Alcohol related harm

Alcohol is an integral part of Highland life with an industry that contributes to our economic development. In some remote and rural areas, a distillery or brewery may be the biggest or only employer. The whisky industry, in particular contributes not only to the economy but also helps to attract tourists to the Highland’s. However, we’ve seen over the years that the more affordable, available and acceptable alcohol has become, the more people consume resulting in increased levels of harm that impact on the quality of life across the Highlands and are estimated to cost Scotland £3.56 billion per year. This includes £866 million in lost productivity, a cost of £269 million to the NHS and £727 million in crime costs.

Like elsewhere in Scotland, alcohol causes significant detriment to the people of the Highlands through unnecessary preventable illness, death and social harm. Alcohol is not an ordinary commodity - it is a psychoactive and potentially toxic and addictive substance and is a contributory factor in fifty different causes of illness and death ranging from stomach cancer and strokes to assaults and road accidents. Unfortunately, many people in Highland are drinking above the recommended weekly limit, 35.2% of men and 21.1% of women. According to revised alcohol consumption levels reported in the Scottish Health Survey, a higher proportion of Highland men are drinking above the recommended weekly limit than the national average. More men in Highland (34 per 100,000) also die an alcohol related death than the national average (30 per 100,000).

Over the past 10 years, the rate of hospital admission as a result of harmful alcohol use has increased in the HADP area, as it has done across Scotland (Figure 1). Rates of harm are in excess of the Scottish average and the difference between the two has widened over the past 10 years. Scotland is one of the worst offenders in the UK and across Europe for alcohol related health harm; it is used in this illustration as a comparator and we do not suggest that this is an ideal standard to be aimed for. This widening gap is a clear cause for concern.

Figure 1: Patients hospitalised with alcohol related conditions in HADP area and Scotland
The highest proportion of alcohol attributable conditions among patients resulted from cardiovascular diseases (41% - hypertensive disease (29%) and cardiac arrhythmias (11%)), mental and behavioural disorders caused by alcohol (22%) and injuries (14% - falls injuries (5%).

We are also concerned that a higher percentage of 15 year olds in Highland (88%) have drunk alcohol than the Scottish average (78%). This reflects a tendency for social attitudes in Highland to view underage drinking as a 'right of passage' where it is almost expected that young people will establish drinking patterns well before turning eighteen. We are concerned there is not enough awareness of the potentially detrimental effects on a young person’s mental and physical development or the increased risk of developing dependency problems later in life when drinking is established at an early age. The affordability and availability of alcohol has also resulted in it becoming increasingly acceptable for parents to model hazardous and harmful drinking to children and young people in many households across Highland.

Alcohol Concern estimates that between 80,000 – 100,000 children are likely to be living in families where one or both parents are dependent on alcohol. We do not currently have an estimate of the numbers of children affected in Highland, but are aware the numbers are likely to be substantial and that the needs of many of the children are for the most part, unmet. We are concerned that chronic alcohol dependency can result in considerable time and attention being focused on consuming alcohol as opposed to parenting. This can mean that children are left unsupervised or that their basic needs for food, warmth and shelter may all be compromised. Children within such families may also be at high risk of maltreatment, neglect or abuse. Whole population measures such as minimum pricing are therefore very welcome and indeed essential to the health and well being of Scottish people, particularly future generations. We believe it will have a protective effect on vulnerable populations whilst also reducing the overall level of alcohol problems.

Responses to the consultation questions

We now consider each of the consultation questions in turn:

1. The advantages and disadvantages of establishing a minimum alcohol sales price based on a unit of alcohol;

From a public health perspective, there are no disadvantages of setting a minimum price on alcohol. Alcohol consumption in the UK has doubled over the last 40 years. The average consumption of alcohol in a population is directly linked to the amount of harm. Consumption is strongly linked to affordability. As price has fallen, consumption has risen. Alcohol is now 69% more affordable than thirty years ago. Tackling price and availability are some of the most effective alcohol policies. A minimum price per unit of alcohol sold would have a significant impact on alcohol consumption and reduce harm, particularly in conjunction with recent licensing legislation and the national roll out of alcohol brief interventions. Establishing a minimum price also puts in place a process and embeds a principle that can be used to tailor future policy and price levels.
The price gap between on and off sales has also widened dramatically over the years and the introduction of a minimum unit price will help to address this. In reducing access to cheap high strength alcohol, we reduce health harm for the individual, with a knock on effect for communities, society and the economy. The current trends in Scotland are to drink more at home and to ‘pre-load’ (the practice of drinking large amounts of alcohol at home before going out to licensed premises to continue drinking), it is therefore necessary to apply this principle regarding minimum pricing equally across off and on-sales.

Many of the opponents to minimum pricing argue that it would not differentiate between cheaper brand alcohol more likely to be consumed in larger quantities by harmful drinkers and the more expensive drinks more likely to be consumed by moderate drinkers. However, research done in late 2009 looking at supermarket pricing of a vast array of alcoholic products showed that a minimum price of 40p would lead to little or no change on the price of most spirits and wine but would lead to a rise in the cost of strong ciders and beers. We are supportive of other continuing efforts to reduce alcohol consumption. Minimum pricing can be most effective when implemented with a series of other measures. The other measures include changes to the overall marketing of alcohol, improved screening and brief intervention programmes, improved access to treatment and support services, as well as health promotion and education.

Whilst other measures will contribute there is no effective alternative to minimum pricing. It is true to say that an increase in pricing may be achieved through increased taxation so we would be supportive of such measures as well. This would also allow additional revenue to be used for the support and treatment of problems caused through alcohol misuse. It is likely that this measure would mainly impact on those who drink heavily. However, the rate of alcohol duty is set by the UK Treasury, and so out with the scope of this bill.

Minimum pricing is supported by all seventeen Scottish Directors of Public Health and the Chief Medical Officer. Useful recommendations have also been made by the English Chief Medical Officer, Sir Liam Donaldson who pinpointed the problem of underage drinking as one of easy availability, lack of adult supervision, and cheap prices: “Alcohol consumption, including heavy and regular drinking, is positively associated with the amount of spending money young people have available to them.” In other words, minimum pricing controls would positively impact upon underage drinking. Just as with smoking, the main health benefits from minimum pricing will be achieved through effective legislation and fiscal measures. Minimum pricing will have an effect on alcohol consumption, where other measures have failed.

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

We recommend that the minimum price per unit should be at the very least 40p. We believe that this would have a significant impact on reducing alcohol related harm in Highland not only for the individual but for families, communities and wider society. We accept pragmatically that a 40p initial
minimum price would be a major step forward but we note that increasing the price to 50p or 60p would also have a significant impact on the affordability of the current ‘cheap / strong’ alcohol choices for young people ensuring long term health benefits. This upper limit would result in a 12.3% reduction in consumption with the majority of the behaviour change seen in harmful drinkers. A change in the affordability will have a positive knock on effect on those who don’t consider themselves to be drinking to excess.

This thinking is echoed by the comprehensive research produced by the team at Sheffield University which modelled the effect of different levels of minimum pricing on alcohol consumption in Scotland. 40 pence per unit has a beneficial effect on consumption (-2.3 per cent), while at 50 pence and 60 pence, there are further significant changes in consumption (-6.7 per cent and 12.3 per cent respectively). It is noted that a minimum price of 40 pence when combined with the quantity discount ban included in the Alcohol Act reduces the impact on consumption to (-5.1 per cent), where as a minimum price of 50 pence and 60 pence will increases the impact on consumption to (-8.7 per cent and -13.7 per cent respectively). For these reasons we would prefer the introduction of minimum pricing at 60 pence per unit of alcohol as this is likely to lead to more significant reductions in alcohol related harm. At this level increases in projected annual spend for hazardous and harmful drinkers (+£96 and +£162 respectively) are likely to be experienced as significant and be more effective at encouraging behaviour change. The comparative projected increases in spend for hazardous and harmful drinkers at 40 pence (+£37 and +£85) are substantially less significant and therefore less likely to encourage behaviour change. The estimated financial value of harm reductions in health, crime and employment over ten years are far more significant at a 60 pence rather than a 40 pence level. For example the reductions in health costs (including QALYs) is projected to be (£236m at a 40 pence level and £1331m at a 60 pence level over ten years). We acknowledge that a minimum pricing policy is likely to affect the off-trade sector more than the on-trade sector due to cheaper alcohol being sold in the off-trade sector. However, as the differential between prices in the different sectors reduces, drinkers may switch from purchasing from off-trade to the on-trade where consumption can be regulated and supervised. Research also demonstrates that alongside reduced consumption, there will be reductions in alcohol related deaths, hospital admissions, alcohol related crimes, work absenteeism, unemployment, healthcare costs and incidences of chronic disease resulting from alcohol. The message is clear, the higher the price, the lower the consumption, and the lower the harm caused by drinking.

3. Any other aspects of the Bill

We acknowledge that all minimum pricing scenarios modelled result in increased revenue to the alcohol industry (excluding VAT and duty) and that the higher the minimum price the greater additional revenues. We therefore welcome the introduction of a public health levy from April 2012 so that large retailers bear some of the costs of alcohol related harm through increased business rates to fund preventative initiatives. However, we would welcome further consideration given to introducing separate entrances and payment
areas for alcohol rather than the current arrangements in existing supermarkets of alcohol being integrated with food sales and thus being treated as an ordinary commodity. We would also like to suggest that public health policy is constructed to require supermarkets at a future date to include till receipts which give alcohol as a percentage of total value. This would enable households to consider their percentage spends on alcohol and health professionals to ask for percentage spend information when discussing alcohol usage. Alcohol units purchased could also be placed at the end of till receipts in a similar manner in to order to inform the general public on the choices they make.

If required, HADP would welcome the opportunity to provide evidence to the committee in order to substantiate any of the points made in this response.

Margaret Somerville
Chair
Highland Alcohol and Drugs Partnership
12 December 2011