Alcohol etc. (Scotland) Bill

NHS Health Scotland

Introduction
1. Alcohol is enjoyed responsibly by many people in Scotland. However, a wealth of evidence shows its excessive consumption is seriously harming an increasingly large proportion of the population, the wellbeing of families and communities and the wider Scottish economy. Levels of alcohol-related harm rise steeply with increasing socio-economic disadvantage, contributing to health inequalities. The size of the problem and the unfavourable comparison with other similar countries [Leon and McCambridge, 2007] demand urgent, effective action if we are to achieve a better balance between the benefits and harms of its use in Scotland. There are three broad approaches to reducing excessive alcohol consumption and drunkenness:

1) Better equipping individuals of all ages to make sensible decisions about drinking
2) Modifying societal attitudes to alcohol and the importance it is given.
3) Modifying the current regulatory and pricing framework or how it is enforced.

2. The international evidence suggests that a combination of all three is needed. We therefore welcomed the package of proposals in Changing Scotland’s Relationship with Alcohol [2008]. It is clear that societal attitudes to drinking are deeply entrenched and that, particularly due to the pleasurable, intoxicating and addictive nature of alcohol, many are reluctant to change their behaviour. Consequently, the role of the legislative, regulatory and pricing framework assumes added importance. With this in mind, NHS Health Scotland supports the proposals set out in the Alcohol Etc (Scotland) Bill [2009] and offers the following specific comments. These concentrate on minimum pricing which we believe has the biggest potential for reducing harmful alcohol consumption in Scotland.

Advantages and disadvantages of a minimum price based on a unit of alcohol
3. Published evidence strongly supports the introduction of a minimum price. Increasing the price of alcoholic drinks is one of the most effective interventions to reduce the harmful use of alcohol [WHO, 2009]. It also delays the initiation of drinking, slows young people’s progression towards drinking larger amounts and reduces heavy drinking [WHO, 2009]. Reviews of the independent, scientific evidence base show that there is indisputable evidence that the price of alcohol influences consumption and alcohol-related harms [Meier et al, 2008; Wagenaar, 2008]. Over the last 30 years alcohol in the UK has become progressively cheaper. Compared with 1980, alcohol was 16% more affordable in real terms in 1991/92, 47% more affordable in 2002 and 69% more affordable by 2007 [ISD, 2009]. As alcohol has become more affordable, its consumption and alcohol related harm have risen, particularly in Scotland [Scottish Government 2008]. It is clear that strong action is needed
to address the real price of alcohol. The availability and price of alcohol must reflect the fact that it is “no ordinary commodity”.

4. Establishing a minimum price based on a unit of alcohol is an appropriate and effective mechanism to raise price in Scotland now. The power to raise tax or duty is not devolved to the Scottish Parliament and tax rises do not necessarily bring about the required increase in price as traders can absorb and avoid passing on the increase to consumers and effectively use alcohol as a loss leader to attract customers. Thus tax increases do not necessarily have the desired effect and can also potentially disadvantage smaller retailers unable to sell alcohol below-cost. Establishing a minimum price is the best way to ensure that the price of cheap alcohol increases.

5. It has been argued that raising the price of alcohol impacts unfairly on people with low incomes. However alcohol is driving health inequalities, with harm disproportionately experienced by people on low incomes. Levels of alcohol-related problems are greatest in more disadvantaged groups and communities. Price rises may thus have a disproportionately greater health benefit in these areas, by encouraging reduced consumption and thereby reducing health inequalities. Research into increases in alcohol-related mortality associated with a decrease in price in Finland showed that in those aged 30-59yrs the biggest increases were found in the unemployed, early-age pensioners and those with low education, social class or income [Herttua et al, 2008].

6. The evidence on the impact of minimum price on the alcohol industry and its wider economic effects is limited and opinions differ. There are relatively consistent estimates that the price elasticity of demand for alcohol lies between 0 and -1. This indicates that for every 1% rise in price, consumption of alcohol falls but by less than 1%. This suggests that although demand will fall as result of minimum pricing, revenue and profitability of the industry as a whole will rise, although price elasticities of demand are likely to vary between products and consumer groups [Ludbrook, 2008;Meier et al, 2008; IFS, 2009; Meier et al, 2009; CEBR, 2009].

7. The average price per unit of alcohol sold by the on-trade in Scotland increased by 17% over the past five years, from £1.12 per unit in 2005 to £1.31 per unit in 2009. This 19p increase was considerably higher than that for the price per unit of alcohol sold by the off-trade which increased by only 3p (7.5%) over the same five year period, from 40p per unit in 2005 to 43p in 2009 (appendix 1 figure 1) [NHS Health Scotland 2010]. Off-trade sales of pure alcohol per person over the age of 16 in Scotland have increased by 0.6 litres over the past five years, from 7.3 litres in 2005 to 7.9 litres in 2009. Conversely, on-trade sales decreased by 0.7 litres, from 4.6 litres in 2005 to 3.9 litres in 2009 (appendix 1 figure 2) [NHS Health Scotland 2010]. The volume of alcohol purchased off-trade per person was therefore - for the first time in five years - more than double that purchased on-trade. Minimum pricing will largely if not wholly affect the cheap products sold in off-sales. Most drinks sold in on-sales currently sell well above any likely minimum price and thus will be unaffected. Minimum pricing thus has the potential to reverse
at least some of the relative price shift, and sales, that has occurred in recent years in favour of off-sales and may help halt the decline in the number of pubs and clubs that offer a more controlled environment for drinking and are important components of the local economy and social fabric of communities. It is important to note that some parts of the alcohol industry such as the Scottish Licensed Trade Association support minimum price for these reasons.

8. In terms of the knock-on effect on employment in the industry, an independent report on alcohol policy across Europe concluded that while further research needs to be done on this issue:
   “..current evidence from alcohol and other sectors suggests that declining consumption may not necessarily lead to job losses in the economy as a whole and may not even lead to large changes in employment in some sectors linked to alcohol ” [Anderson and Baumberg 2006]

For example, there could be employment increases in the hospitality sector due to the shift from off to on-sales. As part of the Monitoring and Evaluating Scotland’s Alcohol Strategy (MESAS) portfolio of studies 1, NHS Health Scotland is commissioning a scoping study to assess the feasibility of measuring the economic impact on the alcohol industry of the provisions affecting prices and availability of alcohol in the Licensing (Scotland) Act (2005) and the Alcohol Etc (Scotland) Bill (2009).

9. It has been estimated that alcohol misuse currently costs the country £3.56bn [Scottish Government 2010]. By reducing alcohol misuse, minimum pricing is predicted to reduce costs to the health, social care and criminal justice services and contribute to an increase in the productive capacity of the Scottish economy as a whole.

10. The House of Commons Health Select Committee recently recommended that the UK Government introduce minimum pricing because it is an evidence based policy supported by many prominent health experts, economists and the Police and that many of the criticisms were myths propagated by parts of the drinks industry. (House of Commons, 2010). The Alcohol Etc (Scotland) Bill (2009) provides an opportunity for the Scottish Parliament to once again lead the way in Public Health.

The level at which a proposed minimum price should be set and the justification

11. There are three important considerations when setting the level of minimum price:
   a) The level needs to be high enough to impact on the negative effects of alcohol misuse. If not, a potentially effective policy could fail by implementing it with insufficient “dose”. The modelling work carried out by the University of Sheffield for Scotland [Meier et al, 2009] estimates that the greater the minimum price for alcohol, the greater impact on public health. Setting a level

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1 http://www.healthscotland.com/scotlands-health/evaluation/planning/MESAS.aspx
of 60p per unit has clear potential benefits with an estimated reduction of 12.9% in population consumption compared to estimated 7.2% reduction at 50p per unit and estimated 2.7% reduction at 40p per unit respectively.
b) The minimum price per unit of alcohol must apply to all alcoholic drinks with no exceptions otherwise heavy drinkers will merely switch their drink of choice and overall consumption and harms will not reduce
c) The impact of minimum price on consumption will depend on its real value. Inflation and increasing disposable incomes over time will diminish the real value of any particular level at which the minimum price is set and diminish its impact. Therefore the level must be periodically reviewed and uplifted to maintain its value and impact on consumption.

The rationale behind minimum pricing as a tool to address all types of drinking
12. The 2008 Scottish Health Survey [Corbett et al, 2009] estimated that 44% of men and 36% of women exceed the relevant daily benchmarks for alcohol consumption. Comparing changes since 2003 in self report alcohol consumption taken from the Scottish Health Survey the authors concluded:
   “At present the most robust conclusion that can be drawn is that drinking levels remained broadly similar between 2003 and 2008. There is somewhat tentative evidence that consumption declined among men in this period but more analysis of this is required.” [Corbett et al, 2009]
It is recognised that self report surveys underestimate consumption due to a combination of factors [Catto, 2008] and sales data are increasingly being used to provide an additional proxy estimate of population consumption. The volume of pure alcohol sold per person (aged over 16) in Scotland has remained stable over the past five years, in contrast to England and Wales where it has decreased every year between 2005 and 2009 [NHS Health Scotland, 2010]. The gap between Scotland and England and Wales has thus widened from 1.8 litres per person in 2005 to 2.4 litres in 2009. Expressed as units of alcohol sold per person (over 16) per week, the gap has widened from 3.5 units in 2005 to 4.6 units in 2009.

13. Opponents of minimum pricing argue it will unfairly impact on moderate drinkers. However, those drinking within recommended daily guidelines, will be affected very little e.g., for a 40p minimum price in combination with an off-trade discount ban, average annual spending for moderate drinkers is estimated to rise by £11, the equivalent to an extra 21p per week [Meier et al, 2009]. Underage and heavy drinkers, who mainly buy cheap alcohol will be more affected by minimum price than moderate drinkers [Ludbrook, 2004; Ludbrook, 2008; Meier et al, 2008; WHO, 2009] However, everyone can avoid paying anything more by drinking a bit less, which is the aim of the policy.

Possible alternatives to the introduction of a minimum price
14. Increased tax or excise duty on alcohol and better education have been proposed as alternatives to minimum pricing. However, as noted earlier, increasing excise duty or tax may not have the desired effect on price and in any case is not devolved to the Scottish Parliament. Contrary to popular belief, more education is not the answer. There is incontestable evidence that
school-based education does not lead to sustained changes in behaviour [Ludbrook, 2004; Mulvihill et al., 2005; WHO, 2009]. While education is an important component of empowerment and helps establish a social understanding that alcohol is a special and hazardous commodity, we cannot rely on it to reduce alcohol misuse [WHO, 2009].

Other proposals in the Bill
15. Health Scotland fully supports the introduction of a social responsibility levy at an appropriate level. We are also in favour of further restrictions on alcohol promotional offers and other promotional materials that may induce people to drink more than they otherwise would. Whilst there is evidence from other countries that raising the age of legal purchase to 21 at a country or state level can have benefits [WHO, 2009], we are less certain if such a change at a local authority level, with the potential for displacement of problems to neighbouring areas, would be effective.

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References

Appendix 1

Figure 1: Price per unit of on- and off-trade sales of pure alcohol (2005-2009)

Figure 2: On- and off-trade sales of pure alcohol per person (aged 16+, 2005-2009)
Figure 3: Sales of pure alcohol per person (aged 16+, 2005-2009)

Figure 4: Sales of alcohol units, on average, per person per week (aged 16+, 2005-2009)