Alcohol (Minimum Pricing) (Scotland) Bill

Royal College of Physicians of Edinburgh

The Royal College of Physicians of Edinburgh (the College) is pleased to respond to the Health and Sport Committee’s call for written evidence on the Alcohol (Minimum Pricing) (Scotland) Bill.

Introduction

The College has been at the forefront of raising awareness about the alarming increase in alcohol-related harm\(^1\)-\(^3\), and was instrumental in establishing the medical advocacy body, Scottish Health Action on Alcohol Problems (SHAAP). We strongly supported the Alcohol etc. (Scotland) Bill which was brought before the previous session of the Scottish Parliament. The current Bill being proposed addresses one very important component of the previous Bill which did not reach the final Act, namely setting a minimum sale price for a unit of alcohol.

The re-introduction of a Minimum Pricing Bill gives due recognition to the irrefutable causal link between the price of alcohol, the level of consumption and alcohol-related harm. The College strongly supported the minimum pricing proposal originally and continues to do so. Alcohol abuse requires to be tackled at a population level via a comprehensive package of measures targeted at both problem drinkers and the wider populace (in which the level of consumption has risen significantly and worryingly in recent years).

The College has the following answers and comments on the specific consultation questions

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

The evidence and rationale for a minimum pricing policy on alcohol was set out in our response to the previous Bill and we re-iterate it here:

1. There is now a large body of scientific evidence providing an irrefutable link between the price of alcohol, the level of consumption and, in turn, the level of alcohol-related harm. This is one of the most researched areas of alcohol policy\(^4\)-\(^6\).

2. In the UK while the price of alcohol has decreased dramatically in real terms in recent decades (alcohol was 66% more affordable in 2009 than in 1987\(^7\)), alcohol consumption has doubled.\(^8\) In Scotland, which has 15 of the 20 worst areas for male alcohol-related deaths in the UK\(^9\), alcohol-related deaths have doubled during this period\(^10\) and mortality rates from alcoholic liver disease, hospital admissions from the acute effects of alcohol and the number of alcohol-related assaults have all risen dramatically\(^11\)-\(^13\). This has occurred during a period in which alcohol has
been promoted irresponsibly by large retailers, often at below cost and as a loss leader.

3. It is clear that if wishing to reduce alcohol-related harm, consumption has to decrease and the most effective mechanism of achieving this is to increase the price of alcohol. Various approaches to increasing price have been tried around the world, including taxation. However, research has shown that where a blanket levy is applied to all forms of alcohol (ranging from the low-cost to premium products), drinkers were found to have simply changed their brand choices from expensive to cheaper drinks (often with a higher alcohol volume). This research also highlighted that a greater decrease in consumption was obtained when cheaper drinks were targeted.\(^{14}\)

4. Minimum pricing should not be seen as a policy measure which will tackle every form of alcohol abuse. It would focus on the lowest cost products favoured by the heaviest drinkers and would therefore provide an effective method of targeting this group without penalising the wider population.

5. It is recognised that the adoption of minimum pricing as a policy measure \textit{per se} is relatively untested, and that there has only been limited research published on minimum pricing to date. However, when taking this emerging evidence together with the mass of scientific evidence in relation to consumption and price, studies on the effects of other forms of price increases and a number of national and international reviews, minimum price has emerged as the policy measure most likely to reduce alcohol-related harm. This is why after reviewing the evidence, the World Health Organisation, a range of leading international alcohol scientists, the House of Commons Health Committee, the Scottish and UK Medical Royal Colleges, the Chief Medical Officers of Scotland, England, Wales and Northern Ireland, the Directors of Public Health of every NHS Board in Scotland and the National Institute for health and Clinical Excellence (NICE) in England have all concluded that statutory minimum pricing should be implemented to reduce the increase in alcohol-related harm. Any counter arguments must therefore be evidence based and have cross-organisation support. Scotland has a proud history of adopting innovative public health policy and similar political leadership will be required to implement this much-needed policy measure.

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

The College supports the principle of setting a minimum unit price in regulation following the passage of primary legislation through the Scottish Parliament. This will allow a greater degree of flexibility in setting and adjusting the minimum unit price than if the price had been set out in primary legislation, and will allow it to reflect the most recent evidence and circumstances.
The Sheffield study modelled a range of possible minimum prices to be applied to a unit of alcohol\textsuperscript{15}. This estimated that if a 40p level was applied this would save about 70 lives in year one, rising to 365 lives per year by year ten in Scotland. As the level increased (e.g. to 50p), so did the level of impact. If looking at hospital admissions, a 40p level would reduce such admissions by 3,600 per year and a 50p unit per year by 8,900.

Ultimately, the level at which a minimum price should be set is a political decision involving the benefit of reducing alcohol-related mortality and harm and the acceptability to the Scottish people. A minimum price should be set at a level the evidence indicates will reduce the burden of harm from alcohol use. Setting an appropriate level requires an analysis of the alcohol market, consumption and expenditure patterns and health and crime data. Should the Bill be enacted, it is important that the impact of minimum unit pricing is evaluated and outcomes are audited.

Introduction of minimum pricing should be matched by provision of alcohol counselling and intervention services as part of a comprehensive strategy.

Conclusion

The scale of alcohol-related harm in Scotland presents the Scottish Government, medical professionals and society with one of its greatest challenges. The statistics make harrowing reading and demand radical action. The fact the level of harm has stopped rising further\textsuperscript{7} does not alter the need for urgent action to improve the situation.

Successive governments have tried a variety of approaches to curb alcohol-related harm without success. Evidence has shown that health education has little impact and bolder action is required.

The Alcohol (Minimum Pricing) (Scotland) Bill builds on the legislation introduced in the previous parliament which, collectively, present an opportunity to tackle Scotland’s alcohol epidemic. The College supports the principle of setting a minimum unit price in regulation following the passage of primary legislation through the Scottish Parliament, which will allow a greater degree of flexibility in setting and adjusting the minimum unit price. The Alcohol (Minimum Pricing) (Scotland) Bill is an evidence-based policy to address the problem which recognises the large body of scientific evidence providing an irrefutable causal link between price, consumption.

There is unprecedented international interest in Scotland’s proposed approach to alcohol, recognising that the adoption of minimum pricing in Scotland may provide an innovatory model for replication elsewhere. Scotland has a long and proud tradition of developing innovative public health policy and we would urge the Scottish Parliament to continue this tradition by supporting the Alcohol (Minimum Pricing) (Scotland) Bill.

Royal College of Physicians of Edinburgh
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References

1. Alcohol attributable mortality and morbidity: alcohol population attributable fractions for Scotland. Information Services Division, 30 June 2009
4. Alcohol Policy in the WHO European Region: current status and the ways forward. World Health Organisation Factsheet WURO/10/05, September 2005
5. Alcohol: price, policy and public health, Scottish Health Action on Alcohol Problems, 2007
7. Alcohol Statistics Scotland 2011, Information Services Division, 2011
8. Calling time: the nation’s drinking as a major health issue, Academy of Medical Sciences, March 2004.
10. Unpublished data supplied by the Office for National Statistics. Data derived from ONS, General Registrar Office for Scotland (GROS) and Northern Ireland Statistics and Research Agency (NISRA)
12. Alcohol Statistics Scotland 2007, Information Services Division
15. Model-based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland, ScHARR, University of Sheffield, September 2009