional activities in licensed premises and by off licenses.

Other issues

Marketing and promotion

Alcohol sales have increased steadily over the past 20 years and a significant proportion of revenue is used to fund alcohol marketing and promotion. It is estimated that the UK alcohol industry spends approximately £800m every year promoting its products. This spending on marketing and promotion is substantial and significantly more than spending on health promotion marketing and advertising.

In September 2009, the BMA published the report “Under the influence: the damaging effect of alcohol marketing on young people” which aims to identify effective ways of protecting young people from the influence of alcohol promotion and marketing, thereby redressing the excessively pro-alcohol social norms to which they are exposed.

The report calls for a total ban on alcohol advertising including sports events and music festival sponsorship. Sponsoring entertainment and sporting events and sports teams has become an important advertising mechanism for the alcohol industry. Sponsorship usually involves providing money to underwrite the event in return for having a logo prominently displayed or distributed on items, such as caps and T-shirts and around the event venue. Children and adults become walking billboards when they wear these items. In addition, the exposure of children to alcohol’s linkage to entertainment events or sporting activities gives alcohol an innocence by association.
The BMA report says that brand development and stakeholder marketing by the alcohol industry, including partnership working and industry funded health education, has served the needs of the alcohol industry, not public health.

The BMA is disappointed that measures to regulate the alcohol industry are not included in this Bill and would welcome an amendment at stage 2.

**Labelling of alcohol products**

Ten years ago, the drinks industry agreed to a voluntary code to label drinks with their alcohol content. However progress published in 2007 showed “disappointing interim results”: 43% of products contained no information and only 3% had all the information required. The Government should no longer accept this failure by the industry to adhere to voluntary measures and should legislate for compulsory labelling to provide consistent advice.

Labelling of alcoholic beverage containers would also be a useful method for providing explanatory guidance on recommended drinking guidelines. More than eight out of 10 doctors believe that alcoholic drinks manufacturers should be compelled to clearly label their products with the number of units of alcohol in each product. This would raise awareness of the amount of alcohol in each drink. This information should also be readily available from retailers at the point of sale, and in all printed and electronic alcohol advertisements.

It is the responsibility of the drinks industry, both producers and retailers, to ensure that their customers are fully aware of the alcoholic content of the beverages they purchase and the potential harmful consequences of excess consumption. The BMA believes that there should be a legal requirement for all containers of alcohol offered for sale and advertisements to carry a prominent common standard label which clearly outlines the alcohol content in terms of units, information on the maximum recommended daily level of alcohol consumption, and a warning of the dangers of excessive drinking.

The BMA would welcome a commitment from the Scottish Government that it intends to lobby at a UK level for legislation to regulate the alcohol industry on this matter.

**Education and raising awareness**

The use of public information and educational programmes is a common theme for alcohol control policies in the UK and internationally. Such approaches are politically attractive but have been found to be largely ineffective at reducing heavy drinking or alcohol-related problems in a population. Mass media campaigns and public service messages aimed at countering the extensive promotion of alcoholic beverages have only been found to raise awareness and not to encourage individuals to reduce their alcohol consumption or alter their drinking behaviour. There is some evidence,
however, that they may be effective in building or sustaining support for public health oriented alcohol policies.

The effect of alcohol educational programmes on raising awareness, increasing knowledge and modifying attitudes provides justification for their use; however given their ineffectiveness at changing drinking behaviour, it is essential that the disproportionate focus on and funding of, such measures is redressed. Educational strategies are not effective as key stand-alone alcohol control policy, but can be used to supplement other policies that are effective at altering drinking behaviour and to promote public support for comprehensive alcohol control measures.

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