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**Inexpensive purchases**

*MUP will remove the very inexpensive purchases, which are the purchases linked to health problems*

2008/9: Vodka was alcohol-patients’ most popular drink (28.6% of their total units purchased v. 13.1% of total purchased by the wider Scottish population for that year).

Super strength lager/beer: rarely drunk by the wider population (0.006% of their total units) but accounted for 7.8% of patients’ total units.

White cider accounted for 16.0% of patients’ week’s consumption but only 0.009% for the wider population. (Other ciders accounted for 8.0% of patients’ and 0.09% of the wider population’s consumption). (Black et al, 2011)

**My hunch:** some beneficial outcomes of MUP, in order of likelihood:

1. Reduce recruitment to the next generation of dependent/harmful drinkers
2. Lower drinking levels in hazardous drinkers, to lessen health damage such as breast cancer, liver cirrhosis, accidents...etc
3. Perhaps reduce drinking by current harmful often dependent drinkers (our research to examine this, *inter alia*)
4. Reduce binge drinking by youth leading to social disorder, unwanted pregnancy, accidents sexually transmitted disease

**POINTS FROM THE THREE EARLIER JANUARY 2012 COMMITTEES on MUP**

1. Clarification re. our Edinburgh research of purchasing by alcohol-patients in 2008/9:

   Although the ‘average’ price paid per unit was 43 pence, there was a wide dispersion; the average is biased up by some expensive on-licence drinking by a small number of patients (Black et al 2011).

   *Of units consumed, 83% was purchased at or below £0.50/unit.*

2. **Unintended outcomes**

   **Substitution** Currently some in the severest group mix alcohol with other substances e.g. cannabis, methadone etc – it may or may not change; some evidence that heavy consumers change to lower priced intoxicants e.g. if cannabis
gets cheaper, some move to more cannabis (not usually start for the first time); but this is not seen in the wider population - if anything, alcohol is the gateway, and drug misuse falls when drinking falls. (Ludbrook 2010; Humphreys 2010)

**Smuggling /crime**  It might happen: enforcement costs – Yes. But England and Wales might follow? – as happened with the smoking in public places. North and South Ireland – governments interested in MUP also.

**Home distilling and methanol poisoning?**  There's no tradition these days. In Norway it has happened, but deaths extremely rare– (nb Norway has very low levels of alcohol-harms)

**EFFECT ON HEAVIEST DRINKERS - ANY EVIDENCE?**  15 severe homeless alcoholics were asked: “Thinking about the PAST 12 MONTHS, what have you usually done when you do not have enough money to buy alcohol?”. The responses in order of frequency were: seek treatment (13), go without alcohol (12), use illicit drugs (9), "re-budget" i.e. go without other things (8), wait for next welfare cheque (7), collect recyclables to earn extra money (6), make alcohol last longer (6), use other people's alcohol (6), drink non-beverage alcohol (2) or steal alcohol (2).  (Stockwell et al, i2012)

NB  Better responses/services for the few extremely severe sometimes homeless alcoholics could be provided with savings made in public service costs that will likely follow MUP.

**Impoverishment of poor families?**  Accepted last week that alcohol was a factor in health inequalities. Price is important in low income groups. When price changes in the opposite direction, the socially deprived are the most affected, as seen in Finland: the price of alcohol rose a lot in 2004, - the increase in alcohol-related mortality was chiefly experienced among the less privileged (Herttua et al., 2008).

But why would there be impoverishment? 80% would not be affected because they are abstainers or very light drinkers (Ludbrook’s evidence). Furthermore, with respect also to ‘passive drinking’ (harm to others), that sector might benefit most. Reduction of alcohol harms in such communities could also help some escape the reiteration through generations of that deprivation (which is perhaps epigenetically as well as culturally transmitted in those heavy-consuming families).

**3. Are heavy drinkers less responsive to price rises than moderate/light drinkers?**

a. When 15 unit per day drinkers on average reduce by 5% this probably means that a few reduce by 33% and some do not reduce at all. But 33% % reduction means some drinkers consume 5 units less per day; that could be significant to health. When 2 units per day drinkers reduce by 10%, they reduce their consumption by on average one fifth of a unit/ day.
b. However, note that all previous empirical studies were of across-the-board Tax rises, and heavy drinkers traded down, making them appear less price-sensitive. MUP prevents trading down.

c. At 50p per unit moderate drinkers will see very little rise in their weekly expenditure. Our patients, consuming on average 198 units/day, many well below 50p/unit, will not be able to afford to continue that level. Some will need help; others will deal with their dependence themselves (as has always been shown in population studies of dependent drinkers)

4. Scotch Whisky Association’s claim that MUP in Scotland would reduce whisky exports:

WHO is working round the world to reduce overall consumption. If other countries saw health gains from the Scottish policy and followed it, that would tend to level the marketing ‘playing field’, because local distilled products albeit of slightly lower % alcohol (at least the legally distilled products) would rise in price which would help to reduce the effect of penalising import duties on Scotch whisky.

WHO eradicated smallpox and will soon have eradicated polio. Its Global Strategy on Alcohol links price to harm.

MY QUESTION FOR THE COMMITTEE Is there still the VAT loophole whereby supermarkets reclaim VAT when a discounted alcohol is called a ‘promotion’ (Bayer, 2009)

REFERENCES


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