Alcohol Etc (Scotland) Bill

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Preamble

The study of alcohol related health and social consequences was initiated at UWS\(^1\) in 1979 by the establishment of the Alcohol Studies Centre. This study grouping was initially funded in its entirety by the Scottish Home and Health Department and emerged in the wake of the liquor licensing changes (Licensing (Scotland) Act 1976). At that time there was recognition of a lack of research on alcohol issues and even less relevant education for those working with alcohol related problems. A post graduate study programme was established in 1979 and is the fore runner of the current MSc/Post Graduate Programme in Alcohol and Drug Studies, perhaps the largest programme of its kind in the UK, offering full time, part time and online study options. Central to this programme is the view that alcohol as a legal drug makes a significant contribution to substance use problems in Scotland.

In 1993-6 Barrie et al (1998) conducted the National Evaluation of Innovative Alcohol Projects funded by the Scottish Office. In addition evaluative studies on alcohol problems were commissioned by a local authority, (McMahon et al 2005). More recently McPhee et al (2009) reported on the high level of problems attributed to alcohol use in comparison to illicit drug use. Currently, Marks (2009) design of an educational intervention targeting young binge drinkers is being tested. Evidence of effectiveness will be published/disseminated in due course.

Given the innovative nature of the proposed elements of this Bill it is crucial that the means are put in place to evaluate the impact of minimum pricing at an early stage and in turn make recommendations for adjustment in the light of findings.

This document is set out to reflect the themes outlined in the Scottish Parliament’s Health and Sport Committee’s call for written evidence, dated 26 November 2009.

The Advantages and disadvantages of establishing a minimum alcohol sales price, based on a unit of alcohol.

\(^1\) The University of The West of Scotland, formerly the University of Paisley.
There is a large body of literature attesting to the connection between the price and availability of alcohol and in turn consumption and health/social consequences (Babor, T. et al 2003; Edwards, G. et al 1995). Therefore increasing the price of alcohol will reduce consumption and resulting problems, at all levels of drinking, including those most severely affected by misuse. Alteration of price and availability are the most powerful interventions available to policy makers in reducing alcohol related problems.

**Advantages**

Depending on the level of price increase or setting of a minimum price of alcohol a modest reduction in per capita consumption of alcohol will be achieved, as only lower priced alcohol products are targeted. More specifically minimum pricing could:

1. Reduce consumption amongst the heaviest (and dependent) drinkers,
2. Decrease the percentage of the population drinking above the recommended safe limits
3. Decrease “binge” drinking as well as public drinking among all age groups.

It would be expected that a range of health and social consequences would decrease in these sub-populations. Minimum pricing would only affect “moderate drinkers” consuming cheaper beverages i.e. those drinks where there is a price increase.

There would be a benefit to public houses in that their prices, which would be largely unaffected by minimum pricing would be more competitive with those of off-sale and supermarket outlets. However it is also clear that much of the social disruption and offending actually takes place in and around public houses.

The Sheffield University study by Meier et al (2009) conducted an independent review of the effects of alcohol pricing and promotion, concluding that general price increases on alcohol exhibited relatively large reductions in mean consumption for the population. Further, minimum pricing options would result in health harm reductions, mostly in relation to chronic rather than acute conditions, and reduce crime. This study further explores the relationship between crime and alcohol consumption and suggests that:

“crime harms are estimated to reduce, particularly for 11-18s because they are disproportionately involved in alcohol related crime and are affected significantly by targeting price rises at low priced products” (Meier et al 2009, p 8).

Further all policy options targeting hazardous drinking are effective in reducing alcohol related harm in the work setting, influencing both unemployment and absences among harmful drinkers.

**Disadvantages:**
Strong opposition from those with commercial interests, who would tend to support minimal regulation and perhaps favour interventions, such as education, or changes in labelling on products which have little demonstrable effect in preventing or changing drinking behaviour which affects health (Babor et al 2003). Minimum pricing will impact on those who are less well off irrespective of whether they are heavy alcohol consumers and possibly increase the potential for the illegal sale and distribution of alcohol. Given that minimum pricing reduces consumption of cheaper beverages there will be an increased profit to the producers: it is unclear whether this increased revenue should remain with the producers or be channelled elsewhere.

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

The University of Sheffield study (Meier et al 2009) set out a range of minimum price levels ranging from 20 – 70 pence per unit. Negative consequences reduce steeply as price per unit increases thereby demonstrating the effectiveness of this policy intervention. Lower minimum pricing may demonstrate little impact whatsoever, being similar to current unit prices at the cheaper end of the market. Lower minimum prices affect beer and spirits more than wine. However the consumption of fortified wine has been cited as a consistent feature of drinking in public places by young people. On the basis of the research evidence we propose that a minimum price of 50 pence per unit is implemented as a result of which all lower priced beverages will be targeted.

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

Minimum pricing as currently conceived would in essence affect only those who consume cheaper alcoholic beverages. Those who are better off and consume more expensive alcoholic beverages will be unaffected despite their potential to drink excessively and harmfully. A general price increase would be required if the harmful and damaging drinking of the whole population were to be curtailed e.g. a volumetric tax based on alcohol content. Such an approach would also provide the opportunity to use taxation directly in funding alcohol prevention initiatives.

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

As price and availability are the main drivers of consumption and in turn negative consequences, the impact of alternative interventions would be distinctly limited in their impact Babor et al 2003). General (as opposed to minimum) price increases result in relatively large reductions in the mean consumption of the population. As far as price is concerned all consumers are targeted equally, consequently the impoverished harmful drinker would reduce his or her
consumption as would the harmful consumer of mid priced alcoholic beverages. In essence a general price increase would be a more powerful intervention than minimum pricing as the whole market would be targeted.

There have been many interventions designed to reduce alcohol related consequences in the last 25 years: educational campaigns/programmes, town/city centre drinking bans, proof of age schemes. However their impact on the overall alcohol consumption and in turn alcohol related problems at a time of high and rising per capita consumption is minimal. Such interventions may appear to be more effective as part of a preventive strategy when part of that approach tackles consumption levels. Consequently a range of interventions will reinforce minimum pricing but would not provide viable alternatives independent of price control measures. An Australian study on the cost effectiveness of interventions to prevent alcohol related disease and injury concluded that “substantial improvements in population health can be achieved at a relatively low cost in the health sector” p. 1646 (Cobiac et al 2009). This evaluation supported the use of volumetric alcohol taxation, advertising bans, and licensing controls on opening hours, brief interventions and drink driving measures including random breath testing. Only residential treatment for alcohol dependence was found to be cost ineffective. These findings reflect the world literature on the subject.

**Introduction of a social responsibility levy for pubs and clubs**

No comment.

**The justification for empowering licensing boards to raise the legal alcohol purchase age in their area to 21**

There are a variety of age restrictions embodied within liquor licensing law in Scotland, namely consumption of beer, cider or wine with a meal age 16 (purchased by an adult); purchase and consumption of alcohol on licensed premises age 18, with the same age restriction applying to the purchase of alcohol from off sales. It is our view that a further extension to 21 for legal purchase age to 21 years for both, or either individually, on and off sales, would complicate the current set of relevant age restrictions. Further it is quite possible that such a change would be very unpopular and may be routinely breached by over 21s prepared to buy alcohol for the newly restricted age group 18-20 year olds.

States in USA and also Canada have age of purchase restrictions set at 21, whether on or off licensed premises. This follows on the age setting in the wake of the repeal of alcohol prohibition in USA in the 1930s (Toomey et al 2009). This age restriction is associated with reductions in accidents and fatalities, commonly concerned with driving, in the 18-20 age groups. Such an intervention might be
seen as discriminating against this particular grouping of young people, who would be quick to advise of their current rights in relation to sexual consent, marriage as well as employment and the right to vote.

Pilot projects in West Lothian and Cleveland where sale of alcohol to people under the age of 21 is restricted have reported reductions in anti social behaviour, however such interventions require full evaluation, on a longer term basis, before forming a cornerstone of policy change.

The notion that restriction of age at off sales will drive 18-20 year olds into pubs and clubs, which offer a “more controlled environment” (Scottish Government 2008) is doubtful, given that most alcohol related disorder takes place close to these establishments. This often occurs in town centre settings where a public drinking ban is in force. It must be concluded then that much of public disorder is associated with alcohol consumed on licensed premises. Further alcohol related crime is more common in the 11-18 age groups.

Stronger ‘proof of age’ enforcement on current age restriction and minimum pricing may reduce alcohol related problems in this age group without discrimination. Further, it is likely that a substantial reduction of road fatalities in Scotland in the 18-20 age group could be achieved by reducing the drink driving limit from 80 to 50 milligrams of alcohol per 100 millitres of blood for all, with a zero limit for younger less experienced drivers.

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

Discounted alcohol promotions contribute to a small proportion of sales though give the impression to consumers of very cheap alcohol being easily available. The independent review of alcohol pricing and promotion (Meier et al 2009) concludes that a total ban on off-sales promotions would reduce consumption by 2.8%. This would be a positive contribution to the overall aim of reducing alcohol consumption in order to reduce health and social harm.

**Any other aspect of the Bill**

The following comments relate to key elements in evidence based policy design for alcohol related consequences.

**Drink driving**

Lower blood alcohol concentrations, including zero tolerance for younger drivers and random breath testing are strongly supported by the research evidence as well as being low cost interventions (Babor et al 2003).
Advertising

Levels of exposure to alcohol related images and messages are related to consumption. As a result advertising may desensitize the viewer and in turn increase the acceptance of alcohol and readiness to drink: holding such attitudes would predict subsequent alcohol consumption. Young people are exposed to high levels of alcohol advertising at levels akin to adults. It is likely that any restriction on advertising or sponsorship will be strongly opposed by the alcohol industry, and this in turn has created significant difficulty in evaluating the impact of advertising controls.

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References


