The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 3 March 2010

Session 3

Printed and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

Wednesday 3 March 2010

CONTENTS

HEALTH AND SPORT COMMITTEE
7th Meeting 2010, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Jamie McGrigor (Highlands and Islands) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Liam Burns (National Union of Students in Scotland)
Dr Emilia Crighton (Committee of the Faculty of Public Health in Scotland)
Jack Law (Alcohol Focus Scotland)
Major Logan (Salvation Army)
Margaret McLeod (YouthLink Scotland)
Dr Peter Rice (British Medical Association Scotland and Royal College of Psychiatrists)
Dr Bruce Ritson (Scottish Health Action on Alcohol Problems)
Carolyn Roberts (Scottish Association for Mental Health)
Tom Roberts (Children 1st)
Shona Robison (Minister for Public Health and Sport)
Bruce Thomson (Aberlour Child Care Trust)

CLERK TO THE COMMITTEE

Douglas Thornton

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 3 March 2010

[The Convener *opened the meeting at 09:33*]

Subordinate Legislation

Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2010 (Draft)

The Convener (Christine Grahame): I welcome everyone to the seventh meeting of the Health and Sport Committee in 2010. I remind everyone to switch off their mobile phones and other electronic equipment. No apologies have been received.

Item 1 is oral evidence on an affirmative instrument, which amends existing regulations so as to increase the thresholds below which local authorities are not permitted to charge for certain types of social care that they provide. The cover paper sets that out in more detail. Members have a copy of the regulations along with papers for the meeting. The Subordinate Legislation Committee did not have any comments to make on the regulations.

The Minister for Public Health and Sport, Shona Robison MSP, is with us this morning, accompanied by Sean Eales, head of the care at home and free personal nursing care branch of the Scottish Government, and Jenny Stevenson, policy officer with that branch.

A motion that the committee recommend that the regulations be approved has been lodged and will be debated following the evidence session. Once that debate has begun, the minister's officials will not be able to participate.

I ask the minister briefly to outline the regulations to the committee.

The Minister for Public Health and Sport (Shona Robison): Thank you. I will be brief. The draft affirmative instrument that is before the committee today reflects the Scottish Government's commitment to increase free personal nursing care payments in line with inflation. If approved, the regulations will benefit vulnerable older people.

Last year, we increased the personal and nursing care payments for residents in care homes in line with inflation. These regulations will further increase the weekly payments by £3 to £156 for personal care and by £2 to £71 for additional nursing care, in line with inflation. In line with our concordat with local government, councils will meet the costs of the inflationary increases, which total around £2.1 million across all councils, from their agreed settlement allocations.

The free personal and nursing care policy continues to command strong support, and I hope that the draft regulations receive the committee's support. I am happy to take any questions.

The Convener: Thank you. Do members have any comments?

Mary Scanlon (Highlands and Islands) (Con): I have a question on an issue that Marilyn Livingstone raised at the cross-party group on Alzheimer's, which is chaired by Irene Oldfather. It relates to Abbeyfield care homes in Fife, although I know that it is an issue throughout Scotland.

The amount that is paid for a person in a council-run home is, on average, around 80 per cent more per person per week than it is for someone who is cared for in an independent charity or voluntary sector home. I say "on average", because I have submitted a freedom of information request to all councils in Scotland. I know that that issue has nothing to do with the increase that we are discussing today but, nonetheless, if 80 per cent more money is spent on keeping a person in a council home, given current tight budgets, it means that fewer people are cared for overall. Is your Government concerned about that, minister? Can you do something about that, as all homes have to meet the same quality standards?

The Convener: As you say, the issue is not relevant to the matter that is before us, but the minister should feel free to address it if she wants to.

Shona Robison: I know that Mary Scanlon has raised that issue before. The differential in payments is certainly a long-standing issue; the pay rates for staff and so on are probably at the root of it.

I say to Mary Scanlon—as I think I have said to her before—that all these issues could be considered as part of the work on reshaping older people's care. That is a chance for us to consider, root and branch, how we deliver services in care homes and in the community. We can also examine the respective roles of local authority-run care homes and those that are run by the private sector, and consider whether a refocusing of roles is necessary. All these things can be put into the mix, and perhaps a resolution to some of the long-standing issues can be found through that route.

The Convener: Thank you. I see that no one else has questions on that matter, so we move to item 2, which is a debate on the motion to

recommend that the regulations be approved. Does any member wish to speak in the debate?

Members: No.

The Convener: I invite the minister to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the draft Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2010 (SSI/2010/draft) be approved.—[*Shona Robison.*]

Motion agreed to.

The Convener: There will be a change of personnel.

Public Appointments and Public Bodies etc (Scotland) Act 2003 (Treatment of Office or Body as Specified Authority) Order 2010 (Draft)

The Convener: Item 3 is an oral evidence session on an affirmative instrument. The order provides that healthcare improvement Scotland and social care and social work improvement Scotland—I remember that we call that SCSWIS, or something funny—shall, for the purposes of appointments to those bodies, be treated as if they were specified authorities listed in schedule 2 to the Public Appointments and Public Bodies etc (Scotland) Act 2003. Members have a copy of the draft order with their papers. The Subordinate Legislation Committee has no comments to make on the instrument.

For this evidence session, the minister is accompanied by Denise McLister, business change manager in the scrutiny bodies project team in the Scottish Government. That title is a lot to say when you are writing a CV.

Ross Finnie (West of Scotland) (LD): If you are in charge of SCSWIS, what else would you expect?

The Convener: Yes—you had better have a long title if you are dealing with SCSWIS.

A motion that the committee recommend that the order be approved has been lodged and will be debated following the evidence session. Once the debate has begun, the minister's official will not be able to participate. I ask the minister briefly to outline the order to the committee.

Shona Robison: The order will ensure that the chair appointments to HIS and SCSWIS come under the remit of the Commissioner for Public Appointments in Scotland. It allows those two new scrutiny bodies, which are being created by the Public Services Reform (Scotland) Bill, to be treated for the purpose of appointments to them as if they were specified authorities listed in schedule 2 to the Public Appointments and Public Bodies etc (Scotland) Act 2003. That will bring them within the remit of the commissioner and ensure that appointments are made in line with the commissioner's code of practice.

The Convener: I see that members have no questions for the minister on the matter, and that no one wishes to debate the motion.

Motion moved,

That the Health and Sport Committee recommends that the draft Public Appointments and Public Bodies etc. (Scotland) Act 2003 (Treatment of Office or Body as Specified Authority) Order 2010 (SSI/2010/draft) be approved.—[*Shona Robison.*]

Motion agreed to.

The Convener: I thank the minister, and suspend the committee for 5 minutes while we await the witnesses for the next evidence session.

09:41

Meeting suspended.

09:46

On resuming—

Alcohol etc (Scotland) Bill: Stage 1

The Convener: Item 5 is an evidence-taking session on the Alcohol etc (Scotland) Bill. The first of our two panels of witnesses comprises organisations representing groups such as young people and those vulnerable to problem drinking, and I welcome to the meeting Major Dean Logan, addictions service officer with the Salvation Army; Bruce Thomson, assistant regional director for dependency services with the Aberlour Child Care Trust; Tom Roberts, head of public affairs with Children 1st; Margaret McLeod, policy and information manager with YouthLink Scotland; and Liam Burns, president of the National Union of Students in Scotland.

Before we proceed to questions, I point out that we were due to take evidence today from the Poverty Truth Commission. Unfortunately, those witnesses were not able to attend this morning's meeting. As we were left with a vacancy on the panel, I decided to take the opportunity to invite another organisation to the meeting and I am pleased to say that Children 1st agreed to come at very short notice. I thank Tom Roberts very much for that.

I will ask for questions from committee members. When a member asks his or her question, panel members should indicate whether they want to respond. No one is obliged to respond, but if two or three of you put up your hands, I will take you in order. Please do not worry—you will get your chance to speak. The same applies to the committee. I hope that, unlike last week, I will have only an A list for those asking questions, not an A list and a B list.

Mary Scanlon: I thought that the Aberlour Child Care Trust's submission was excellent, first-class and very interesting to read. On page 3, you say:

"the Bill represents something of a missed opportunity"

with regard to

"the provision of education and awareness raising".

Although you make that comment in relation to foetal alcohol spectrum disorder, the tone of your whole submission suggests that the bill will not be enough to address the very complex issue of high alcohol consumption. How should we take advantage of this opportunity?

Bruce Thomson (Aberlour Child Care Trust): Our learning about what should be done about Scotland's alcohol problem is still evolving. It is, of course, a major problem and has over time proved to be intractable. However, we feel strongly that the minimum pricing policy, which is relatively cost effective and could have quite a quick impact, will set down a marker showing that the Government means business and is determined to address the issue. That said, in our submission, we make it clear that there is no quick fix or magic bullet and that a number of other measures have to be implemented in concert if we are to make a significant impact. We also feel strongly that this measure must have cross-party support lasting well beyond the lifetime of a single Parliament. Although we say that the bill is a missed opportunity, we appreciate that, at the moment, it is covering only certain elements. I guess that those involved in pushing through the bill will have to think about what needs to be done on a number of fronts to deal with the problem.

The Convener: What gaps have you identified?

Bruce Thomson: We are particularly interested in the impact on families and children of parental problem drinking and, indeed, drug use. We know that those things are not mutually exclusive. In many families alcohol and drug problems occur together, and we need to do a lot more to identify earlier children who might be at risk and to put in the necessary support. Such an approach is not cheap, but the resources need to be in place.

Our submission also refers to the role of parents. There has been something of a loss of faith in the impact of education on people's drinking habits, but I do not think that we can afford not to provide education. It is important that people have the right information to be able to make informed choices. As parents, we have a responsibility to provide a model of drinking behaviour for our own children, and a lot more needs to be done in that area.

The Convener: With regard to your comment on identifying children at risk, the committee has heard about difficulties in that respect because the children themselves will not tell teachers or others about their parents for fear of social workers taking them away from their families. How might such children be identified?

Bruce Thomson: According to a recent and very interesting ChildLine report, the name of which escapes me, a large proportion of children are contacting the organisation. For me, the frustrating thing is that, although those children are coming forward and looking for help, things do not really go much further because they get worried about the consequences of having to give their name and other personal details. As you say, they think that social workers or police officers might descend on their home.

The message from the report is that these children are saying, "I have a problem here."

When, five or six years ago, we tried to contact children in the Govan area who were living in problem drinking and drug-using families to get a sense of their experience, we managed over an 18-month period to speak to only seven. We found it very difficult to get children to come forward; of course, there were other parties who were preventing them from doing so. However, ChildLine's experience seems to suggest that they are coming forward and that they want something to be done. The question, though, is what can be done and how we can do it.

Mary Scanlon: I want to look at the wider issues that most of the witnesses have raised in their submissions. I know that the Poverty Truth Commission has not been able to attend this morning but, in its submission, it says:

"we see that Scotland's relationship with alcohol has cultural and psychological roots which minimum pricing alone will not address".

Moreover, the YouthLink Scotland submission says:

"pricing schemes are less important in solving issues related to misuse of alcohol than education, counselling, and health interventions."

Given those comments, what other proposals or recommendations would the witnesses make?

Margaret McLeod (YouthLink Scotland): With regard to Bruce Thomson's comments about messages from young people and relationships within families, YouthLink Scotland strongly supports the whole-population approach to alcohol. In our "Being Young in Scotland 2009" survey, the results of which were launched just last week, young people strongly indicate that families and their peers within the family circle are the most important influence on them. Our concern is that we tackle this as a whole society issue and do not focus only on young people.

On the educational aspect, we send mixed messages to young people through the media and through things that we do. We need to get some of those mixed messages sorted out. We are particularly concerned about the messages that are sent by alcohol advertising being linked to sport and to people whom young people see as being successful. We must consider the key drivers as to why young people are drinking, what starts it and what encourages it.

The Convener: I am grateful for those comments, but I remind the panel that we are taking evidence on a bill, so I ask you to focus on what is in the bill. We agree with many of your comments, but we want to test what is in the bill and establish whether you think that it will work and whether you disagree with it. It will be helpful if they focus on what is in the bill, or on what is not in it but ought to be.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): That is the point. The big point that will emerge from this morning's evidence is that many issues that the panel members have raised in their written and oral evidence are not in the bill.

The Convener: However, we must bear in mind that the purpose of a bill limits what can go into it. We cannot start bolting stuff on to a bill, even though it may have its inadequacies. At this stage, we are considering the bill at stage 1 and I would like the general focus to be on the measures that the Government is trying to implement. People are entitled to make other comments, but it will help us to deal with what is before us today if they focus on the bill.

Rhoda Grant (Highlands and Islands) (Lab): I have a supplementary on Bruce Thomson's response to Mary Scanlon. It is concerning that we know about children out there who need help but, because of how we offer help, will not accept or are afraid to accept it. Could we add something to the bill that would make help available to young people in a way that is acceptable to them?

Bruce Thomson: Within the scope of the bill, we have advocated that some of the money raised by a social responsibility levy on off-licences could be used in some way for the public good. One of our suggestions was that it could be used for investment in youth services. Perhaps it could also be used to find ways of identifying and supporting children earlier.

Helen Eadie (Dunfermline East) (Lab): My question relates primarily to the NUS Scotland submission, which I was interested in for a number of reasons. NUS Scotland has given a lot of thought to the issue and it has also recognised issues with the legal competence of the bill—I congratulate you on having picked up on that.

What I will ask you to comment on specifically, because it relates directly to the bill, is your opposition to the application of any social responsibility levy to student associations. Bearing in mind that, depending on what level of minimum unit pricing is set, something like £70 million, £80 million or £90 million will go directly into the pockets of the industry and retailers, the effect will be that there is no money around for organisations such as yours to provide assistance to those who need it. I ask you to expand on that, because it is an interesting aspect of your evidence and you have given good examples of initiatives that NUS Scotland has rolled out. I congratulate NUS Scotland on that work.

Liam Burns (National Union of Students in Scotland): First and foremost, we are not against the principle of a social responsibility levy. The point that we are trying to make is that it has to be targeted where it will make a difference and will

not be to the detriment of good initiatives that are under way. For a long time, our student associations have had to deal with the idea of having a duty of care to their members, because they are very different from commercial operations. That has ranged from participating in initiatives such as best bar none, which is a scheme that gives student associations the opportunity to win awards for ensuring that they have a positive impact and observe a positive duty of care to their customers. Many student associations also run alcohol awareness initiatives. A few student associations have started to work with universities to help to educate academics in early intervention over problems associated with alcohol. There are many good initiatives but, if a social responsibility levy were introduced, it would take money away from developing those activities. I do not think that student associations are alone in having a culture of responsibility for what their members do. The proposal would also have a detrimental impact on other organisations, which is contrary to the bill's intention. If money is to be generated from a social responsibility levy, we support the idea that it should be focused on local communities. It should be directed to the communities where it is generated so that a difference can be made there, rather than being kept centrally.

10:00

Helen Eadie: Will you expand on your proposal for a social responsibility charter, which you mention on page 5 of your submission?

Liam Burns: The national organisation of which we are a part, NUS UK, is working on that. The stimulus for it was a different debate. In England, the debate about minimum pricing is based on on-sales rather than the off-trade. That started a debate within our membership about what we should do on minimum pricing, which led to a wider discussion about whether we should have a minimum standard that all our members must achieve with regard to their duty of care to their members. That work is proceeding through the NUS and our buying consortium, and we are fairly interested in introducing such a standard in Scotland.

Helen Eadie: What are the panel's thoughts on a waiver of the social responsibility levy? YouthLink Scotland's submission proposes that the levy should be waived for certain on-sales and off-sales licence holders. I invite it to justify that.

Margaret McLeod: The proposal picks up on a point that the NUS made. Some retailers are responsible. They comply with the proof-of-age schemes and ask people for proof of age when they come into their establishments, particularly in rural areas where the service might be attached to a small corner shop or a post office. We would like those retailers' efforts to be recognised and not dismissed. If people make extra effort, that should be supported rather than penalised.

The Convener: Section 10(3) states that the purpose of the social responsibility levy is to meet expenditure that is incurred

"in furtherance of the licensing objectives, and ... which the authority considers necessary or desirable with a view to remedying or mitigating any adverse impact on those objectives attributable (directly or indirectly) to the operation of the businesses of relevant licence-holders".

That does not cover what you said, does it? Good premises that do not cause problems will not have to pay the fee. It will be levied only on premises that cause problems.

Margaret McLeod: I do not think that the bill is clear enough about the conditions in which the levy would be applied.

The Convener: I just thought that I would pick up on the point because I was not sure about it. The levy is targeted. It is not just a general thing, as I understand it.

Ross Finnie: Good morning. I have two questions on separate aspects.

Your written submissions contain what we could safely describe as mixed views on minimum pricing—some very much in favour and some heavily qualified. There is a thread going through them that raises some concerns. I know that we are talking about principles, but it is amazing how those principles appear to vary slightly depending on the possible price that might be imposed. I would like to try to tease that out from you.

The Salvation Army states that a level of 50p per unit would be required before it became significant. That is a view that has been expressed by others. Aberlour Child Care Trust's submission contains quite a few paragraphs in which it argues for and against a level but without specifying what it should be. YouthLink Scotland states that alcohol should be priced to make it less attractive, but it does not specify how that should be done. One or two of you are concerned that, at certain levels, it might affect those on low incomes. We start with a bold statement of the principle, but positions vary as soon as we start discussing the different levels at which a minimum price might be set. I invite you to assist me by indicating whether there is a range—you do not need to be specific—that you could support and a range that you would find difficult to support, for other socioeconomic reasons.

Tom Roberts (Children 1st): We have given broad support to minimum pricing because it tackles what I regard as one of the roots of the problem: consumption by parents who are looking

after their children. The minimum price must be set at a level that impacts on consumption, because we want to achieve reduced consumption across a fairly wide range of the population. It is important not to get sidetracked into thinking purely about heavy, problematic drinkers who may already be in touch with social services—we are looking at the wider range of drinking.

My colleague Bruce Thomson mentioned the ChildLine report "Untold Damage: children's accounts of living with harmful parental drinking", which shows the impacts of parental drinking on children to be long term and significant. Those impacts range from significant levels of neglect and abuse to impacts on family life and relationships within the family, leading to isolation among children. The range of impacts on children is significant, so pricing must seek to reduce consumption across the population, rather than just heavy consumption. That is why we have supported a level of minimum price that will impact on consumption. There are probably people who are more expert at assessing what price will deliver that outcome, but it is important that we should focus on that outcome.

Bruce Thomson: It seems to us that the bill will target the cheaper end of the scale and drinks that are thought to cause problems for particular groups—for example, young people buying cheap cider. However, there are people who consume other types of drinks to excess. Some ordinary table wines are very strong. They are relatively more expensive at the moment, but we understand that minimum pricing will have no impact on the consumption of more expensive drinks of that sort. We are concerned about the impact across the board. We are broadly in support of minimum pricing, but the evidence seems to be evolving. I admit that we have limited knowledge of the evidence, but it seems that there are issues in how we translate what might happen elsewhere into a Scottish context.

Margaret McLeod: YouthLink Scotland is broadly in favour of sensible pricing. We are concerned about particular drinks that are targeted at young people and would like such drinks to be targeted. We do not have the expertise to say at what level minimum pricing will have an impact economically or will drive down demand; that is not our area. However, we are concerned about drinks such as alcopops, which taste considerably different from other alcoholic drinks. Young people have told us that they do not see alcopops as such a high risk because of how those drinks taste. That lulls them into a false sense of security as regards the amount that they are drinking. Our concern is to target products that are aimed specifically at young people.

Ross Finnie: One difficulty that we have with the proposal is that it is aimed, as Bruce Thomson said, at drinks whose price relative to their alcohol content is low. As the French Government has discovered, unless one has a clever formula to create an equation that combines sugar and alcohol, and tax that accordingly, it is difficult to increase the price of alcopops.

Major Logan (Salvation Army): One of the questions that we were asked to answer in our submission was specifically about the level at which the proposed minimum price should be set. We looked at the evidence that accompanied the request to provide evidence to the committee on the bill, particularly the Sheffield study. After considering the impact of a minimum price on a range of alcohol use, we decided that a price of 50p per unit seemed to be the level at which we could get the most benefit without putting the price out of the range of normal social drinkers. We were comfortable with a minimum price of 50p.

Ross Finnie: My second question is on a completely different subject—the proposal that provides the capacity to limit the sale of alcohol to under-21s, which, as I understand it, is still in the bill, although the Aberlour Child Care Trust seems to take a different view. I believe that section 8 contains that proposal, although the trust said in its submission that it might have opposed the bill if it had continued to contain such a provision. In other words, it thought that the provision had been removed. However, I will not debate that, if Bruce Thomson does not mind, and we can agree to disagree. The trust's view is not material, because section 8 is in the bill.

My question is about 18 to 20-year-olds. I do not support the proposal for that group on discrimination grounds but, to be fair to those who proposed it, it is predicated on the view that access to cheaper alcohol in off-sales premises might be an issue. However, it relates to what is happening now. The purpose of the bill is to propose the setting of a minimum price and to radically reduce the level of offers on alcohol, which will mean that access to "cheap" alcohol will be severely constrained. None of the submissions takes up that point. The witnesses' organisations say that they are for the proposal or that they are against it because people have access to cheap alcohol, but one of the bill's purposes is to eliminate the availability of cheap alcohol. Does that alter your view on whether the minimum age for off-sales should be increased from 18 to 21?

Liam Burns: Absolutely not. As we understand it, the idea of the drinking age proposal was, as you say, to deal with the issue of access to alcohol, particularly by underage drinkers. We have a huge issue with the fact that the debate seems to be operating in an evidence vacuum. We

know that the number of prosecutions for underage drinking is incredibly low and that enforcement of the current law has been nowhere near stringent enough. That should be the Government's focus, not bolting on legislation simply to deal with the failings of the current legislation.

I guess that the committee is looking for positive suggestions on the issue. We fully support the Young Scot initiative to roll out the national entitlement card more widely. As the card is proof-of-age standards scheme—or PASS—accredited, it provides proof of age. One idea involved extending the scheme to university and college matriculation cards. We are fairly supportive of that, but I understand that funding for it might have dried up. The committee might wish to look into that.

We are still completely against the principle of raising the drinking age, just as the Parliament was against it. As I understand the bill, unless I have got it wrong, the principle is still there, but its implementation is to be devolved to local licensing authorities.

I have some evidence to offer on that. We made a freedom of information request to all local authorities asking what kind of young person representation they have on licensing boards. We have had nine responses so far and the picture is patchy. Most licensing forums do not have young people of between 18 and 21 on them and when they do have a representative of young people, that person is significantly older than 21. There is a problem with devolving the issue to local communities in the belief that consultation with and responses from those communities will make decisions more informed. That is certainly not the case as far as the people who will be affected by those decisions are concerned.

Margaret McLeod: I agree that enforcement of the current legislation is a significant issue. If we are having difficulty enforcing a minimum age of 18, I am not quite sure what difference increasing the minimum age to 21 will make. When the use of the Young Scot card as a proof-of-age card has been backed up by the provision of support such as the age-restricted sales pack that North Lanarkshire Council has provided for retailers in its area to help with enforcement, it has proved more successful than the alternatives.

10:15

Tom Roberts: We are heavily guided by the views that we heard from young people at an event that we held last year at which they clearly told us that they felt stigmatised by approaches to alcohol that focused purely on their age group. Young people's drinking is certainly problematic, but it is often more visible because they may be drinking in our communities, whereas the heavy drinking that happens throughout our society is more hidden because it takes place in pubs or at home, which is a growing issue. The idea that problematic drinking is not okay at 20 but is okay at 22 loses sight of some of the priorities in tackling alcohol issues. On that basis, we did not support any change in the age.

The Convener: Is part of the problem for us that, when we consider the age restriction in the bill, we are considering public order issues but, when you give evidence on other matters—the impact on families and behind-the-net-curtains drinking—we are looking at health issues? They are often interlinked but more often so with young people because we are talking about long-term damage from drinking.

Liam Burns: I would not mind if the point about public disorder was linked to evidence. The only police force that gave proper statistics for the drinking age trials was Lothian and Borders Police. It saw a reduction of one incident per week in vandalism and public disorder and a 0.1 increase in minor incidents. I use those figures in a reserved way because the Royal Statistical Society branded the statistics that we have from the trials as insignificant and disappointing. We are operating in a vacuum and I find it disappointing that we are targeting efforts at young people with no evidence to say that raising the age has an impact.

The Convener: That is helpful because the Association of Chief Police Officers in Scotland is coming before us on 17 March.

Ross Finnie: Even if one accepted those figures and was not as critical of them as Liam Burns is, they come from an experiment that was based on the current existence of cheap alcohol. The purpose of the bill is to eliminate that issue. If that element of the bill is successful, part of the reason for raising the age from 18 to 21 will have been removed, will it not?

Liam Burns: If you are asking whether that means that the change in age should not be pursued, I agree absolutely.

Ross Finnie: It is a different basis; it is not the argument but the basis that has changed. The question was directed not only at you but at all the witnesses on the panel.

Major Logan: The Salvation Army made no substantive comment on that question when it made its submission. However, the earlier the age of onset of drinking behaviour, the more problematic that behaviour becomes as the person gets older. If the purpose of the bill is, as Mr Finnie has clearly said, to use the current legislation to enforce the age of 18 as the cut-off point for the

use of alcohol, I agree with his argument. If we can delay the onset of drinking behaviour through the alcohol bill, the societal benefits in a generation in Scotland will be significant. I agree that raising the drinking age to 21 as a stand-alone measure would not be as effective as ensuring that we drive through the other parts of the bill. If we do that, perhaps the drinking age will not be the concern that we currently think it is.

The Convener: Do you agree, Mr Burns? You are nodding, are you not?

Liam Burns: No, I am trying to differentiate the ideas of raising the drinking age and stopping the early onset of drinking alcohol. In America, where the drinking age is higher, many states are now considering a reduction in age because the higher age has not had the desired impact.

Major Logan: To clarify, I am looking at the matter in the round. We are considering the whole impact of the proposed legislative package. If we maximise the opportunity that it presents on a societal scale, the debate about whether the drinking age should be 18 or 21 will probably not be as significant as it currently is.

Michael Matheson (Falkirk West) (SNP): It is clear from the written evidence that, with one exception, the witnesses' organisations broadly support the principle of introducing minimum pricing as a mechanism to tackle the alcohol problem. The exception is YouthLink, whose submission I am a little confused about and would therefore like some clarity on. YouthLink questioned whether minimum pricing is "an effective tool" and stated that the approach to take is to have "a sensible way" of pricing alcohol. Could the witness from YouthLink give me a clearer understanding of what is meant by "sensible" pricing? In addition, what are YouthLink's views on how such pricing should be delivered through the bill?

The Convener: It would be helpful for the official report if you could say what page and paragraph you are referring to.

Michael Matheson: It is paragraph 3.1 on page 2.

Margaret McLeod: The issue that we were trying to elaborate on was not the minimum unit price. The big issue for us is the promotion of alcohol through, for example, the promotional activities of supermarkets, in that people who might previously have bought only a couple of cans now buy a couple of cases, because the pricing is more attractive. We perhaps should have clarified that point in our submission. Our approach is to consider all the evidence, but there were mixed views among our membership about minimum pricing. However, members recognised the damage that is being done by many of the promotional aspects of the sale of alcohol and believe that that must be tackled.

Michael Matheson: Would it be fair to say that YouthLink's view is that price must be one of the components to be addressed in dealing with the issue of cheap alcohol?

Margaret McLeod: It is certainly one of the components, but we also made it clear that education, counselling and health must go alongside pricing, which will not work on its own.

Michael Matheson: That is helpful—thank you.

My second question is to Bruce Thomson. I take it from your evidence that you support the policy of minimum pricing. However, in the final paragraph on page 2 of your written evidence, you raise specific concerns about minimum pricing. You refer to the

"potential impact of increasing the cost of alcohol"

on

"the disposable income of a family".

You refer to the potentially disproportionate impact that a price increase could have on families with a low disposable income but a chronic alcohol problem. You believe that, if the minimum pricing policy is pursued, it must be monitored closely, and that there is a lack of evidence on the impact that minimum pricing could have on some families. Do you think that research work should be undertaken prior to introducing any policy on minimum pricing, or do you believe that close monitoring and research should be undertaken once minimum pricing is in place in order to evaluate its impact?

Bruce Thomson: It should happen in parallel. On the link between price, consumption and harm, if we assume that consumption and therefore harm must go down when price goes up, that will be very good for children growing up in problem-drinking families. However, if the problem is more intractable than that, so that a price rise does not reduce consumption but results in people paying more for alcohol—we are talking about families who already have very limited means—we are concerned about the impact of that on meeting children's basic needs for food, clothing and so on. We therefore said in our submission that we support the principle of minimum pricing but that its impact on families should be monitored to ensure that it works.

Michael Matheson: In your and your organisation's experience of working with children and families in such situations, do you think that such research could reasonably be undertaken in parallel with the minimum pricing policy being in place?

Bruce Thomson: Yes, I think that it could. One of the other things that we need to consider is the comparative impact on children of home drinking, which Tom Roberts mentioned, as opposed to pub drinking. I am talking about excessive drinking. Are children more subject to harm if the drinking takes place in the home rather than elsewhere?

The Convener: I do not know whether Mary Scanlon wants to ask about the focus on families that we saw in Finland, which is a point that she has raised before. It would be an interesting point to put to our witnesses.

Mary Scanlon: No, I would like to follow up Ross Finnie's first question.

The Convener: If you are not going to raise it, I would like to put the point to our witnesses. You have raised the issue before, citing the Finnish example. Do you want to ask about that, as you have raised the matter previously?

Mary Scanlon: In Finland, we were impressed that the public health message asked parents to examine their conscience about the effect that their drinking was having on their family. We all agreed that the advertising was clever and forced people to question their drinking. We also discovered that, as a consequence of that, the level of drinking among those aged 18 to 25 had fallen significantly. We have heard about the issues regarding peers and families, and we have heard from the NUS about the issues for young people. There seems to be an assumption that drinking is a problem for young people, but, if we look only at young people and think that they are the problem, we will miss what the Finns are doing. One of the most impressive things that we saw on our visit was the public health message, which made parents look at the effect of their drinking on their relationships with their children. It was a very powerful message.

The Convener: It is useful to put that on the record. The advertising was focused on the child's point of view. The parent thought that they were dancing with the child, or the father thought that he was embracing the child, but they were being rough and the child was being hurt. The parent did not realise it because of their intoxication. That was a very powerful message. I do not know whether you have come across that in the projects that your various organisations have undertaken. We will move on, but I thought that it was useful to point out that we had seen that and had been impressed with it.

We will hear from Richard Simpson, followed by Rhoda Grant.

Dr Simpson: Do you want to go first, Rhoda?

Rhoda Grant: No, you—

The Convener: Whatever. You are friends, so you can resolve it. Rhoda, are you deferring to Richard—for once?

Rhoda Grant: Yes, I will defer to Richard.

Dr Simpson: My feeling is that we are focusing too much on minimum unit pricing. I want to bring us back to the child issues, which are crucial, in order to address what is missing from the bill. In my experience as a consultant in addictions working with alcohol problems, I found that the presence of children in problem families was not being recorded—that was simply not happening when I worked in Glasgow, Edinburgh and West Lothian. The bill does not require the recording of that information by treatment services.

There are some other issues that have been raised with me. The Young Scot card is the only one that has not been—what is the word?—used fraudulently. Driving licences and passports can all be used fraudulently but, so far, according to the Scottish Business Crime Centre, no attempts have been made to use the Young Scot card fraudulently. However, I wonder whether we should impose on local authorities a duty to support such initiatives as street pastors and taxi marshals to handle people who are drunk and incapable and related issues. We might also encourage the promotion of social peer norms research such as is carried out in America, which we learned about from Scotland's Futures Forum. There are a range of issues that the bill does not address. Should we impose on local authorities a duty to prepare an annual plan that includes such things and should the local health boards impose on their addiction services a requirement to address the child issues?

The Convener: I think that the word that you were looking for was "counterfeited".

Dr Simpson: Yes.

The Convener: The official report may wish to put that in instead, gently to amend as we go. I do not know whether we are entitled to ask that.

10:30

Bruce Thomson: A lot of work has been done on the development of policy and procedures to identify children of parents who are attending services, on the sharing of information across professional boundaries and generally on finding the best way to tackle the problem. Our experience is that that is not happening as it should. Without pointing the finger at professional colleagues elsewhere, I would say that there are patches of good practice, and there is a lot of focus on the person who is presenting the addiction problem, rather than on the impact that their addiction is having. We need to do an awful

lot more in that regard, perhaps developing policy documents and working at a strategic level. People need to be confident that the procedures are in place. The evidence on the ground suggests that that is not happening as consistently as it should. That is a concern.

Margaret McLeod: I welcome the comments that have been made about the Young Scot card. I was involved in its early days, as it changed from what was known as a dumb card to a smart card. I find that gratifying—that is nearly 10 years ago now. The big thing that has changed the situation round and brought about a lack of counterfeiting has been the engagement of young people in the process. They feel ownership in their local areas, as they are involved through the discounts that are offered. The education services have been engaged, and the engagement of young people in the process has helped that change to take place. If we are to consider some form of enforcement with local authorities in other areas, we need to continue with that engagement with young people. That is where success lies.

Liam Burns: Our members made a few points about what is not in the bill. Pardon me if I do not necessarily know about the things that it is possible for it to cover. We have talked about alcohol pricing, but people also came back to us about the pricing of soft drinks and their inaccessibility in the on-trade, with people choosing to drink alcoholic drinks simply on that premise.

We have been discussing the role of local authorities. Some members, particularly those from Edinburgh, where there is a student safety forum, drew our attention to the idea of taxi marshalling. That has involved a strong partnership between the local authorities and the various colleges and universities in the area. Local authorities could do more in that regard.

I have already mentioned young people being on licensing forums. There is provision for that now, but participation is incredibly patchy, and we could step up our efforts to ensure that that happens more, so that young people are contributing to the debates and are seeking local solutions to local problems.

I absolutely support the idea of the Young Scot card being rolled out. That has been done successfully at the University of Abertay Dundee, together with Dundee City Council. It has now become a local services provision card more than anything else. The card is actually the national entitlement card, although it is fronted as "Young Scot". A lot of benefit with regard to proof of age could come from rolling the card out to universities and colleges across Scotland.

Major Logan: I thank Dr Simpson for his additional questions. There is a firm belief that alcohol misuse can be familial—there are strong family links to the use of alcohol. We recently conducted a study among people who utilise our homeless service provision. There have now been more than 1,000 forensic interviews with people who have come into our units, and 70 to 80 per cent of them have significant alcohol problems. Many of them speak of early childhood experience of alcohol as a predictor of their exclusion in later life. Any intervention that can be offered at an early stage—by considering the whole family in situations where someone presents with an alcohol problem—is of vital importance, although I am not an expert, and I do not know how we do that. If we are to break the cycle, there must be more than just a legislative response. Other interventions must be made available.

The Salvation Army is active in the street pastor movement. We do not particularly want local authorities to legislate for the work that street pastors do, but they form a valuable part of the response to problematic drinking, particularly in major towns and city centres. The street pastor's role is in its name, and it is to offer assistance to anyone who needs it at the time.

The argument about designated places to deal with people who are drunk and incapable needs to be raised again. I know that there are questions about who funds it, but we know that the success of designated places in arresting problematic behaviour and helping to identify problematic drinking cannot be argued against; it does work. When it is implemented, it is very successful. That is an adjunct to the committee's discussion, but designated places need to be high on the agenda alongside the bill.

Dr Simpson: I thank the witnesses for those answers. Arrest referral has rather stuttered as well; we have only five schemes in Scotland. Arrest referral provides an opportunity for people to address their problems and link to treatment right away. We have not rolled that out.

Over Christmas, I spent some time working with carers' groups in part of my constituency. When I talked to the youth worker involved, I was horrified to learn that he reckons that they have only identified somewhere in the region of 15 per cent of young carers who are responsible for parents who have a variety of conditions. Some might have mental health problems, but a significant number of those parents have alcohol problems and the youngster has to act as a young carer. I do not want to impose more legislation on local authorities to make them act, but I want to impose more legislation on them so that they plan to deal with or consider those issues. Would any of the organisations that are represented here today like

to talk a bit about young carers and whether we need something more in legislation or some requirement for action by the national health service or the local authorities working with voluntary organisations?

The Convener: I think that that is a question that was not answered. It could be put into legislation that local authorities or NHS boards are required to publish annually or be audited on their strategies for dealing with alcohol problems in their area.

Tom Roberts: That point links back to the earlier point about recording and identifying children who are affected by alcohol use in the family. Our submission raises a number of points on that, particularly about the need for services to be joined up. When an adult presents with alcohol issues, services should also look at the wider family, including who is caring for that adult, because all too often it is the children and young people. Also, that care is often unseen. It might well start off with the children getting themselves ready for school in the morning, and extend from there. It is a huge issue.

We also raised the need for universal support for families. At the moment, it is high-tariff families with significant difficulties who come to the attention of social work departments, and that is understandable. However, it means that we miss an awful lot of children who are significantly affected by alcohol use, and caring is just one aspect of that. There is an important point there, some of which might be dealt with in legislation by requiring local authorities to identify such children and provide services for them.

The role of health visitors and the recent changes to that role also needs to considered. Health visitors are a group of professionals who have almost universal access to parents, and the support that they can provide has diminished. Through our parentline service, we hear that services are simply not available. That is a hugely important issue.

The Convener: The committee was unanimous and quite firm on the important role of health visitors in its report on child and adolescent mental wellbeing.

Bruce Thomson: I want to emphasise what Tom Roberts said about young children and the role of young carers. We all appreciate that young carers play an extremely valuable role in keeping families together and looking after siblings and parents. However, when very young children find themselves in such situations, it starts to have an impact on their childhood—their experience of being a child, having fun and so on, which is important. We need to bear that in mind.

The Convener: Throughout the years since the Parliament was established, we have received very important presentations from young carers. Many did not even know that they were young carers—they were just getting on with life. They indicated that their role as carers impacted on their education, as it led to their falling asleep at school and so on. Your point is well made, but could we include in the bill a duty on local authorities and NHS boards to publish an audited strategy on what they are doing in their areas to draw together social work, housing, the NHS, education, the police and so on with regard to alcohol issues?

Major Logan: There is value in holding local authorities to account on the issue. We know that early childhood experience of alcohol, especially in the family, has an impact on the direction a young person's life may—not will—take. We have evidence that it can lead to social exclusion and addiction issues for the young person.

We would support any early intervention. In some cases, it is about a lost childhood. Young carers should be given as much opportunity as possible to blossom. That cannot be done through legislation, but we can hold local authorities to account on whether they are identifying the points of need and developing strategies to assist as much as possible. There is enough evidence to hold them to account. That should happen as an adjunct to the bill as it progresses.

The Convener: Those comments are helpful.

Rhoda Grant: I return to the issue of price, consumption and harm. We heard from the University of Sheffield that the study that it published was based on modelling rather than evidence and practice, because no country has ever gone down this road and the university had nothing other than modelling on which to base its research. Last week, it was suggested to us that the modelling may have been based on price reductions rather than price increases. When we were in Finland, we saw that the impact of price reduction was huge—people's drinking rose immediately and there were much greater sales of alcohol. However, when an attempt was made to redress that by increasing prices, sales did not fall proportionately. That is a concern.

Most people who are in favour of minimum pricing say that they support it because of the evidence—the belief that it will lead to an overall reduction in consumption. I am keen to know whether you have any evidence—other than the Sheffield study, which is not evidence but modelling—that minimum pricing will work.

Tom Roberts: In our written evidence, we explained that we see minimum pricing as only one way of tackling the issue. We have seen some of the Finnish research, which shows that there is

not an exact link between price and consumption. However, from what we have seen, there is enough evidence to suggest that, as price changes, consumption habits change. Price is one important way of tackling the real crisis in drinking that exists in Scotland, which is why we have supported minimum pricing.

To my mind, it is common sense that we should tackle price as one way of tackling people's consumption, just as, for a number of years, we have increased the price of cigarettes. That is not the sole reason that more people have stopped smoking, but it is one reason for that. People say that they are quitting smoking to save money; the NHS uses the money that people save from not smoking as one motivation to quit. That takes us back to the issue of the public health messages that are sent to parents about the impact of drinking on families. We should encourage people to look at its impact not only on behaviours and their children but on their pocket. That adds up to something that might start to make a dent on the problematic drinking that exists in this country.

10:45

Major Logan: I appreciate that the University of Sheffield paper is based on modelling. My journey began when I read the book "Alcohol Policy and the Public Good" by Griffith Edwards et al, which was published by the World Health Organization. That work clearly shows how, even way back in the early 1980s, there was a distinct link between the availability and price of alcohol, and public health, which makes it a societal issue. Thomas Babor backs up that point in his book "Alcohol: No Ordinary Commodity—Research and public policy". Only last week, I received by e-mail a copy of the WHO's latest pronouncement on alcohol, which also comes out strongly in favour of Governments effecting a societal change in drinking behaviour by using the two levers of price and availability. Therefore, the issue is not just about modelling, although I understand that the model goes deeper. As no country has ever trialled what the Scottish Government is proposing, it is always difficult to say what the effect will be. However, I think that enough of a body of evidence exists from over the years to say that price and availability are the two levers that can be used to affect alcohol consumption at a societal level.

Bruce Thomson: Over the past 50 years, the trend has been that alcohol consumption in this country has more than doubled while the price in real terms has come down significantly. Another point is that using minimum pricing as a lever was first proposed, I think, by the royal colleges of medicine.

Rhoda Grant: The University of Sheffield study did not consider the impact of a minimum price on different income groups. Given that the jury is still out about the real impact, I am concerned that a minimum price might affect the child who is growing up in a low-income family in which alcohol is already being abused. Could a minimum price for alcohol create more problems for such children? Should we consider alternatives—and, indeed, consider the impact on different income groups—before implementing a minimum pricing policy, so that we can see whether the policy stacks up?

Bruce Thomson: We have already commented that we think both things could be done in parallel. On balance, we feel that minimum pricing is worth trying. The policy could have a significant impact, but no one in this room knows what the impact will be. Our view is that, on balance, the policy is worth trying but it would need widespread support to work. In addition, the policy could not work in isolation from other measures, which, as people have suggested, need to be part of the whole package.

Ian McKee (Lothians) (SNP): I have found this evidence session very helpful. Indeed, the convener will be pleased to hear that some of my questions have already been answered. We all agree that much more needs to be done about our society's alcohol problem than can be done in this—and probably in any—bill, because the problem is not just for the Government but for the whole of society. I think that we all accept that all sorts of different things need to be done to tackle the issue. However, for the moment, we are considering the bill.

A controversial measure in the bill is the proposal for a minimum price on alcohol. Just a couple of days ago, the Health and Sport Committee and others received a joint statement, which says:

"A consortium of Scottish children's organisations are today ... calling on the Scottish Government to put children's interests at the heart of alcohol policy.

The NSPCC's ChildLine service in Scotland along with seven organisations – Children 1ST, Aberlour, YouthLink Scotland, Barnardo's Scotland, Action for Children, Quarriers and Parenting across Scotland – have submitted a joint statement to the Scottish Government in support of policies aimed at reducing alcohol consumption, including minimum pricing on alcohol."

For the sake of clarification, do all the witnesses agree with that statement?

Witnesses *indicated agreement.*

Ian McKee: Thank you very much.

Mary Scanlon: My question was touched on by Rhoda Grant and Ross Finnie. The NUS's written submission states:

"NUS Scotland would oppose a minimum price set at a level which would prevent individuals on low incomes from purchasing alcohol to drink responsibly."

What is the minimum minimum price that the NUS is looking for?

Secondly, there is no doubt that demand for alcohol is relatively inelastic among those who drink less responsibly. My concern is that, as has already been touched on, parents in that category will continue their level of alcohol consumption and their children will go without food and clothes. How will a minimum price affect such people, particularly those who are on low incomes?

Liam Burns: On setting the minimum price, the short answer is that we have absolutely no idea. I think that it is not for our organisation to do that.

If the legislation on minimum pricing is to be successful, it must cause a reduction in unhealthy consumption. That is how we would sum up what the bill is meant to do. If unhealthy consumption ends up continuing because households simply make do with less money, the bill will clearly have failed. If it results in those on low incomes who consume a healthy amount of alcohol having to consume less, it will also have failed. We can give those broad principles, but we are in no position to say what the minimum price should be.

The Convener: We have already considered the level of the minimum price in response to Ross Finnie's question, to which we heard two counter-arguments. Mr Thomson has already addressed the impact that minimum pricing will have on family budgets, so I think that we are going back over old ground. Therefore, I feel that it is time to bring this evidence session to an end. I thank the witnesses very much for their evidence, which has been very helpful.

The committee will be pleased to know that I will suspend the meeting for five minutes before we move on to the next team of witnesses.

10:51

Meeting suspended.

11:00

On resuming—

The Convener: The witnesses on our second panel represent medical and health organisations. I welcome Dr Peter Rice, consultant psychiatrist at the British Medical Association Scotland and chairman of the Royal College of Psychiatrists. Are you wearing both hats today?

Dr Peter Rice (British Medical Association Scotland and Royal College of Psychiatrists): Yes.

The Convener: Right. I also welcome Dr Bruce Ritson, chair of Scottish Health Action on Alcohol Problems; Dr Emilia Crighton, convener of the committee of the Faculty of Public Health in Scotland; Jack Law, chief executive of Alcohol Focus Scotland; and Carolyn Roberts, head of policy and campaigns at the Scottish Association for Mental Health.

You are all experienced panellists, so you know that you should indicate to me when you want to comment. We will move straight to questions from committee members. I call Helen Eadie, to be followed by Mary Scanlon.

I beg your pardon, Helen. Ross Finnie is ahead of you. He asked even before we went on microphone. This is new—we have pre-emptive bids. I call Ross Finnie to be followed by Helen Eadie, then Mary Scanlon.

Ross Finnie: I was just trying to be helpful to the convener. I did not realise that it was going to cause a kerfuffle.

I would like to ask you the same questions that I asked the previous panel. First, I ask you to be more specific about price. We are trying to get to the bottom of whether the principle of minimum pricing will have a significant impact. The Faculty of Public Health is clear in its written submission. I refer to the final sentence on page 1. It has polled its members and, interestingly enough, it tells us that 59 per cent favour a price of 60p per unit, 35 per cent favour a price of 50p and only 5 per cent support a price of 40p. That is germane to what level you think a minimum price would be significant.

The BMA wants the policy to have

"a significant and positive impact"

but it is not specific about the range of prices within which there would be such an impact. SHAAP states:

"For a minimum price to be effective, it will need to be reviewed",

but it does not tell us what will need to be reviewed. Alcohol Focus Scotland does not comment on any particular level. SAMH mentions an interesting test on page 3 of its submission, stating:

"SAMH would expect minimum pricing to be set at the level at which the greatest health benefits would be felt by the greatest number of people".

Again, however, that is a general comment rather than a specific one.

I invite the panel to tell us, in relation to the principle of the bill, at what level we will get the significant impact that you all appear to believe should be achieved.

Dr Rice: The BMA's position, which I think is shared by many of the royal colleges, is that that is

a matter for the Parliament; it is a matter for the legislative process.

Ross Finnie: Hang on a minute. You have far greater knowledge and understanding of these matters; parliamentarians acquire that knowledge by taking evidence. The whole purpose of taking evidence is to guide and help us. We do not pluck figures out of the air and vote on them; we vote on the basis of evidence. With all due respect, we are looking to people with your levels of knowledge, understanding and experience to assist us. It is not a matter just for the Parliament.

Dr Rice: I was going to go on to say that the Parliament requires good data and good econometric modelling. The committee has already taken some evidence on that. Considerably more data are available than we have had access to in the past. An enormous amount of data is available from retailers on a localised basis, and that could feed into the debate.

The price range that has been considered, of 40p to 60p, seems to me to be right. For instance, we know that only 9 per cent of alcohol at 40p per unit is consumed by moderate drinkers—people who drink less than 21 or 14 units a week—and that it is considerably preferred by heavy drinkers, which is those who drink more than 50 or 35 units a week. Parliament must make a decision that is based on the best data that it has. It already has economic modelling studies, which could be further improved with more data. I would not expect Parliament to give me the sole right to decide on the issue—that would not be wise at all because the decision must be made by a group of people—but if you want to nail me down to a price, the appropriate level seems to me to be 50p. However, the decision must be based on further data and modelling.

Ross Finnie: That is helpful. I was not necessarily looking for a specific price; rather, I wanted to find out whether you believe that a price in the range of 30p to 40p would not make a significant difference and that therefore the principle of the bill could not be sustained. I am trying to get a discussion of a range, but not too wide a range, as that is not helpful to us. A figure of 40p to 60p is now unhelpful in terms of the debate, although that is not your fault.

I invite comments from other witnesses.

Dr Bruce Ritson (Scottish Health Action on Alcohol Problems): I have no quarrel with the range that is being discussed. The price must be set at a level that will improve public health. It is hard to know what conditions will prevail when a minimum price is introduced, which raises problems for predicting an exact level now. Also, the price would have to be revised from time to time depending on the prevailing economic state. The range that has been given is sensible, but to be more specific would be unwise. Our intention is to have a level that will radically improve the public health of the nation.

Ross Finnie: If I were to absolutely guarantee that my colleagues and I would take account of all material economic changes between now and then—which would be the sensible and rational thing to do—what should our starting point be?

Dr Ritson: The range that you have described is reasonable.

Dr Emilia Crighton (Committee of the Faculty of Public Health in Scotland): Based on the current evidence, most of our faculty members went for 60p in the survey that we conducted, simply because of their desire to maximise the public health benefit. Any price in the range that has been suggested in the evidence would be acceptable, because it would have an impact but, as public health specialists, our members wish to maximise the benefit to the population. That is why we gave that figure in our submission.

I agree with the other witnesses that the price should track the prevalent conditions in society at any time. We should not fix a price; we should say that, with today's prices, we would have a certain level, but we will have to revise and update it.

Jack Law (Alcohol Focus Scotland): I have little to add to what the other witnesses have said, other than to remind ourselves that we are talking about the relationship between price and consumption. Irrespective of the eventual outcome of the Administration's decision, all the modelling suggests that there is a range of minimum unit prices that would be effective. That is the important point. Certain factors would need to be considered in that context, such as price inflation. We are in a period in which it seems that inflation will increase. It is difficult to give a specific unit price at the moment, because all the other factors must be taken into account. However, Alcohol Focus Scotland believes that a range of 45p to 60p is a reasonable one within which to set the price. According to the modelling that has been done, anything less than that would not really have the required impact on overall population consumption.

Ross Finnie: I want to add something before Carolyn Roberts comes in. I do not think that there is too much argument about the relationship; the difficulty that arises in connection with the bill's principles and whether it will be effective is that there has to be a significant change to justify the kind of market interference that is proposed. That is why we want to be clearer about what we mean by "significant", which relates to the price that you would impose.

Jack Law: That is the importance of modelling; it creates an understanding that enables decision makers to make the right decision.

Carolyn Roberts (Scottish Association for Mental Health): I do not have much to add. I agree with what my colleagues have said: it is not appropriate to set a price immediately; you have to take into account the change in economic conditions between now and when a price would be set. I do not think that we are the best organisation to advise on setting a price.

Ross Finnie: My second question is on your views about raising the age for off-sales purchases, from 18 to 21. The BMA did not have a policy on that.

Paragraph 3 of the Faculty of Public Health's paper said that minimum pricing was more likely to have an impact on younger people's habits and that we should look at that rather than raise the age from 18 to 21.

On the other hand, paragraph 7 of the SHAAP paper states:

"Restricting young people's access to cheap off-sales alcohol is likely to lead to an overall reduction in the alcohol consumption".

Alcohol Focus Scotland was broadly of that view. SAMH commented on that in paragraph 3 of its submission, in which it talked about alcohol being cheaper.

Do you think that minimum pricing is more effective than drawing distinctions between the type of sale? I asked the first panel about cheaper alcohol being available in off-sales. The bill seeks materially to alter that by a combination of setting a minimum price and reducing offers and discounting, which would change that focus. Does that affect your view of whether pricing is more effective than raising the age for off-sales?

The Convener: I got lost in your question. You all followed it, but I got a bit lost. I thought that we were talking about raising the age limit from 18 to 21.

Ross Finnie: We are.

The Convener: I am sorry. It is my fault, not yours.

Ross Finnie: The Faculty of Public Health says that it thinks price is more important than the age limit. My second point is that some have referred specifically in their evidence to cheap alcohol in off-sales and yet one of the purposes of the bill is to change that. I was just asking whether they would still support raising the age to 21.

The Convener: Right. I am with you now.

Dr Crighton: I will start answering the question, which was addressed to us specifically. We have looked at the effectiveness of different interventions. In our answer to the specific questions, we argued that interventions on price and availability are more effective than simply changing the age limit. Therefore, we strongly support the principle of minimum pricing and banning discounts, which will reduce the availability of cheap drink to this specific group of individuals. We are not necessarily against raising the age limit, but reducing availability and modifying the price would be higher in the hierarchy of effectiveness of interventions.

Dr Rice: Perhaps I can say a bit about the under-18s, because drinking among that group is an important issue. The Scottish schools adolescent lifestyle and substance use survey of 13 and 15-year-olds shows us that, increasingly in Scotland, access to alcohol for 13 and 15-year-olds is through agents—third-party purchase; it is not through direct purchase. Age verification schemes have worked and have led to quite big changes in purchasing practice. The opportunity for 15-year-olds to buy has fallen. Their access is now through agent purchase rather than buying alcohol themselves.

Much of the agent purchase is by 18 to 21-year-olds. When I was in New Zealand it was popular for 18, 19 and 20-year-olds to buy alcohol and pass it on to younger people; it was especially common for 18-year-old males to pass a bag on to younger girls. It does not matter whether it is challenge 21, challenge 25 or challenge 45—it will make no difference to agent purchase. We need to find a way to address that issue. One of the appeals of the age 21 limit in off-sales is that it will make a difference to under-18s' access to alcohol. You are correct that minimum pricing will make a big difference to that group; they have access only to limited funds and they are likely to be price sensitive. A sensible approach might be to implement minimum pricing and see what happens with drinking among under-18s. If agent purchase continues to be a big problem, further action might have to be considered.

11:15

Jack Law: The approach that Peter Rice suggests is sensible, but I remind the committee that we are talking about relationships between initiatives. We have a major alcohol problem in Scotland. The price of alcohol is undoubtedly one of the issues. Alcohol is incredibly cheap, which means that it is more readily available to young people on a limited income. Attached to that is the issue of licensing and enforcement. One of the primary objectives of the Licensing (Scotland) Act 2005 is the promotion and improvement of public health, which this bill also seeks to tackle. The question is about availability and enforcement of

the law. We keep missing the fact that the first point of enforcement of licensing legislation is the licensee. If there has been a failure in the voluntary codes on the introduction of challenge 21 and so on across the board, something else needs to be introduced.

One of the big issues that we have to tackle is underage drinking and drinking among young people. Raising the age limit to 21 is one of the ways of doing that, but the primary way in which to tackle the issue is by setting a price for alcohol that will discourage young people from buying it, or at least reduce the availability of alcohol to young people.

Dr Ritson: If we are setting priorities, I would strongly agree with Dr Crighton that price is a key factor—and more important than raising the age to 21. As others have said, we are talking about a raft of measures—no one is suggesting that one measure on its own will make all the difference to this major problem. We also have to be conscious that we do not want to demonise young people. We are talking about young people now, but alcohol problems go right across the board in age.

There is some evidence that younger people are more vulnerable to alcohol because of their brain development. That may be a health reason for trying to protect young people. We know that the younger age groups are those most likely to be involved in various sorts of disorder related to alcohol, and that has health consequences. There have been one or two pilot studies in Scotland in which raising the age to 21 seemed effective, although they are small studies and would need much closer evaluation. In terms of first principles, we would favour the age 21 move. It would not be a priority—certainly not in my book—but there are good reasons for doing it, especially in certain areas.

Ross Finnie: Would you increase the age as a matter of principle, not just for off-sales but for on-sales?

Dr Ritson: In terms of consequences for health there is a good case for it; in terms of fairness and many of the other issues that have been debated, it would have to be very carefully evaluated.

Helen Eadie: Will members of the panel comment on the evidence base for minimum pricing for alcohol? In particular, I highlight the Scottish Health Action on Alcohol Problems briefing paper entitled "Minimum Pricing for Alcohol: *Frequently Asked Questions*", which includes the unreferenced statement that where social reference pricing

"has been linked to alcohol content, so that the minimum price rises"—

The Convener: I am sorry to interrupt, but can you give the number of the page of the paper to which you are referring for the official report?

Helen Eadie: I do not have the briefing paper with me; it was circulated previously, to me at least. It states that where social reference pricing

"has been linked to alcohol content, so that the minimum price rises as alcohol content goes up, the impact on reducing demand has been seen to be particularly effective."

The Parliament has its own researchers in the Scottish Parliament information centre, who contacted each of the Canadian provinces to ask about peer-reviewed research on the effect on things such as consumption, health, crime and the drinks industry of social reference pricing. Those who responded referred to the research in which prices and consumption had been examined. A literature search did not uncover any published analysis of the effect that the social reference pricing model has had in Canada. Therefore, can anyone explain where the evidence to support minimum pricing comes from?

Dr Ritson: Reference pricing has been explored by Dr Tim Stockwell. I think that largely positive evidence has been taken from him. I have not seen that evidence, but I understand that such information is available.

The Convener: We have not taken evidence from Dr Stockwell, but we will have—

Helen Eadie: I would like to follow up on what has been said. SPICe spoke to Dr Timothy Stockwell, who is head of the centre for addictions research of British Columbia and was part of the systematic review team for the Sheffield research. He confirmed that there is no published evidence that social reference pricing has had any significant beneficial effect except for Canadian distillers, as it guarantees a stable market and stable profit margins. Do you concede that Dr Stockwell is well placed to know about that issue?

Dr Ritson: I have not seen those data so I cannot comment, but perhaps one of my colleagues can.

Dr Rice: Dr Stockwell is well placed to comment. The point that has been made has been identified as one of the weaknesses in Canada, where there is an interesting range and mix of price controls. In general, there have not been the rises in alcohol-related harm in Canada that there have been here, so there are lessons to be learned from it, but I think that it is recognised that it has not evaluated things as well as it should have done.

I return to the question about the evidence base for minimum pricing. Earlier, Dean Logan from the Salvation Army spoke about his 30-year odyssey

and the interesting relationship between price and harm. There is a considerable evidence base on that, which has been well reviewed, meta-analysed and so on.

Some things have changed in how prices come about. Many studies were based on the assumption that prices directly relate to taxation, but that has been less the case in the United Kingdom in particular. People may have noticed that, after the previous increase in excise duties, many retailers boasted that they had paid the tax and the shelf price had not changed. Much of the evidence base was based on the consideration of taxation and taking tax as a proxy for price, but that relationship has started to break down with different retail models, particularly in the United Kingdom. That is one of the unusual things about the United Kingdom that might explain why we have been so unusual in world terms.

The econometric studies look beyond taxation and flat-rate prices to a more sophisticated analysis of pricing. Last week, members heard from Professor Beath that econometric studies are widely used. The evidence that has started to be gathered on the impact of the cheapest price on alcohol comes from that which was used by the Sheffield group. Studies have also been carried out in Scandinavia, which has the considerable advantage of having state-controlled retail outlets that are able to gather accurate real-time data.

A peer-reviewed article published by Paul Gruenwald shows that changes to the cheapest floor prices of alcohol have a considerably bigger impact than across-the-board changes. Gruenwald's estimate is that a 10 per cent increase in the cost of the cheapest alcohol led to a more than 4 per cent reduction in overall alcohol consumption, whereas an across-the-board 10 per cent change led to a decrease of less than 2 per cent. The more it is looked at, the more it is recognised that floor price is what matters. There is an absolutely solid logic model that links price and harm. It shows that floor price is the most important price and its relationship to harm. That is the evidence base.

Helen Eadie: Forgive me for having a healthy scepticism about modelling given that people throughout the UK are victims of modelling when it comes to road design, traffic modelling and weather forecasts.

Dr Ritson and Dr Rice, you signed a letter to my colleague Jackie Baillie that stated:

"To state that there is no published evidence of it [Social Reference Pricing] having had any significant benefit is not entirely correct in our opinion. It would be more accurate to acknowledge that the impact of social reference pricing on rates of alcohol-related harm has not been evaluated separately from the effect of other federal and provincial taxes and mark-ups that apply to alcohol beverages in Canada".

Aside from the fact that Dr Stockwell pointed to the dearth of evidence—we have had only modelling—about the impact of social reference pricing, and given the number of measures other than social reference pricing that are in place in Canada, is it not rather bold to claim, as the SHAAP briefing appears to do, that the Canadian experience proves the case for minimum unit pricing?

Dr Ritson: The case for the influence of price on consumption is well made. Long before the modelling study was undertaken, SHAAP commissioned a study of price measures that might reduce harm. It was published about two years ago. The evidence that price influences consumption was very strong.

We then have the problem of what is applicable in Scotland. Taxation is often used as a way to influence consumption, but it is not available because it is not devolved. We considered measures that Scotland might take. At the end of our discussion, the favoured measure was minimum pricing because it would influence consumption, particularly among the heaviest drinkers, and is preferable to the other possibilities we considered. We can go into those. We felt that minimum pricing would have the most impact on the people who are drinking most heavily in our communities; that is why we favoured it.

The health problems that Scotland faces are such that doing nothing is not an option; we have to take some serious measures.

Helen Eadie: In the letter that you wrote to my colleague, Jackie Baillie, which was also signed by Dr Rice, you said that the Labour Party was overstating our concern about the profit to retailers that would accrue from minimum unit pricing. However, the Sheffield study modelling states:

"For a 40p minimum price, total retailer revenue is estimated to increase by £90m per annum."

The letter also asks:

"Bearing in mind that the Scottish Government's annual Alcohol treatment budget currently stands at around £40m per year, what difference do you think that an extra £90m per year could make in terms of dealing with causes and effects of alcohol abuse?"

Remember that that £90 million would go to the industry, not the Government. That is part of the misleading aspects to the bill; there is a perception that that £90 million would go to the Government, but it would not—it would go to the industry. How can you ask me and other politicians to justify putting more money into retailers' pockets?

11:30

Last week, the Centre for Economics and Business Research told us that one of the impacts of minimum pricing in Canada seems to have been a growth in spirit sales in minimum-pricing provinces relative to non-minimum-pricing provinces. That is not a desirable outcome from my point of view or from a policy point of view, as it suggests that drinkers are moving to higher strength products as a result of the policy.

You have to answer these questions for us—

The Convener: Before they do, could you clarify which parts of what you are saying are quotations and which parts are your own comments?

Helen Eadie: I can give the quotations to the official report after the meeting.

The Convener: It would be useful if members of the committee could be told, though. We do not have that letter.

Helen Eadie: I am quoting from a private letter between Jackie Baillie and a number of other people—

The Convener: It is not private now, because you have quoted from it.

Helen Eadie: I am happy to read out the quotations.

The Convener: Could you tell us which parts of what you are saying are quotations and which bits are your comments?

Helen Eadie: Here are the quotations. Page 7 of the Sheffield study says:

"For a 40p minimum price, total retailer revenue is estimated to increase by £90m per annum."

The letter also says:

"Bearing in mind that the Scottish Government's annual Alcohol treatment budget currently stands at around £40m per year, what difference do you think that an extra £90m per year could make in terms of dealing with causes and effects of alcohol abuse?"

The Convener: Who is that quotation from?

Helen Eadie: It is from the letter from Dr Rice and Dr Ritson.

The Convener: So that is the quotation from your letter, Dr Rice.

Dr Rice: Since that letter was written, there has been an uplift in investment in alcohol treatment services of about £80 million. In Tayside, to answer your—

Helen Eadie: I am sorry, I have just been corrected by Mary Scanlon. It is £130 million, not £90 million.

Dr Rice: To answer your question about what difference that investment has made to treatment, we have three times as many people in specialist alcohol treatment as we had a year ago; we delivered 3,500 brief interventions in general practice last year—

Helen Eadie: I am sorry—

The Convener: No, please, Helen.

Helen Eadie: I think that he has misunderstood my point, though, convener.

Dr Rice: You asked what difference an investment of £90 million would make in terms of treatment.

Helen Eadie: That is not the question that I asked.

The Convener: What is the question?

Helen Eadie: My point is that that £90 million—or £130 million—will not go into the public purse. It would make a huge difference to you if it did, but it will not; it will go into private commerce. That is what the bill would do.

Dr Rice: Further investment would be welcome. There has been a big uplift in investment in alcohol services in the past two years. That has made a difference.

Helen Eadie: There is no mention of further investment—

The Convener: I cannot follow the line of questioning if people interrupt each other.

Helen Eadie: There is no mention of further investment in the bill, convener.

The Convener: We are getting nowhere, and I feel a wee headache coming on again.

Dr Rice, could you deal with the quotation that Helen Eadie read out? After that, Helen Eadie can come back in.

Dr Rice: A further uplift in investment in treatment would be welcome. We have shown that we have been able to deliver using the increase in investment that we have already had, and we will continue to do that across the whole sector.

As for minimum pricing resulting in more money going into the retail sector, my view is that it would be welcome if there were a mechanism that ensured that that increase could be used to fund treatment.

Helen Eadie: The bill contains no such mechanism. The money would simply go to the industry. The issue of a separate levy is a totally different matter; the part of the bill that we are discussing would put profit directly into retailers' pockets.

The Convener: We can hear further views on that point from Dr Crighton and Mr Law.

Dr Crighton: If we are victims of modelling on the roads and in weather forecasts, we are victims of modelling on the minimum wage. Modelling is a way of exploring the what-ifs when complex reality exists. Modelling is widely used and it has been used in positive ways in health.

The modelling is the best that we can have. We can look at specific pieces of reality but, coming back to what Dr Ritson and Dr Rice said, we have to think about the context of the Scottish reality. How can we envisage what would happen if we changed certain things, such as price? The modelling is the best that we can have at present.

On the point about money going back to retailers, it is up to the politicians to work with retailers to reinvest that money or to bring the price of other commodities down.

Jack Law: Saying that no mechanisms are proposed in the bill to recoup some of the money is a false assertion; there are several. The social responsibility fee is the most obvious. It would enable not all but some money to be taken back. Another mechanism exists—taxation. Companies are taxed on their profits. If the profits were significant, some of them would go back to the Exchequer.

A false comparison is being made between profits and investment in public services. It is a false dichotomy.

Modelling presents the case and its consequences; it is up to politicians and the rest to decide how best to manage them.

Helen Eadie: In the written papers that we received from the witnesses, you all talk about evidence, but you have now admitted to us that you are talking only about modelling. That seems to be the case.

Jack Law said just now that pricing is important and that there is a mechanism for a social responsibility fee. The reality is that taxation through the Treasury is one mechanism. We should also remember the opinion of the European Economic and Social Committee, which has examined the issue. There are 129 members, all of which, bar five, have signed up to a policy of pricing per se, but not minimum unit pricing—no countries that we know of have gone down the route of minimum unit pricing.

You are asking us to formulate a policy and make Scotland a guinea pig. Well, we had the poll tax—sorry, Mary Scanlon—when Scotland was a guinea pig and we have had other policies in which Scotland has been a guinea pig. We have to be very careful that what we do is based on sound modelling and evidence. You are asking us to take a quantitative leap into a policy development in Scotland that could impact severely on the people in my constituency—which includes one of the most disadvantaged groups of people in Fife—and put £130 million of profit into retailers' pockets. Will you explain what I would say to my constituents to justify that?

The Convener: Let me say to everybody—not just Helen Eadie—that we should have shorter questions.

Dr Rice: The data that I quoted from Scandinavia are based on the behaviour of Swedish consumers in those stores. I do not know whether that counts as evidence in your book, but that is where that information is from.

The Convener: I recall that from your earlier evidence, Dr Rice. We will be able to see it in the *Official Report*.

Dr Ritson: We must bear it in mind that the disadvantaged communities of Scotland suffer most because of alcohol-related problems. The number of deaths from liver disease is vastly higher in some of the most deprived areas. We have to take that into account when we consider the benefits to deprived areas. We have to argue from a health point of view.

There are, of course, other countries that have begun to introduce minimum pricing—the illustration of Russia was recently widely publicised—and I do not see why Scotland should be reluctant to be the first to try something new in public health. We have a long tradition of innovation in our public health measures. The smoking ban is one that comes to mind, but there have been others over the centuries. We should not be shy of going into minimum pricing in a major way just because we would be the first to do so.

You will take evidence from the supermarkets and the retail industry. The other wee aside that occurs to me is that I have not been aware of them being vociferous in favour of minimum pricing, although I presume that, if their profits were going to be increased, they would be. I am sure that you will be able to ask them about that in due course. Perhaps they are in favour of it.

Dr Crighton: First and foremost, modelling can be seen as evidence. We cannot design a randomised controlled trial to put populations through minimum pricing, taxation or any other measure, so we need to build a model of the reality of using different interventions, and the best way we can achieve that is to use mathematics. It would be unethical to have randomised controlled trials of minimum pricing.

Helen Eadie asked why Scotland should be a guinea pig for minimum pricing. It should because

it has the fastest growing rate of deaths from chronic liver disease based on alcohol. We have the biggest problem. We have the local authorities with the five highest mortality rates among males because of liver disease in the UK. Helen Eadie works in Fife; I work in Glasgow. I have five local areas there that have the highest mortality rates among males because of alcohol.

We cannot afford to sit back and see what others will do for us. We have a problem and we must find a solution. We have to be brave and find what will work best. A lot of people have put a lot of effort into thinking about what would work. Taxation would be wonderful, but it is not really in our powers. We have modelled the effects of minimum pricing. We went to the best available experts. We have used Sheffield and now have feedback from experts worldwide who say that that work has advanced the knowledge about what we can do to tackle the tremendous problem that we face. We face it even more in Scotland.

We are a UK faculty, but we have a Scottish problem that we have to address.

Carolyn Roberts: We know that there is an extremely strong relationship between the misuse of alcohol and mental health problems. That is one of the main reasons why SAMH broadly supports the bill. Up to one patient in two who have alcohol problems will also have a mental health problem. The recent national confidential inquiry into suicide by people with mental health problems specifically stated that it is likely that alcohol and drugs lie behind Scotland's high rates of suicide. Also, around a sixth of all discharges from psychiatric hospitals are alcohol related.

I could go on about statistics for a long time because the relationship is very close. It is essential that action be taken to reduce the level of harmful drinking because it will also have a substantial impact on mental health.

Mary Scanlon: You mentioned mental health, which was timely because that is the topic that I want to get on to. Many of the submissions discuss our complex and cultural relationship with alcohol. We drink when we are happy and when we are sad; we also drink to celebrate. My question is not so much about liver disease or alcohol-related brain disease, which is mentioned in the SAMH submission, but about the comment in the Audit Scotland report that up to three out of four problem drinkers have an underlying health problem. Would you and Peter Rice comment on alcohol as a form of self-medication and the elasticity of demand for those people in terms of minimum pricing?

Carolyn Roberts: You are right to raise that. Alcohol can be used as a form of self-medication. That is why we were clear in our submission that we support minimum pricing but a broader range of measures is needed. Through our own experience we know that people who are seen as having alcohol problems often also have mental health problems but, because they have been sent to an alcohol service, their mental health needs are not met. The same happens in reverse.

I listened to the earlier evidence-taking session, in which important points were made about the impact that harmful drinking has on the whole family. We want there to be better links between services. We want it to be easier for people to get the help they need early on instead of their having to go through a long journey through services and perhaps be routed in the wrong direction.

You are right to say that there is a wider issue, but the measures in the bill will go some way towards improving the situation.

11:45

Mary Scanlon: Including measures, for example, to treat those with mental health problems to stop them resorting to alcohol?

Carolyn Roberts: Yes. If people get the correct treatment early on they might be prevented from resorting to alcohol. The fact is, however, that people are continuing to drink. The profile of people who use our alcohol-related brain damage services is getting younger and younger, which is why we are so concerned about the high levels of alcohol consumption in Scotland.

Dr Rice: I acknowledge Mary Scanlon's long-standing interest in the issue—indeed, we have discussed it in the cross-party group on mental health. The fact is that alcohol abuse and mental health problems go hand in hand. As members will know, a group that I chaired produced for the Government a report that suggested that the two issues are so intertwined that we need services that deal with both and do not simply pass people from pillar to post. That is certainly what we try to achieve in our services.

I think, however, that by the time people seek treatment they are being led slightly more by the alcohol problem. They need to get through the chaos and be thinking more clearly before they can engage properly in therapy, and it makes a big difference if a person seeking treatment is drinking a bottle or a half bottle a day. As for the difference that a minimum pricing policy will make, although those heavy drinkers are, as you said, relatively price inelastic, they are nevertheless price sensitive. They are actually more sensitive to changes in floor price, but we will not get back into all that.

When I see people in my practice and they tell me, "I drink a bottle of spirits a day," I have to ask

them about the size of the bottle, which more often than not will be a litre. Five years ago it would have been 700ml. Even among the treatment group, consumption begins to edge up and, as that happens, their thinking becomes less clear, their physical health gets worse and they are not as able to make changes, get back into employment and so on. That group is price sensitive and the more heavily they drink, the harder the road to recovery becomes. Minimum pricing—I was going to apologise for coming back to the issue, but in fact I am not sorry at all given its importance—will benefit that group by ensuring that fewer people get into the situation and by making the journey easier for those who are trying to get out of it.

I repeat that treatment services need to tackle both issues. Traumatic early life events, including sexual abuse, are very common in our treatment population and all our staff must be used to dealing with such issues in-house as part of the treatment. The point is that the less people drink, the better the treatment will work for them.

Dr Ritson: I want to offer a personal reflection. For 25 or 30 years now, I have been working with people with alcohol-related problems, many of whom have had psychological problems that have led them to use alcohol as a drug. Of course alcohol is a drug; that is why we have to manage it differently from other commodities. My impression is that it is the consequences of drinking on the individual and the individual's family that become overwhelmingly more important than the initial factors that led to the excessive drinking. There is an interplay between the two issues, but the consequences of alcohol misuse have a huge psychological impact that has become more and more prominent.

Rhoda Grant: I understand that no work has been carried out on how minimum pricing would affect different income groups, particularly lower-income families. If, as has quite often been suggested, the minimum price is set at 40p, it would have no impact on people at my income level because the alcohol that they buy will always be more expensive than that, but it would have an impact on people on lower incomes such as pensioners on fixed incomes, who might buy cheaper or value brands. Would that mask the effect of a minimum price? People who do not have an alcohol problem but are on a lower income would, unless they can free up some more income to pay for alcohol, have to reduce their consumption. That might show up as an overall reduction in consumption but there would be no impact on people who are harmful drinkers and can afford to buy alcohol at that price—it would not reduce their consumption. That element is missing from the equation, and I am keen to hear views on it.

Dr Rice: We do not know as much as we would like to about the income profile of people who purchase cheap alcohol. As I said earlier, there are data lying around in databases in Scotland that would, if we could access them, be very useful.

We know a reasonable amount about the alcohol consumption levels of people who drink cheap alcohol. Less than 10 per cent of alcohol that costs less than 40p per unit is drunk by moderate drinkers; about two thirds of it is drunk by people who mainly drink more than two bottles of spirits a week. Cheap alcohol is drunk predominantly by people with alcohol problems, so taking action on it would predominantly affect heavy drinkers.

There is in my catchment area, which, although I do some work in Fife too, covers the local authority areas of Perth, Dundee and Angus, around a threefold difference in mortality rates—the death rate in Dundee is about three times that in the other areas. If you look at the map of high alcohol death rates in Scotland to which Emilia Crighton referred, you see that they coincide strongly with deprivation. Alcohol misuse is hitting deprived communities in Scotland very hard, as I see every day, and action to reduce heavy consumption will considerably benefit those communities.

Dundee has the second highest alcohol death rate for women in the United Kingdom—mothers, daughters and spouses are dying in their 40s, 50s and 60s. That is not good for the city. Deprived communities have been badly hit by the changes in alcohol death rates that we have heard about during the past 20 years. Anything that reduces alcohol-related harm will really benefit the deprived communities in which I work.

The Convener: Before I let Rhoda Grant back in, I will bring Jack Law and Dr Crighton in on that point.

Jack Law: We must remember that poor people—people on a limited income—are not a homogenous mass. People behave differently, irrespective of their income or status. We know that those with the lowest incomes spend the least on alcohol and that those with the greatest alcohol problems spend most on alcohol—about 80 per cent of the alcohol that is sold is bought by 20 per cent of people who drink.

People who consume a lot of alcohol are a very small cohort of the population. People on the lowest incomes do not necessarily spend an awful lot of money on alcohol. It is suggested that the impact of the policy will be greater on those who spend more on alcohol—that if the price goes up, it is more likely that that person will have to think about how much they buy. We think that the policy

will have a differential effect on different sectors of the community, depending on two things: a person's drinking behaviour and their level of disposable income.

Dr Crighton: A male who lives in a deprived area is 11 times more likely—a female is six times more likely—to die from the effects of chronic liver disease on the back of alcohol. Our poor communities are already severely affected, so any measures that reduce the amount of alcohol that people consume would have a beneficial effect.

Rhoda Grant: Given that people in non-deprived areas have more disposable income you might say that if the issue was the affordability of alcohol more affluent people would have higher rates of chronic alcohol-related disease. Given your answers, we are perhaps missing something. Why do people in deprived communities appear to fare worse from alcohol consumption? Why does alcohol have more impact on their health? Are there other measures that we should take? Is the impact on people in deprived communities greater because they have fewer life chances and are more dependent on alcohol? No one is saying that they are more dependent on alcohol, but the evidence seems to suggest that the impact of alcohol on deprived communities is greater. Why is that the case?

Dr Rice: That is an interesting question that cuts right across health inequalities work. Cigarette by cigarette, deprived communities are harder hit by smoking disease than affluent communities; we do not fully understand the reasons for that. With alcohol, we have clues that there may be a dietary factor. I am working with colleagues to put together some research into the issue. Green vegetable consumption varies considerably across Scotland and the United Kingdom. There are theoretical reasons for thinking that it might protect against liver disease, for example.

The second possibility is that, although the amounts of overall consumption across deprivation groups do not vary, the patterns of drinking do. We are starting to understand more that drinking in bouts is worse for your liver than steady drinking. We used to think the opposite, but now we realise that, with the overloading of the alcohol metabolism system, more harmful chemicals come from using other metabolic pathways.

The question is important; I have mentioned the clues that are floating around. For the moment we need to focus on the modifiable determinants and the levers that we can push and pull, but there are important research questions that cover the whole health inequalities picture.

Dr Crighton: As Dr Rice indicated, we do not know fully why alcohol has a greater impact on deprived communities. We know from the Scottish health survey that people who live in deprived areas are more likely than people in the more affluent sections of society to drink heavily—more than 50 units a week. We have still to find out why, but we must take measures to reduce consumption, as prevention is the only way of reducing the inequalities that we currently face.

Dr Ritson: The differences in mortality between social classes in Scotland, with high prevalence in deprived areas, are a major concern. Recently the chief medical officer for Scotland identified alcohol as one of the drivers of that discrepancy. The situation has improved in some respects, but not in respect of factors and illnesses relating to alcohol, which seems to be one of the important influences on the difference in mortality between deprived and more affluent areas. It is worth bearing in mind that people in deprived areas are paying for that in other ways: the cost of health damage due to alcohol impacts directly on those individuals and they pay for the consequences in the increased cost to the health service and in the damage to their communities—the public order issues that make their surroundings less desirable.

The earlier panellists touched on the impact of alcohol on children who live in deprived communities; we have mentioned the ChildLine study in which we took part. It is clear that there is a high level of damage to people who grow up in such circumstances. The problem is not confined to deprived areas, but it is another example of the effect that alcohol is having not just on the individual drinker but more widely.

Rhoda Grant: I am conscious of what you say about drug abuse. Has there been any work on mixed alcohol and drug abuse and on whether, if people do not have access to alcohol, they will use drugs instead?

12:00

Dr Rice: Yes, there has been such work. Alcohol is a gateway drug for other drugs. Young people who drink will also smoke and use other drugs; young people who use less alcohol will smoke less and use other drugs less. The only setting in which any substitution behaviour has been shown is in nightclubs during the rave era—access to stimulants reduced alcohol purchases in such close spaces—but in the great big wide world we can be fairly clear that alcohol is a gateway drug, so if people drink less, they will use tobacco and illicit drugs less.

Dr Simpson: I think that the committee and, indeed, the whole country recognises that we have a serious problem and that it has got significantly

worse—I do not think that that is in doubt. I also think that, certainly from the committee's point of view—I hope that I am not misquoting or misrepresenting my colleagues—price, availability and culture are the three main drivers. We accept all that. However, I want to look at the issue from a slightly different angle. Given the changes that have occurred over the past 20 or 30 years that have led to our increasing alcohol problem, which groups are you most concerned about? Treating the problem as a homogeneous one, as I think Jack Law said, even in terms of the poor, is perhaps not the best way to look at it. Which population groups, in terms of age, gender or whatever, give you the greatest concern regarding increases in consumption and increases in hazardous or harmful consumption?

Dr Rice: I will be unfashionable and say men, who are often forgotten about. There is a lot of focus on the changes in women's drinking, but the lines on the graph follow each other in parallel and it is easy for men to get forgotten about. The other group is older people. For example, the over-45s are among those who have the fastest-rising rates of hospital admissions. I guess we must admit that they are older people.

The Convener: They are still young to me.

Dr Rice: Well, the over-65s—I will test this one out—have hospital admission rates that are rising fast in Scotland.

The Convener: We are all silent.

Dr Rice: Last week, I spoke to Professor Colin Drummond of the national addiction centre, who told me that he had looked at survey data from England that showed that the rates of hazardous consumption are rising fastest in women over 65; it is from a low base, but the rates are increasing fastest in that group.

I referred to those groups because they are often forgotten about. We often talk about women and young people, but men's alcohol problems are worse than women's and always have been. The older age groups are also easy to forget about.

Dr Crighton: I am anxious about the whole population. Overall, we are drinking far too much. The effect on people living in the most deprived areas is more marked. I am most concerned about the west of Scotland, because we drink far too much.

Dr Ritson: My answer is the same, in that I think that the problem covers all people in Scotland. One is reminded that no man is an island, because everyone's drinking influences all the rest of us. Further, the heavier a population drinks, the more people get caught up in the heavy drinking culture. I would therefore say that it is a problem for everyone.

I was involved in one of the first studies—I think that it was the first—of the influence of price on consumption. The study was done in Scotland back in the 1980s, when there happened to be a major change in price-related taxation, which outstripped cost-of-living changes. We were able to survey the same group of people over a three-year period by going back and reinterviewing them, which is a rare opportunity. Contrary to our expectations, the heaviest drinkers changed their consumption most. They were quite sensitive to price. Furthermore, that group showed a marked reduction in all kinds of health measures. In a sense, it is the heavy drinkers whom we want to influence most but, as I have said, people do not become heavy drinkers overnight. There are many intermediate steps to becoming a heavy drinker. That is why I say that, when it comes to what we are trying to do, I am concerned about the whole population.

Jack Law: I reiterate that we are concerned about the whole population. As a population, we are drinking far more than is good for us. However, there are certain cohorts that we are particularly concerned about, one of which—older people—has already been mentioned. A recent survey that Alcohol Focus did through one of our projects found that more than 85 per cent of the respondents of pensionable age drank significantly on a daily basis and had very little knowledge of the impact that their alcohol consumption was having on their general health and wellbeing, or of the relationship between their alcohol consumption and any medication that they were taking.

The next group that we are particularly concerned about is women of child-bearing age. We are not particularly well informed about or aware of foetal alcohol disorders, even though it is understood that drinking during pregnancy could have a significant impact on the foetus. That cohort needs to be looked at.

Another group is parents and carers. If we as a population are drinking far more than is good for us, somebody is doing that, and it is probably ordinary, everyday people who are drinking ordinary, everyday drinks. Increasing and improving awareness of alcohol consumption and its impact on others, particularly the family and communities, is vital.

The final group is made up of people who use alcohol as substitute medication. We are thinking, in particular, of people who have come out of the armed forces. Increasingly, there is an interrelationship between being in the services and alcohol problems and, indeed, mental health problems. That group, too, needs to be looked at. It is almost the case that we could target anyone, so significant is the drinking problem that we have in Scotland.

Dr Simpson: The answer is that we should be concerned about pretty well everyone, although there may be certain groups that we should be particularly concerned about, which may shift.

I come back to the point that Rhoda Grant was trying to make. I am sure that Dr Rice or Dr Ritson will correct me if I am wrong, but it seems to me that people who are serious, harmful drinkers, whose health is being affected by their drinking, are liable to drift and to lose their jobs, with the result that their social class will decline as their alcohol problem increases. The deprivation of such people is not associated with an original family class; it is associated with the shift that occurs as they move from being a hazardous drinker to being a harmful drinker.

As all the witnesses have made clear, we are trying to tackle the impact of alcohol on the whole population, but we are getting hung up on a minimum unit price that will affect primarily people who have less capacity to buy, either because they are drinking such a lot—I accept the argument for addressing that group—or because their income will not allow them to buy alcohol. If we were talking about tobacco, I would not have a problem with minimum pricing. There is no health gain from tobacco, so I would have no problem with putting the price up for everyone, even if low-income groups were affected disproportionately.

According to the Sheffield study, 16 per cent of the basket of alcohol for moderate drinkers is made up of cheap drink, most of which will be purchased by low-income groups but, given that cheap drink accounts for only 23 per cent of the basket of alcohol for hazardous drinkers—in other words, there is a difference of only 7 per cent—and that hazardous drinkers are the people whose behaviour we need to affect if we are to change the culture and improve the situation in the future, I just cannot see how a minimum pricing policy would deal with the problem.

If the policy would change the habits of a generation by having a predominant effect on 18 to 24-year-olds such that their drinking became less hazardous—Dr Ritson spoke about the development of habits—I would say that we could consider it, but the Sheffield study says that a minimum price of 40p per unit would produce a reduction in consumption among 18 to 24-year-olds of only 0.7 per cent. Dr Meier confirmed that in evidence to us.

Anyone whose income is above a certain level will simply not be affected by minimum unit pricing, so it will not address the drinking of the whole population or of the younger generation. As Dr Rice has said, we now know that binge drinking by young people, not just heavy consumption on a weekly basis, sets up problems for the future. I do not think that that has been addressed. We have not talked about discounting, which also raises an important principle. We should not encourage people to drink larger volumes of alcohol by making it cheaper to buy more. That is why I support a strong attack on discounting and consideration of its effect. We should deal with the general issue of price to address the whole population, but we should not attack a particular income group, whether or not the people in it are heavier drinkers. Would the panel like to comment?

Dr Crighton: First and foremost, minimum pricing will affect everyone, more or less. Making small changes for very large numbers of people in the population will have a significant effect. What we will see with minimum pricing is a population shift. We have modelled the benefits from that. I would argue that it is not true to say that it will not affect moderate drinkers. It will, but in smaller numbers. Again, people will not behave in a homogeneous way. Within the population, different individuals will behave in different ways.

Another element of minimum pricing is the cultural message that we are putting out. It is not okay to continue drinking. We have to change our mindsets. The important thing is not just the price that we will or will not pay but how we think about alcohol, so minimum pricing will affect the population as a whole.

Dr Simpson: Sorry to interrupt but, to be clear, are you really saying that someone with the sort of income that I have will be affected one jot by minimum pricing? Are you really saying that the proportion of the population with an income above the average, which is £24,000, will be affected by minimum unit pricing? Will they really be affected, rather than there being a population effect, which is predominantly a result of those who have lower incomes in relation to their alcohol consumption buying less?

Dr Crighton: Minimum pricing is not the only measure that the Government is proposing. Changing the culture is not to do with minimum pricing by itself. It is also to do with everything else that goes with it. It is about changing the mindset. It is about the fact that we now have a dialogue. The papers are full of articles saying that we drink too much. It is all those things that will make people think twice when they go to buy alcohol. I have certainly changed the way in which I run the faculty conference. I allow just enough alcohol to be within the drinking limits. Those are the kind of changes that we will see because of the wider debate, and minimum pricing will be one of the measures.

Jack Law: Richard Simpson is right, but the debate is not just about minimum pricing. Unfortunately, the discourse has been pushed towards minimum pricing for many different

reasons. We might have different views about that. We argue that minimum pricing is an important part of the package of approaches because it underpins so much else that needs to go on, but I remind you that the bill contains other things to do with education, improving knowledge and understanding of alcohol, working in communities to shift and change understanding and attitudes, and improving people's knowledge of harmful and non-harmful drinking. All those things are part of the package.

We are faced day in, day out with a barrage of messages that alcohol is an ordinary commodity, but it is not. It should not be sold like bread and beans. We have gone through the argument before, but attacking and challenging price has symbolic importance as part of changing that ordinariness into something else. By setting a minimum price, we will shift people's attitudes—not everyone's—and understanding of why they buy a particular commodity that they know is harmful to them.

12:15

Dr Rice: As Jack Law said, there is a range of actions. I would add that, for hazardous drinkers, screening and brief intervention are important. If that can be achieved throughout Scotland, huge numbers of people will be positively influenced. Primary health care is the key area for that. Breath testing and driving limits will also have an effect on hazardous drinkers.

As has been said, 18 to 24-year-olds are predominantly on-sales drinkers. We would be hard pushed to find a drink in any on-sales premises in Scotland that will be affected, no matter what the minimum price is. The enforcement of server training on serving intoxicated patrons needs to come into place. However, 18 to 24-year-olds are not 18 to 24 for ever, as I have found out. People do not establish drinking patterns at that age that stay fixed throughout their lives—big variations occur. Alcohol consumption can fall among older people, but a worrying point is that it rises among middle-aged and older people as the price falls, so those people are price sensitive, too. Jack Law is right that a range of actions is needed.

I have an additional point about minimum pricing and substitution. Substitution undermines the effectiveness of across-the-board price changes, such as excise duty changes. The retail data from Sweden show that, as I think the UK retail data would, if we had them. People trading down undermines such changes. One advantage of minimum pricing is that it fixes the floor price, so people do not move—I will not name brands—from well-known brands of malts to own brands and value brands, because there is nowhere to go.

I agree that minimum pricing is not the single measure that will solve everything, but it is important. A whole bunch of other initiatives in Scotland will also be of benefit but, if we do not have minimum pricing in place, we will be swimming against the tide.

Michael Matheson: Some questions that I wanted to ask have been covered. I do not have a background in the field of modelling for the purpose of developing public health and other policy measures and I am conscious that questions have been asked about the work that the University of Sheffield undertook. The CEBR report, which has been mentioned, critiqued and expressed concerns about the university's report, although I should say that the critique was sponsored by SABMiller, which has a clear interest.

I was taken by Dr Crighton's comment that such modelling is seen in the public health sector as evidence to demonstrate the benefits of some policy measures. I would find it helpful to understand better how commonly modelling such as that which the University of Sheffield did is used to develop public policy measures. That would give me a clearer picture of whether that modelling is unusual and peculiar and has been contrived to try to justify minimum pricing or whether it represents a fairly robust approach that is taken in trying to develop a range of public policy measures.

The Convener: Are members cold? I feel the temperature dropping. I would like somebody who is in front of a control panel somewhere to know that we are cold. The witnesses must be getting cold—just say yes, so that we can have the heating turned up.

Jack Law: It is quite hot here.

The Convener: My nose is cold.

Dr Rice: This feels more like the hot seat.

The Convener: Yes—you are in the hot seat. We certainly cannot take a wee malt to warm us up in the middle of the session. I am sorry about the temperature.

I ask Dr Crighton to talk about modelling.

Dr Crighton: Michael Matheson asked how common modelling is. Under the National Institute for Health and Clinical Excellence technology programme, which tries to assess different measures and different elements that interplay to achieve a certain effect, big population studies cannot necessarily be designed. We take studies that paint the reality and we use mathematics to model what will happen. NICE uses modelling as the basis for making recommendations and that is probably the most-used way of making recommendations on public health interventions.

I used modelling to examine the impact of implementing two-view mammography screening and I supervised one of my trainees on that. The mathematicians and statisticians say, "These are the assumptions," and they use bootstrapping and other mathematical techniques. We use that approach fairly commonly.

Michael Matheson: What is your response to the argument that modelling is not evidence?

Dr Crighton: Modelling is a mathematical way of guessing what would happen if we did certain things. It is based on certain assumptions, which must be tested. Once the measures are put in place, we must go back and see how many of the assumptions that we made were correct. That is why, when we are asked what the minimum price should be, we have to see whether the assumptions have been realised and we must have a way of adjusting and bringing things up to date, testing whether the assumptions that we made for the future were right.

Dr Rice: Yesterday, I was involved in a decision in Angus to invest a six-figure sum in prescribing software that encourages general practitioners to prescribe generic rather than branded products to save money. It is estimated that that will save £700,000 over the next year. We went for it on the basis of calculations about the number of branded products that are prescribed and the difference in price of the cheaper generic products, multiplying the figures to reflect how much prescribing goes on in Angus. We made that decision because everybody thought that it was a good idea to save money. That is an example of a real decision that was made on the basis of modelling.

The most useful thing about the Sheffield report is its comparative look at different approaches to pricing, which compares those that involve across-the-board increases in the minimum unit price to those that just address discounting. That modelling is useful because it looks not so much at the absolute figures as at the relative figures. The report looks at the impact of minimum pricing approaches on harmful, hazardous and moderate drinkers, showing which affect the harmful drinkers most and the moderate drinkers least. That is the most useful part of the Sheffield report. I usually find the comparative bits of modelling studies more useful than the absolute bits.

Dr Ritson: I have nothing to add on the acceptability of modelling in public health—it has been clearly stated. The methodology of the Sheffield study received a strong endorsement from scientists and alcohol specialists around the world when it was published recently in a peer-reviewed journal. Modelling is not only well established; it was seen as a real advance in methodology on these issues.

Michael Matheson: There is no question but that price is one of the factors that must be addressed in dealing with the alcohol problem. If we were not to go down the route of minimum pricing, what alternative method could we use to address the issue of the price of alcohol in Scotland?

Jack Law: If we did not introduce this kind of measure, we would add a huge burden to the other measures that will need to be introduced. In other words, we would disadvantage some of the other measures that will, undoubtedly, be introduced. Things can be done to address promotions and discounting whereby someone buys three products for the price of two, which encourages people to buy more alcohol. In Scotland, we are not particularly renowned for storing our alcohol.

The Convener: Except inside ourselves.

Jack Law: Yes, and that is not for very long. Essentially, such promotions encourage us to drink more and more frequently. We undertook a brief study on the issue that suggested that that was the case. People buy more and return more frequently when alcohol is discounted, so stopping discounting would be an important measure.

Other measures could include setting a specific size of glass and not encouraging consumers who go into bars to double the size of their drinks or add to the quantity that they intend to drink. There is also the issue of selling alcohol by association. I am thinking of meal deals whereby, if someone buys a meal from a particular retailer, they get a cheap bottle of alcohol. Stopping such things would help, but the underpinning issue remains price consciousness and the cheapness of the alcohol. The underlying issue is price.

Dr Crighton: I would ask how real you are about trying to do something that is effective. It is clear from WHO evidence that dealing with pricing and dealing with availability are the two most effective ways of tackling alcohol consumption. Therefore, we do not see any alternative that would achieve the same as the implementation of minimum pricing together with a ban on discounting.

Dr Rice: I made the case earlier that floor price—the price of the cheapest alcohol—is the most important factor. If we are going to start somewhere, that is where we should start. Affecting the price on the shelf is what matters.

There is a football tournament coming up later this year, for which the beer companies and retailers will be gearing up. There is a big sales opportunity for them, and they will be making decisions now about pricing and sales promotions with a health and social welfare voice nowhere near the decisions.

Minimum pricing may not be perfect, but I argue that it would indisputably do good. We have an opportunity to do something, and it would be a great shame if we did not take it. We talked earlier about how, if the money that is generated could do some good, it would be a bonus. If there is another mechanism that can affect the price of the cheapest alcohol on the shelf, that is terrific.

My point is that pricing decisions are being made now not by people in this room but by people in the alcohol and retail industries, with no recourse to the health, public welfare and public safety considerations. That worries me. It has been our situation for the past 20 years and, as long as it remains the situation, we will struggle.

Dr Ritson: I agree with all that has been said. We considered some other mechanisms on price. As has already been mentioned, taxation is not a mechanism that is available to us. Furthermore, the merit of taxation has been undermined in recent years by the power of the multinational corporations, which can absorb tax increases or redistribute them over other commodities. As we have seen from recent figures, some of the impact of taxation has been weakened.

At a local level, we considered measures against pricing below duty and VAT level, but they would not have anything like the same impact on the price of alcohol as minimum pricing. Many cheap alcohols would remain cheap under that measure. We also considered measures against below-cost selling, but that is a very difficult measure to monitor. It would be costly and difficult to implement such a system, so it was discounted as an unrealistic approach.

Therefore, there are other approaches, but they have been looked at in the earlier reports that I have mentioned. I can make some of our work on that available to the committee, if you would like me to.

The Convener: That would be very helpful.

Dr Ritson: However, our work did not come up with any realistic option other than minimum pricing. That is just in relation to price—I agree with all the other measures, which would reinforce the basic measure of changing the price in relation to disposable income.

Ian McKee: We know that alcohol is a tremendous problem in Scotland and we learn that 70 per cent of it—we might quibble about a percentage point or two—is bought in supermarkets, where some alcohol is sold at very low prices. We have also heard evidence that when changes in duty have been attempted, outlets have boasted that they have absorbed the duty increase so that the shelf price remains the same. Apart from the rest of the United Kingdom, do you know of any country where there is such a strong link between the sale of alcohol and the purchase of other grocery goods—or is the UK only place in the world where that link occurs?

12:30

Dr Rice: That is a very interesting question. I very rarely see pub drinkers in my clinical work now—that has changed over the 20 years that I have been in practice—and the same thing came out of the survey that was done in Edinburgh. There has been a big shift in drinking. It is difficult to run a good pub now, given the competition.

When I was in New Zealand, I found much interest in what is happening in Scotland. I did a presentation, at the end of which hands went up with the question, "Why not just stop selling spirits in supermarkets, like here?" I stopped and thought about it: why not? It seemed almost unthinkable. We have drifted into that being normal, but it is not the norm in other countries. In Australia, Canada and New Zealand, the legislation is quite different. We have had a laissez-faire alcohol market. We must ask ourselves why we have become so different over the past 20 years. That really leaps out.

It has been interesting to be part of the debate over the past couple of years. Producers might sometimes come and have chats in little corners. They say the same sort of thing as the Perthshire farmers who live near me; they talk about the big multiples, the driving and setting of prices, and the price point having to be hit otherwise the product does not get sold and the business loses market share. That is why a number of producers support the minimum price; they do not like the spiral. Not all of them have come out and said that publicly, however.

The focus on alcohol in retail situations in the UK is very unusual. Other people will say the same. One of the appeals of the proposals in Scotland is the idea of breaking some of those practices in some chains. I do not know whether it is conceivable in Scotland—it is really an issue for politicians: are the public ready to have alcohol moved out of mainstream retailing into separate shops?

The link between alcohol and the rest of the grocery market is crucial. We uncovered some information from the trade about alcohol being a footfall driver, to use the term. It is a matter of getting people in. People notice the price of alcohol, but they do not notice the price of bananas; they will still buy some bananas and the retailers will make their money there. Alcohol is part of the grocery market—it is part of the toxic mix. If something could change that, it would be of great benefit.

Dr Crighton: The WHO regularly surveys alcohol consumption across the world, and a report showing what happens in different countries is available. There are some countries in which there is a monopoly on the sale of alcohol—there are specific shops where people have to go. In the UK, we have allowed supermarkets to run how alcohol pricing has developed. There has been a shift in the amount of alcohol that gets sold through their premises, simply because of prices dropping year on year compared with the retail prices index.

Ian McKee: If that is the case and the situation and the relationship with alcohol in this country are fairly unique, we are perhaps wasting our time waiting for evidence from other countries where the same situation does not exist, as there will be different ways to deal with the matter elsewhere; the solutions elsewhere will be different. Do you agree?

Dr Crighton: That is why we are using the modelling, which tries to put the current situation into the mathematics.

Dr Ritson: Absolutely. Scotland has escalating consumption and harm at almost epidemic proportions, as I think we all agree. We compare very unfavourably with most of the rest of Europe in that respect. The situation is exceptional and just tinkering will not be enough. That is what seems to be coming across. That exceptional situation exists for a variety of reasons.

Carolyn Roberts: We have frequently heard that Scotland has a unique relationship with alcohol. From what my public health colleagues are saying, that seems to be the case. We may well have to consider unique ways to address the situation. Other countries might not have done exactly what is proposed here but, given the state of the relationship with alcohol in this country, we might well need to consider things that have not been tried elsewhere.

The Convener: It is useful that we will take evidence next week from the representatives of individual supermarkets as well as from the producers. Two other members want to ask a supplementary question.

Ian McKee: Convener, I first have another supplementary, which I hope will not take long.

I am a little confused about what effect minimum pricing will have on the heaviest drinkers. We have heard some evidence that those are the people who consume the cheap alcohol, so raising the price of such alcohol will cut down their drinking. On the other hand, we have also heard evidence that very heavy drinkers will be so keen to get their alcohol fix that they will spend any amount, so all that will happen is that their disposable income will shrink and other things will go to the wall. I would be grateful for the panel's opinion on what effect the introduction of minimum pricing would have on the heaviest drinkers.

Dr Ritson: Let me make two points. First, the study that was done a long time ago in Scotland—it was an Edinburgh-based study back in the 1980s, which seems very long ago—showed that the heaviest drinkers reduced their consumption significantly and that the level of harm that they experienced also reduced significantly. They did not just carry on drinking at the previous level and pass on the cost to other family members. There was no evidence for that.

The other, general point is that, all over the world, where the price of alcohol has gone up, the levels of consumption and harm have reduced. That shows that those who drink in a harmful way respond to a rise in price. Although an overall decrease in consumption might be caused just by moderate drinkers cutting back, the significant reduction in harm shows that a rise in price affects the heaviest drinkers, who are the people who produce the most harm—not all the harm but the most harm. I think that there is evidence for that at a survey level and at a population level.

The Convener: We will hear responses from Dr Rice, Ms Roberts and then Dr Crighton before I let Mary Scanlon and Helen Eadie ask their supplementaries. I advise both members that time is pressing, so I hope that their questions are new and short. We have had an hour and a half with this panel; I do not want us to go over old stuff again.

Dr Rice: Rhoda Grant, I think, mentioned the Finnish experience. Sadly, we in Scotland have much more experience of the impact that falling prices have on the heaviest drinkers than we have of the reverse. My experience over 20 years is that alcohol-dependent people are not brand loyal—or even drink loyal—but will switch. They used to drink super-strenth lagers, they switched to white ciders when those came on to the market and they have now switched to vodka.

When patients tell me that they drink a bottle a day, I need to ask what size the bottle is because sometimes they are talking about a litre and a half. There is a big level of plasticity and dynamism, or change, in their drinking. Would that apply if the price of alcohol went up? Yes, that is shown in the study to which Bruce Ritson referred and in other bits of evidence. I think that that fits with our model. Even alcohol dependence is not a fixed phenomenon but can change as people's social circumstances change. People can hit a turning point and many people spontaneously recover from severe dependence without any intervention. We can sometimes forget that people can hit turning points and change. In addition, many people are helped by interventions. We are not

talking about a group of people whose consumption is absolutely fixed, come hell or high water.

People in recovery do not blame anyone but themselves, which is a healthy thing for them to do. They will say, "I got myself into this trouble. I need to tackle it. I am not blaming my spouse or my parents or the supermarkets or whomever." It is healthy that they think that the problem is down to them. As part of that, they will often say, "It would not have mattered to me what it cost. It is nobody else's fault but mine." However, that is not the case when we look at communities. For groups of people, we know that price makes a difference.

I think that we have good evidence, locally and internationally, that alcohol-dependent people will change their drinking if the price of the drinks they consume—which are the cheapest drinks—changes. That will be to their benefit. Many of them will drink less and be subject to less health harm, and more of them will stop. As I said, we have much more experience of people increasing the amount they drink as price falls, but there is every reason to think that the drinking habits of that group of people—which is an important group, as members will know—would also change as price increased.

Carolyn Roberts: Speaking from a service provider's perspective, I point out that some of our services are specifically for alcohol-related brain damage. We also have services for homeless people, many of whom have serious drink problems, and more of our mental health services are now dealing with people with serious alcohol problems. We are working with the kind of heaviest drinkers we have been discussing; indeed, when we put together our submission for the committee we considered the issue very carefully and spoke to the people who work in the area. Obviously we do not have the wherewithal to put together a proper model, but our perception is that consumption would fall as a result of minimum pricing. We know that it is not a magic wand; it will not fix everything and people will not stop drinking just because of it, but we think that it will lead to a reduction in consumption and the associated reduction in harm to health that Peter Rice talked about.

As we make quite clear in our submission, we need more than minimum pricing. For example, we need to tackle not only the supply of, but the high demand for, alcohol. Why are some of the people we work with drinking a bottle of vodka a day? Nevertheless, our best response to the question is that we think minimum pricing would reduce consumption by the heaviest drinkers.

Dr Crighton: Colleagues of mine who work with people with severe dependency and who visit the wards have been asking questions about what would happen if the policy were introduced. Such drinkers have a fixed budget and buy as much as they can for their money, so if the alcohol is much more expensive they will buy less of it.

The Convener: Mary Scanlon, do you have a short supplementary?

Mary Scanlon: Well, it is not short. I asked only a very short question on mental health and I think that this question is important.

The Convener: And no one else has asked it?

Mary Scanlon: No.

This is now a health bill and its competence as far as the European Union is concerned depends on the effect of minimum pricing on the reduction of alcohol consumption and health harms. The Sheffield study says that there will be no time lag for acute conditions and predicts a fall of 800 in hospital admissions in Scotland in the first year. However, according to the Scottish health survey, between 2003 to 2008 consumption among men and women fell and industry data obtained by NHS Health Scotland shows that between 2005 and 2009 consumption has levelled off. Despite those figures, alcohol-related discharges from general acute hospitals increased by 9 per cent between 2005 and 2009. It is estimated that a 40p minimum price per unit would result in a 2.7 per cent reduction in alcohol consumption, but in Scotland reduction in consumption has not been matched by a reduction in alcohol-related discharges. I point out that in England over the same period there has been a 7 per cent reduction in consumption and a 13 per cent increase in hospital discharges that are wholly attributable to alcohol.

Dr Crighton: As you say, the data on reduction in consumption come from the Scottish health survey. It does not matter how accurate they try to be, people will always be subject to recall bias when they are asked how much they drink. I can give you the exact figures that you referred to in your question. According to the survey, alcohol consumption fell from 34 per cent in 2003 to 30 per cent in 2008, but that figure is based on a certain number of males saying that they cut down on their drinking, which does not mean anything. A more accurate measurement is the amount of alcohol that has been released for consumption, which has plateaued. Of course, it, too, has certain shortcomings as a proxy for alcohol consumption because, for example, not everyone drinks the same. We continue to see hospital admissions because we are still drinking. The pattern of drinking might have changed because, after all, the issue is not only what you drink but how you drink. If someone is completely plastered at the weekend and becomes acutely ill and comatose,

they will end up in casualty. We still see that, despite the drop from 34 to 30 per cent. That means that the patterns of drinking are different and that we continue to drink quite a lot.

12:45

Jack Law: We have to put some of the statistics into historical context. We have more than doubled our alcohol consumption in the past 50 years. Our starting point now is a significant level, which has a considerable impact. There has been a 500 per cent increase in liver disease in the past 25 years and a 700 per cent increase in women in their 20s with chronic liver disease in the past 20 years. We are starting with an extremely high level of evidence of significant alcohol misuse.

Dr Rice: I agree with my colleagues that consumption data are a better indicator than survey data. It has always been a pity that we do not get customs data at a Scotland level, as they would tell us where we really stand. As Mary Scanlon said, the evidence from the Nielsen data is that consumption has plateaued. I would be interested to see those data corrected for age. The population is getting older, and although older people drink more than they used to they drink less than younger people, so we would expect the per capita consumption to be falling a bit because of demographic changes, but it looks as though it is stable at about 12.2 to 12.4 litres.

I think that the data that NHS Health Scotland published last week showed that, in the past year, hospital admissions have stabilised and are in fact falling in mental health settings. We might be seeing a plateauing effect, which is pretty much what we would expect. In other words, consumption is levelling out and hospital admissions are starting to level out. However, as Jack Law said, that is on the back of our having more than doubled our consumption since the 1950s and increased it by more than half on the level in the 1990s.

Mary Scanlon: The data that I am using are dated 23 February and they came from the Information Services Division.

My final point, which is in response to Michael Matheson's point on modelling, is that modelling predicts only on the basis of the data that are used. How can the prediction of a decrease in consumption be accurate when the modelling has not taken into account cross-border sales, internet sales—the fastest growing sector of alcohol sales—illicit production, concentrates, marginal propensity to consume, elasticity of demand, the utility gained, the income elasticity of demand, the cross-price elasticity of demand and drugs and other types of alcohol-based products? The modelling has not taken account of binge drinking or the use of natural products such as elderberries, rhubarb and dandelions to make alcohol.

I could go on, but time does not permit me to do so. None of those issues has been examined in the so-called model. Does that lead to concerns regarding the prediction about the consumption of alcohol? We heard about cross-border sales in Finland and we know that that is happening in Ireland because of the strength of the euro. Internet sales are a fact.

Helen Eadie: Convener—

The Convener: I am coming to you shortly.

Helen Eadie: I am going to help you.

The Convener: You are going to help me?

Helen Eadie: Yes. Mary Scanlon has covered my question, apart from one small point, which is about the booze cruise phenomenon that we have seen in England and France. I ask the witnesses to add that point into their answers.

The Convener: It is difficult to have a booze cruise between Hawick and Carlisle, but we will think about it.

Helen Eadie: What about between Rosyth and Zeebrugge and Scotland and Ireland?

The Convener: I understand. I am sorry—I was being flippant, because I am cold.

Dr Rice: I will give some quick-fire answers. It would be great to know more about cross-border sales. Again, the industry will have a lot of data on that. I doubt whether people will travel to buy cheap cider in the same way as they travel to buy a cheaper version of an expensive malt. With minimum pricing, we are talking about the cheapest alcohol and I do not think that the cross-border traffic will be the same for that.

On illicit alcohol production from fruit and so on, this might be a reflection of my generation, but I have never seen a patient who drinks either illicit or adulterated alcohol, because real alcohol is so cheap in the UK and will remain so. That would need to be monitored, but it is certainly not a big issue in the UK at present.

The committee heard from an economist last week on the elasticity issues. That is complicated stuff, so I will not attempt to comment on it.

I commented earlier on drugs. We have had correspondence on that. The balance of evidence is that alcohol acts as a gateway to other drug use and not as a substitute.

The Convener: Dr Crighton can have the last comment. That is for my own comfort, because I am absolutely frozen and I do not know what has happened to the man at the controls.

Dr Crighton: I will be brief. None of the aspects that have been mentioned is a concern because the current pattern of consumption in Scotland is not particularly based on them. On cross-border sales, we are lobbying the UK Government to ensure that minimum pricing will be implemented UK wide. As a UK faculty, we are trying to ensure that.

Helen Eadie: That has not answered my question. With respect, Dr Rice has not answered it either and nor did he answer Mary Scanlon's point.

Mary Scanlon: That is right Helen—you stand up for me.

The Convener: I am glad that you are chairing the meeting, now, Mary, because I am about to abdicate. Could somebody deal with the booze cruise issue?

Helen Eadie: I just want to ask about internet sales. I could sit in my home in Fife and order on the internet. There could be massive deliveries to any address in a major conurbation. If I purchased alcohol from a location outwith Scotland, it could retain that cheap price.

The Convener: I will leave that hanging in the air as it is a really good question for the supermarkets. We can ask them about internet ordering because they are hot potatoes on that now.

Helen Eadie: That highlights the lack of an impact assessment for various issues. That has not been done in the Sheffield report, which had a limited remit.

The Convener: That point has been made several times in several evidence sessions.

I bring this very cold evidence session to an end. I am looking at the sound operator—I know that he has nothing to do with the heating, but somebody somewhere should be in charge of the heating in this building.

I thank the witnesses very much for their evidence—those in the hot seats and the cold seats. We now move into private session. I thank the members of the public for paying attention to the meeting.

12:52

Meeting continued in private until 13:09.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

Members who wish to suggest corrections for the archive edition should mark them clearly in the report or send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP.

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

Single copies: £5.00
Meetings of the Parliament annual subscriptions: £350.00

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Available in e-format only. Printed Scottish Parliament documentation is published in Edinburgh by RR Donnelley and is available from:

Scottish Parliament

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

For more information on the Parliament, or if you have an inquiry about information in languages other than English or in alternative formats (for example, Braille, large print or audio), please contact:

Public Information Service
The Scottish Parliament
Edinburgh EH99 1SP

Telephone: 0131 348 5000
Fòn: 0131 348 5395 (Gàidhlig)
Textphone users may contact us on **0800 092 7100**.
We also welcome calls using the Text Relay service.
Fax: 0131 348 5601
E-mail: sp.info@scottish.parliament.uk

We welcome written correspondence in any language.

Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

E-mail orders, subscriptions and standing orders
business.edinburgh@blackwell.co.uk

Blackwell's Bookshop

53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

Blackwell's Bookshops:
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh.

Accredited Agents
(see Yellow Pages)

and through other good booksellers

e-format first available
ISBN 978-1-4061-6182-3

Revised e-format available
ISBN 978-1-4061-6183-0

Revised e-format ISBN 978-1-4061-6183-0