Alcohol (Minimum Pricing) (Scotland) Bill

British Medical Association Scotland

The British Medical Association represents doctors from all branches of medicine throughout the UK. It is a registered trade union and professional association with around 70% of practising doctors in membership. The BMA in Scotland represents more than 15,000 doctors and is considered the voice of the medical profession.

BMA Scotland welcomes the opportunity to provide the Health and Sport Committee with written evidence outlining its reasons for supporting the Alcohol (Minimum Pricing) (Scotland) Bill. Alcohol is the third leading cause of disease burden in Europe and this burden weighs heavy on the NHS in Scotland. A study by the University of York\(^1\) has found that the cost of premature deaths and healthcare related costs to Scotland are £1.46 billion and £268.8 million respectively.

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. At the 2011 meeting, doctors once again called on the UK governments to introduce minimum pricing\(^2\). The BMA therefore wholeheartedly supports the Alcohol (Minimum Pricing) (Scotland) Bill and would urge members of the Committee to support this legislation. The BMA believes that the introduction of minimum pricing, as part of a wider strategy to tackle alcohol misuse, is essential in order to help change Scotland’s drinking culture.

Background

The BMA’s views on tackling alcohol misuse have been widely publicised and are detailed in a range of policy documents, most recently *The human cost of alcohol – doctors speak out* (2009); *Under the Influence* (2009); *Alcohol Misuse: tackling the UK epidemic* (2008). Many of the key policy recommendations highlighted in these publications are reflected in the Scottish Government’s strategic approach to tackling alcohol misuse, some of which do not require primary legislation.

Although alcohol is widely consumed and enjoyed by many, the effects of excessive alcohol consumption on health and the related social and economic impacts are significant. Alcohol misuse transcends age and social groups. It is a population-wide problem that requires a population-wide solution.

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1 York Health Economics Consortium *The societal costs of alcohol misuse for Scotland for 2007*, University of York, 2010
2 That this Meeting calls on the UK governments to acknowledge the seriousness of the risks posed to the health of the nation by alcohol and the unsustainable burden this places on public services, including the NHS, by acting as a matter of urgency to introduce wide-ranging measures including:-
i) restricting licensing hours;
ii) banning alcohol advertising except at point of sale;
iii) introducing a realistic minimum price per unit.
Decades of health promotion campaigns have tried to inform people of sensible drinking limits, with some limited success. However, awareness on its own does not alter behaviour and more direct action is required to make a difference to drinking patterns.

One of the most effective and cost-effective ways for society to minimise the damage caused by alcohol consumption is by regulating the price of alcohol. There is clear evidence that rising consumption is linked to the increased affordability of alcohol products\(^3\). The more affordable alcohol has become, the more consumption has gone up. The more consumption has gone up, the more alcohol related harm and mortality has risen.

**Alcohol Misuse: the facts**

Alcohol is related to more than 60 types of disease, disability and injury\(^4\). The daily recommended guidelines for sensible drinking set out by the UK Government state that men should drink no more than 3-4 units a day and no more than 21 units a week. Women should drink no more than 2-3 units a day and no more than 14 units a week. In addition it is recommended that everyone should have at least two alcohol free days a week. However evidence suggests that drinking as little as one unit a day can increase risk of cancers such as breast and oesophageal cancers.

Despite these well publicised guidelines, many Scots continue to regularly drink far more. According to the most recent Scottish Health Survey\(^5\) 27% of men and 19% of women reported drinking more than the recommended weekly limits. However, alcohol consumption in Scotland is likely to be significantly higher than the Scottish Health Survey suggests as people are known to under-report the amount of alcohol they drink when questioned in surveys.

According to recent statistics, there was a fall in the number of alcohol-related discharges from general acute hospitals in Scotland between 2008/09 and 2009/10. This is in line with the previous year’s data which also showed a slight reduction. However, alcohol-related discharges remain high at 39,278\(^6\). 92% of these discharges were the result of emergency admissions.

Despite this recent improvement, there is no room for complacency. Scotland still has one of the highest cirrhosis mortality rates in Western Europe. Over the last 30 years, UK liver cirrhosis mortality has risen by more than 450%.

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\(^3\) Academy of Medical Sciences, *Calling Time: the nation’s drinking as a major health issue*, 2004

\(^4\) WHO *Public health problems caused by harmful use of alcohol*, 2004


across the population\textsuperscript{7}, with a 52\% increase in alcoholic liver disease between 1998 and 2002\textsuperscript{8}.

One of the reasons for the reduction in alcohol-related hospital admissions and alcohol-related deaths is likely to be a result of a recent stabilising of the affordability of alcohol since 2008. For example the off-sales price of a unit of spirits has risen from 39p in 2000 to 41p in 2009. However, ciders remain far cheaper with 38\% of all ciders being sold at less than 25p per unit\textsuperscript{9}. Given the significant health gains that result from changes to pricing practices in the off trade, the need for regulation is clear.

A snapshot survey carried out by BMA Scotland suggested that on one day in April 2011, alcohol was a factor in more than 5,500 consultations in general practice. This equates to around 1.4 million consultations per year, costing the NHS in excess of £38 million and accounts for 6\% of all GP consultations\textsuperscript{10}.

The misuse of alcohol is recognised as a contributory factor in a wide range of health and social problems such as long term health conditions, accidental injury and violence, and mental illness. Problems associated with alcohol misuse do not just affect the individual drinker they have a significant impact on friends and family members, wider communities and society at large. Alcohol misuse in Scotland costs £3.5 billion every year in both direct and indirect costs\textsuperscript{11}.

**Price and Consumption**

Analysing trends in alcohol price and consumption in the UK shows that as the real price of alcohol has fallen over the past 50 years, consumption has risen. The increase in affordability of alcohol is linked to changes in the alcohol market with the gap between prices of the on and off trade widening considerably in recent years, most significantly in the supermarket sector. Supermarkets admit to selling alcoholic drinks below cost price as a marketing tool to encourage greater ‘footfall’ in their stores.

The pricing practices of alcohol producers and retailers have resulted in the profit margins on the unit price of an alcoholic drink being squeezed. This means that in order for producers and retailers to maintain their total profits, they have to sell more; and in order for producers and retailers to sell more, consumers have to drink more.

The availability of cheap alcohol is not the sole reason for problem alcohol use in Scotland. It is however, a factor in rising consumption levels and

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\textsuperscript{7} Academy of Medical Sciences, *Calling Time: the nation’s drinking as a major health issue*, 2004

\textsuperscript{8} Leon D, & McCambridge J *Liver cirrhosis mortality rates in Britain from 1950 – 2002 ONS* 2001

\textsuperscript{9} NHS Scotland, *Alcohol Statistics Scotland 2011*, ISD publications, Feb 2011

\textsuperscript{10} Based on a sample of 3\% of all GP practices in Scotland.

\textsuperscript{11} York Health Economics Consortium *The societal costs of alcohol misuse for Scotland for 2007*, University of York, 2010
associated harm. It is a policy area in which government regulatory action will make a difference in reducing the level of alcohol related harm.

Why does the BMA support minimum pricing?

Establishing a minimum price per unit of alcohol would be an innovative measure and economic research suggests that it will have most impact on the cheapest forms of alcohol and alcohol sold below cost. A minimum price for alcohol is important in tackling problem alcohol consumption because:

- Alcohol is available for sale at very low cost. The cost of the manufacturing and retailing of cheap alcohol does not reflect the high cost to society associated with its use.
- Some retailers sell alcohol at a loss in order to attract more customers. This practice means that alcohol taxation by itself is not sufficient to ensure that alcohol is priced responsibly. A minimum price, or floor price, stops alcohol being sold below cost.
- Harmful drinkers are known to favour cheaper forms/brands of alcohol. If the price of cheap alcohol is increased then the consumption of harmful drinkers will fall and so will levels of alcohol harm.

Minimum pricing will primarily target high strength drinks, sold at the cheapest prices and is likely to have a greater effect on the heaviest drinkers.

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.

There is strong evidence that alcohol consumption is closely linked to price; as alcohol becomes more affordable, consumption increases. A meta-analysis by Wagenaar et al. identified 112 studies worldwide and concluded that a 10% increase in price leads to a 4.4% decrease in consumption.

One example of this link between price and consumption comes from Finland. Cross border trading accounted for a high percentage of unrecorded alcohol consumption in Finland. In 2004, in an attempt to

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14 Wagenaar A.C et al, Effects of beverage alcohol taxes and prices on consumption: a systematic review and meta-analysis of 1003 estimates from 112 studies, Addiction: 2009, 104
compete with low-cost alcohol from neighbouring EU countries, and to reduce cross-border trading, Finland lowered its excise taxes on alcohol. The policy has since been acknowledged as a mistake. Research found that Finnish alcohol price reduction had a significant effect on alcohol related mortality. Liver cirrhosis deaths rose by 30% in one year as alcohol consumption increased by 10%. Subsequently, excise taxes were increased twice in 2009.

More recently Professor Tim Stockwell, from the University of Victoria in Canada, has presented interim findings from his research on the impact of minimum pricing systems operating in the Canadian Provinces and its effects on consumption and alcohol-related hospital admissions\textsuperscript{17}. This research shows that in British Columbia, the introduction of a minimum price model led to a reduction in consumption of 3.4% and the model in Saskatchewan led to a reduction of more than 5%.

This research bears out the modelling work undertaken by researchers at Sheffield University\textsuperscript{18} which indicated that increasing the price of alcohol under the minimum pricing model can bring significant health and social benefits and lead to considerable financial savings in the health service. The research also noted that minimum pricing targeted products with high alcohol content sold cheaply. Cheaper alcohol is often the drink of choice for harmful drinkers and is popular amongst younger drinkers. Minimum pricing will have a greater cost impact on those individuals who drink more. However, these drinkers are more price sensitive and the subsequent rise in price of the cheapest alcohol will have an impact in reducing consumption for this group. For those moderate drinkers, the Sheffield Study estimated a small annual increase in cost of around £10 per annum.

The BMA has not seen any compelling evidence to suggest that an alternative mechanism is available (e.g. banning below cost selling, 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 that exists on minimum pricing. In fact a ban on selling below duty and VAT could see prices remain the same or even decrease further\textsuperscript{19}. 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.

**The level at which a minimum price should be set**

The Sheffield University modelling work 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

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\textsuperscript{17} Presentation to MSPs in the Scottish Parliament, September 27\textsuperscript{th} 2011

\textsuperscript{18} Sheffield University A model based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland, using the Sheffield Alcohol Policy model (v2): an update based on newly available data, 2010

\textsuperscript{19} Scottish Health Action on Alcohol Problems Limiting the damage of cheap alcohol: what are the options 2009
significant and positive impact on health outcomes (i.e. reduced hospital admissions and decreased death rates).

The BMA is pleased that the minimum price will be set via regulations subject to an affirmative parliamentary process. This will allow the minimum price to be regularly reviewed in line with changing market conditions, without the requirement to amend primary legislation.

Other issues relating to the Alcohol (Minimum Pricing) (Scotland) Bill

Supermarket reward schemes
It is clear from the industry’s reaction to the introduction of the quantity discount ban earlier this year that supermarkets will seek to undermine licensing laws and continue to attempt to sell alcohol cheaply in order to maintain market share. In the first week when the Alcohol Act was implemented, supermarkets encouraged customers to buy alcohol online from distribution centres located outwith Scotland to ensure that they could still take advantage of quantity discounts. To get around the ban, some supermarkets have simply slashed the prices of individual units of alcohol diluting the impact of the Act. It is therefore essential that minimum pricing is implemented as a matter of urgency. The supermarket industry has described itself as a responsible retailer, but their behaviour indicates otherwise.

With this in mind, the BMA remains concerned that supermarkets will seek to undermine any minimum pricing legislation by using supermarket reward points and vouchers to reduce the price of alcohol. During the passage of the Alcohol Act in 2009/10, the BMA called for a ban on the use of supermarket loyalty card schemes, reward points or vouchers for alcohol to avoid supermarkets being able to offer further discounts to alcohol which could take the price below the established minimum price per unit. While we accept that there was little political support for such a measure, we would welcome, at the very least, a commitment from the Cabinet Secretary that this is an issue that will be monitored closely to ensure that supermarkets adhere to the legislation.

Public health levy
The BMA understands that with the introduction of the ‘Public Health Levy’, as announced by the Cabinet Secretary for Finance, during the Comprehensive Spending Review in October this year, there is no intention to introduce the Social Responsibility Levy as set out in the Alcohol Act. However the BMA is concerned that this Public Health Levy will be used to fund ‘preventative spending measures’ set out by the Scottish Government. The BMA would argue that as this money is raised through the taxation of some large retailers based on alcohol and tobacco sales, any money raised through this levy should be ring-fenced and used for purely public health prevention measures focusing in particular on alcohol and tobacco services.

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BMA Scotland, December 2011