Introduction

Tackling alcohol misuse and its consequences are key issues for the NHS in Scotland in general and NHS Lothian in particular. There is clear evidence that Scotland has a significant problem with alcohol: between 1998 and 2004, 15 of the 20 local authority areas in the UK with the highest alcohol-related death rates were in Scotland. This included Edinburgh and West Lothian, for both men and women. Between 1998 and 2002 there was a 52% increase in alcoholic liver disease in Scotland and we now have one of the highest death rates from liver cirrhosis in Western Europe.

Changing Scotland's Relationship with Alcohol: a Framework for Action sets out the need for change and draws on a variety of reports that chart the costs and impact of alcohol in Scotland. We welcomed this Framework as it clearly took a population and evidence-based approach. This is not just about young binge drinkers and dependent street drinkers: as the Framework acknowledges, we all need to drink less.

As with many issues, we need to take action across a range of areas. For instance, NHS Lothian has had considerable success in training over 80% of Lothian GPs in screening and delivering Alcohol Brief Interventions (ABIs). Initial data suggests that on follow up patients are reporting, on average, a decrease in consumption after an ABI: 41% for men and 43% for women, which is in line with the research evidence from trials. This is very encouraging. The programme continues to be rolled out and by the end of March 2010 all 250 community midwives will be trained and actively delivering this initiative. However, action by the NHS alone will not solve this problem.

Consultation questions and response

1. The advantages and disadvantages of establishing a minimum alcohol sales price based on a unit of alcohol
2. The level at which such a proposed minimum price should be set and the justification for that level
3. The rationale behind the use of minimum pricing as an effective tool to address all types of problem drinking;
4. 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

Response to Questions 1, 2, 3 and 4

There is a clear and long standing relationship between the affordability of alcohol and levels of consumption. This has been established across many countries over time. In the UK, alcohol is now 69% more affordable than in
1980, with consumption increasing by around 20% over the same period. The World Health Organisation considers that tackling the affordability of alcohol is a key component of an effective alcohol strategy. To implement the rest of the *Framework* and ignore the price of alcohol would not make sense.

There are a number of ways in which governments might seek to affect the price at which alcohol is sold:

**Taxation:** Excise duty is not within the gift of the Scottish Parliament to change but it is an important lever for change. Excise duty currently varies according to beverage type. Beer and spirits are taxed in relation to their alcohol strength. Duty on wine, cider and perry is fixed by volume and takes no account of alcohol strength. In the UK wine between 5.5% ABV and 15% ABV has the same rate of duty. This area is governed by EU Council Directive (92/83/EEC) but it has been argued that the UK Government would have scope to increase taxes on higher strength alcoholic drinks and lower duty on lower strength alcohol on the grounds of public health. This differential has been introduced in Australia, where around 40% of the beer market by value consists of drinks with lower alcohol content than 3.8%. Since 1980 alcohol consumption in Australia has decreased by 24%. Cider is in a particularly anomalous position. Under the current duty regime a litre of beer at 5% ABV has 65p duty added, while the equivalent litre of cider has 26p of duty levied. While this difference has roots in an attempt to preserve rural traditions, over 50% of cider made in the UK is by one multi-national company.

**Prevent sales at below tax and duty:** One potential difficulty with taxes is that there is no guarantee that increases are passed on to the consumer. UK retailers have in the past marketed on the basis that ‘we pay the tax for you’ and so it might be anticipated that without other action (such as a ban on selling below cost price or a minimum price) the effect of taxation would be undermined. The issue here is that the effect would be limited under the current duty regime – probably creating a minimum price of around 20p per unit – and therefore have little impact on consumption and concomitant harm.

**Ban on discounts:** Discounts – such a ‘buy one get one free’ or ‘3 for £10’ - are probably the most conspicuous price reduction mechanisms used in off-sales. This is an important measure in the new Bill and one that balances the ban on promotions in on-sale premises in the Licensing Act. However, if discounts are tackled without also establishing a minimum price then it is arguable that retailers will simply adjust their marketing model to reduce the price of an individual bottle or can.

**Minimum pricing:** Introducing a minimum price would create a price below which a unit of alcohol could not be sold. Minimum pricing would apply to all alcoholic drinks but it would not result in an increase in the cost of all drinks, only those which are currently sold below the level set. It would primarily affect low cost, high alcohol products such as ciders and
own-label vodka and would impact most on harmful drinkers. On this, the modeling work by the University of Sheffield is very persuasive.

For example, if a 40p minimum price was introduced, a moderate (i.e. those drinking within sensible weekly limits of 21 units for men and 14 for women) drinker’s spend on alcohol would go up by just £11 per year (21p per week), but that of a harmful drinker, who tends to buy more and cheaper alcohol, would go up by £137. A study conducted in two Edinburgh Hospitals compared alcohol purchasing and consumption by ill drinkers in Edinburgh with wider alcohol sales in Scotland. The study looked at last weeks or typical weekly consumption of alcohol by type, brand, units, purchase place and price. Patients consumed a mean of 198 UK units per week. The mean price paid per unit was 43p (lowest 9p per unit) which is below the 72p mean unit price paid in Scotland in 2007. Of units consumed, 70% were sold at or below 40p/unit, and 83% at or below 50p per unit.

There is a surprisingly short time-lag in the strong correlation between affordability of alcohol and deaths from liver cirrhosis. Based on the available evidence, the Chief Medical Officer’s assessment is that – like the smoking ban – minimum pricing would save lives within a year. The Sheffield study supports this: their model suggests a 40p minimum price would save about 70 lives in year one, rising to 365 lives per year by year ten.

There is near universal support among the medical profession for the Bill including the minimum pricing aspect. Minimum pricing is also supported by the UK’s other Chief Medical Officers and by the Scottish Directors of Public Health Group.

Any minimum price be set at a level which will have an impact on consumption and ultimately alcohol related diseases and deaths. While most attention has been paid to a minimum price of 40p it should be noted that this should be in tandem with a ban on promotions. Together these produce an additive effect. The Sheffield study found that at higher minimum prices the additive effect of a promotions ban lessened until at 60p there was little additional effect. In the end this is a political judgment and is the reason that the Bill seeks to give Parliament the right to set the price rather than, for instance, it being fixed to the retail price index. Put starkly, it is a choice between how many deaths might be prevented and what might be a publicly acceptable level for the minimum price.

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

Alcohol related harm imposes major burdens on health service use, especially in Accident and Emergency departments at the weekend in Lothian. Such funding may be a way of resourcing facilities to look after drunk and incapable people.
6. The justification for empowering licensing boards to raise the legal alcohol purchase age in their area to 21

There is evidence that raising the legal age of consumption and purchase reduces consumption levels in young people (including binge drinking), and reduces the levels of alcohol-related traffic crashes, injuries and fatalities. Age verification is an important aspect of this area and the Challenge 21 and Think 25 policies used by some retailers are very welcome. All licensees should be encouraged to sign-up to these initiatives. It may be that the threat of a locally imposed purchase age will reinforce this voluntary measure.

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

Longitudinal studies consistently suggest that exposure to media and commercial communications on alcohol is associated with the likelihood that adolescents will start to drink alcohol, and with increased drinking amongst baseline drinkers and to drink more if they are already using alcohol.

The WHO in their submission to the World Health Assembly noted that it is very difficult to target young adult consumers without exposing cohorts of adolescents under the legal age to the same marketing practices. Controls or partial bans on volume, placement and content of alcohol advertising are important parts of a strategy, and research results underline the need for such controls or bans, in particular to protect adolescents and young people from pressure to start drinking. Marketing practices that appeal to children and adolescents could be seen as particular policy concerns.

Conclusion

In tandem with a ban on off-sales discounts and promotions, minimum pricing does appear to be a proportionate and pragmatic approach that is within the gift of the Scotland Parliament to implement. This would not put up the price of every drink, only those which are sold at an unacceptably low price such as cheap spirits and cider. It would also be much clearer to enforce.

Clearly, the area of drugs misuse is benefitting from a political consensus around the recovery agenda. NHS Lothian would be keen for a similar consensus around alcohol to emerge that includes action on the affordability of alcohol. From the evidence presented to NHS Lothian, minimum pricing has a substantial part to play in Scotland’s response to this challenge along with the other proposals mentioned in the Bill and considered above.

Jim Sherval FFPH
Specialist in Public Health
NHS Lothian
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