Alcohol (Minimum Pricing) (Scotland) Bill

NHS Lothian

Introduction

Tackling alcohol misuse and its consequences are key issues for the NHS in Scotland in general and NHS Lothian in particular. NHS Lothian welcomes the introduction of the Alcohol (Minimum Pricing) (Scotland) Bill as it is an evidence based policy that will directly address problematic drinking.

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.

Alcohol contributes disproportionally to deaths in Scotland under the age of 65 which are generally classified as premature deaths. Alcoholic liver disease is the third most common cause of death under 65 and accounted for more than 6% of all premature deaths between 2007 and 2009 (more than 700 per year on average). Mental and behavioural disorders due to alcohol caused another 2.3% of deaths in the under 65s during the same time period.

A review of the literature for the Home Office in England published in January 2011 found that

“Overall the research literature supports an established association between alcohol consumption and many negative health outcomes and the balance of research finds that increases in alcohol prices are linked to decreases in these health harms.”

In 2004 Finnish alcohol policy changed dramatically with excise duties on alcoholic beverages reduced on average by a third, while quotas for travellers’ tax free imports of alcoholic beverages from other European Union countries were abolished and Estonia joined the EU. This change in taxation policy in Finland was reversed quite rapidly as the effects of these changes became apparent on the population. A study into mortality in the years preceding and after the changes in 2004 found that alcohol-related mortality increased by 16% among men and by 31% among women; 82% of the increase was due to chronic causes, particularly liver diseases. The increase in absolute terms was largest among men aged 55–59 years and women aged 50–54 years. Among persons aged 30–59 years, it was biggest among the unemployed or early-age pensioners and those with low education, social class, or income.

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 issue 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 and antenatal staff in screening and delivering Alcohol Brief Interventions (ABIs). NHS Lothian was given a HEAT target of delivering 23,594 ABIs between 2008-2011 and achieved 127% of the target (29,884). Work is now underway to establish this approach in other areas such as smoking cessation, sexual health clinics, acute mental health, and pharmacy. NHS Lothian is also extending the training to promote the delivery of ABIs into community and voluntary and other statutory organisations such as the police, prisons, youth workers, and the fire and rescue service. However, action by the NHS alone will not solve this problem.

Consultation questions and response

- The advantages and disadvantages of establishing a minimum alcohol sales price based on a unit of alcohol;
- The level at which such a proposed minimum price should be set and the justification for that level;
- Any other aspects of the Bill.

Response to Questions

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 introduced by the Alcohol etc (Scotland) Act 2010 and one that balances the ban on promotions in on-sale premises in the Alcohol Licensing (Scotland) Act 2005. 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 197.7 UK units per week. The mean price paid per unit was 43p (lowest 9p per unit) which is below the 71p mean unit price paid in Scotland in 2008. Of units consumed, 70.3% were sold at or below 40p per unit, and 83% at or below 50p per unit. The study found that the lower the price paid per unit, the more units a patient consumed.

Therefore, NHS Lothian suggests that a minimum price of 50p per unit is adopted.

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 introduction of a minimum price for alcohol. Minimum pricing has been supported by the UK’s other Chief Medical Officers and by the Scottish Directors of Public Health Group.

Any minimum price needs to 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 Ministers 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.

Enforcement of a minimum price is also much easier than other measures as it is easy to calculate using the formula MPU x S x V x 100 where MPU is the minimum price per unit,

S is the strength of the alcohol, and V is the volume of the alcohol in litres.

**Conclusion**

In tandem with previous legislation 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 previous legislative, policy and service elements introduced over the last few years.

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iii See http://www.scotpho.org.uk/home/Populationdynamics/Deaths/deaths_data/deaths_top10causes.asp accessed 10th November 2011


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vi Marmot M et al. Calling Time: the nation’s drinking as a major health issue, Academy of Medical Sciences, 2004

vii Meier P et al. Model-Based Appraisal of Alcohol Minimum Pricing and Off-Licensed Trade Discount Bans in Scotland: A Scottish adaptation of the Sheffield Alcohol Policy Model version 2. School of Health and related Research, University of Sheffield, September 2009