Alcohol etc. (Scotland) Bill

NHS Tayside

Below is set out evidence presented on behalf of NHS Tayside in relation to the Alcohol etc. (Scotland) Bill. This response has been developed on behalf of the Board by senior clinicians and managers with significant knowledge and experience of the impact of alcohol related health harm and of the effectiveness of interventions to address this problem.

In 2007 NHS Tayside undertook an analysis of the impact of alcohol on the Tayside population, a review of the evidence supporting interventions and developed a comprehensive plan in response to the local issues identified.

From this work it is clear that, in line with the rest of the Scottish population, the prevalence of alcohol related health harm in Tayside is increasing dramatically. The evidence for these changes is incontrovertible and there is also evidence that there is much greater harm amongst those living in the most socially deprived circumstances.

In response we are working to develop a range of supports and interventions for those drinking at hazardous, harmful and dependent levels. We are also developing, with our partners, approaches to primary prevention of alcohol problems among local populations and a range of activities and interventions targeted at particular groups and communities with the aim of reducing their use of alcohol. We are also participating in the local licensing forums established in support of the licensing Boards. The approaches we are developing are based on our understanding of the published evidence, clearly referenced in our report “Improving NHS Alcohol Services in Tayside 2007”.

However our work in 2007 recognised that such local interventions alone are unlikely to achieve the necessary changes in behaviour and culture that would have a significant impact on alcohol related health harm. Culture is a result of a complex and dynamic interaction of legislation, formal and informal controls, general and specific environmental influence and personal belief systems. Education alone is not a powerful enough factor to change behaviour and culture. Examples such as seat belt laws, drink driving and smoke free legislation demonstrate how legislation and regulation, preceded by education and consensus building can bring about a change in culture. We are of the view that regulation of price and availability of alcohol are the greatest determinants of levels of consumption within a population. Other interventions, including harm reduction, the early identification of people with alcohol problems and the delivery of support services, education, and controls on advertising and sponsorship are in themselves much less effective than controls on price and availability. The efforts of local services to deliver a comprehensive tiered approach to alcohol problems prevention, identification and management are likely to be significantly less effective in the absence of supportive national policy, including legislative measures. This position is
based on the published evidence and in particular we would wish to highlight the following:-

Price, specifically affordability, of alcohol has fallen in the UK since the 1980s and consumption has risen (Brennan et al 2008). There is an extensive international literature over many years supporting the close relationship between price and consumption and this is consistent with the Scottish experience over the past 20 years.

Price changes have not been uniform. There have been much bigger price falls in the off trade sector and this is reflected in changing patterns and loci of consumption (Brennan et al 2008. University of Shefield School of Health and Related Research, Alcohol pricing and promotion effects on consumption and harm. Part A systematic reviews). This is also probably linked to the increased consumption among women and young people.

There is a clear relationship between the affordability of alcohol and consumption (Brennan et al 2008). This has been established across many countries over time. The World Health Organisation considers that tackling the affordability of alcohol is a key component of an effective alcohol strategy (Babor et al 2003. Alcohol - no ordinary commodity).

The increase in alcohol related deaths in Scotland over the past 20 years has been predominately among the more economically deprived.

The “Finnish Experiment” of cutting alcohol costs in 2004 led to an increase in alcohol deaths within 2 years, mainly in deprived communities (Prof Anne Ludbrook 2008, HERU, Minimum pricing of alcohol - an economic perspective. Report commissioned by SHAAP).

The price of cheapest alcohol has consistently been shown to be related to rates of harm. Ludbrook states that the impact of minimum pricing will be larger on those who currently purchase the lowest cost products and this may include a greater proportion of those whose drinking habits cause most concern – young people and harmful drinkers.

Modelling undertaken by Sheffield University has demonstrated that increasing the price of alcohol should reduce deaths, hospital admissions, unemployment, family impact and crime (Meier 2009).

The modelling study also demonstrated that increasing the price of alcohol would be expected to have a targeted impact on heavier drinkers and to reduce alcohol dependence. 64% of all cheap off-trade alcohol is consumed by harmful drinkers (only 9% by moderate drinkers), 26% of harmful drinkers’ alcohol is “cheap”, 17% of moderate drinkers’ alcohol is “cheap”, 17% of moderate drinkers’. (Meier 2009)

NHS Tayside are therefore of the view that the specific proposals set out in the Bill in relation to controlling the price of alcohol are likely to have a beneficial impact. We would further contend that a minimum price per unit of alcohol is likely to be more effective than controls through increased taxation
or voluntary pricing policies by suppliers. Despite alcohol taxation going up by 6% in 2008, supermarkets continued to sell heavily discounted alcohol so tax increases have been ineffective in tackling cheap alcohol. Supermarkets have made it clear that they use alcohol as a loss leader in order to attract people to their stores. Any alternative approaches to the regulation of the price of alcohol, apart from minimum pricing, would need to be able to demonstrate at least the equivalent benefit of minimum pricing, including the differential impact on groups at highest risk of alcohol related harm associated with the consumption of the cheapest forms of alcohol.

A minimum price of 40 pence per unit is seen as the lowest level at which a minimum price should be set. This would have the effect of increasing the cost of cut price own brands and special offers but would have little or no effect on the price of premium brands or prices charged by smaller traders. Although a higher minimum price would be likely to have a greater impact on the levels of consumption it is important to consider the need to develop support and consensus over these measures to help change underlying cultures.

Similarly we are supportive of the intention to introduce restrictions for off-sales on supply of alcoholic drinks free of charge or at a reduced price. The modelling undertaken by Meier et al (2009) has shown the potential impact of a total off-trade discounting ban. We especially note that the ban on off-trade promotions was more effective than minimum pricing in reducing predicted consumption of ready to drink items (‘alcopops’), although the effect was smaller than for other classes of alcoholic beverage. Hence, combining these approaches offers a comprehensive and coherent policy that should effectively reduce consumption of the products most associated with alcohol-related harm in our communities. A ban on off-trade promotions would also provide consistency with controls on sales from licenced premises.

Introducing the requirement for licence holders to operate an age verification policy is a sensible and proportionate measure to assist in the prevention of purchase of alcohol by or for under 18's, which is often then consumed in ‘hidden’ locations (such as parks) where risk is greatest and represents a significant public health risk.

Similarly the provision to empower licensing boards to raise the minimum legal age for the purchase of alcohol to 21 will allow local action to address specific problems associated with problem drinking by younger people. Such targeted action as part of wider community supported initiatives is likely to command greater public support and be more effective than a blanket ban on purchase by under 21s.

We consider the evidence for the introduction of a social responsibility fee as less clear cut. NHS Tayside recognises the very substantial financial costs incurred across agencies in the management of alcohol-related harm. We anticipate a number of challenges in administering a social responsibility fee fairly, and potentially perverse incentives for premises where existing practice is at a high level if they are none the less ‘penalised’ for the poor practice of
adjacent premises. It is also clear that the main growth in alcohol consumption in recent years has been within off-sales for drinking at home. This provision is therefore not really targeting reducing population levels of alcohol consumption. Given the very high true cost of managing alcohol-related harm, any realistic social responsibility fee is going to make little or no impact on the financial position of key public services in terms of reimbursement of the costs of responding to alcohol-related harm and nuisance. This proposed provision, therefore, might aim to achieve either an improvement in premises standards or a reduction in the number of premises overall by making it financially more burdensome to hold an alcohol licence. Depending on Government aims, the first goal might be better achieved by looking at the structure of licensing fees, and linking the level of these to certain quality standards, such as involvement in ‘Best Bar None’, the quality of staff training, contributing to improving the local environment around premises, or engaging in community initiatives. This approach would use existing charges levied on licensed premises, and use more of a ‘carrot’ than a ‘stick’.

Overall, NHS Tayside is of the view that the proposed legislation contains provisions that are appropriate and commensurate with the nature of the problem being addressed. The proposed legislation represents, in our view, a coherent package of measures that, taken in their entirety, represent a potentially very substantial step towards tackling the pervasive damage caused by alcohol in Scotland today. The enactment of this legislation will have a positive impact on the health and well being of the population of Scotland, and in Tayside it will support the existing and developing programmes of education, prevention, treatment and support being taken forward by the NHS Board with its community planning partners.

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Chairman
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