The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 10 January 2012

Session 4

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HEALTH AND SPORT COMMITTEE
1st Meeting 2012, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Jackson Carlaw (West Scotland) (Con)
*Jim Eadie (Edinburgh Southern) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Fiona McLeod (Strathkelvin and Bearsden) (SNP)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Jan S Gill (Queen Margaret University)
Dr Evelyn Gillan (Alcohol Focus Scotland)
Professor Anne Ludbrook (University of Aberdeen)
Dr Peter Rice (NHS Tayside)
Benjamin Williamson (Centre for Economics and Business Research)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 10 January 2012

[The Convener *opened the meeting at 10:30*]

Interests

The Convener (Duncan McNeil): Good morning and welcome to the first meeting of the Health and Sport Committee in 2012. I wish you all a happy new year. I remind everyone present that mobile phones and BlackBerrys should be turned off, as they can interfere with the sound system.

Under agenda item 1, I welcome Drew Smith, who is replacing Mary Fee on the committee. I take the opportunity to thank Mary for her work since the start of session 4 and wish her every success on the Equal Opportunities Committee. In accordance with section 3 of the code of conduct, I invite Drew to declare any interests that are relevant to the committee's remit. I remind him that any declaration should be brief but sufficiently detailed to make clear to any listener the nature of the interest.

Drew Smith (Glasgow) (Lab): I thank you for the welcome, convener, but I have nothing to declare.

The Convener: Thank you.

Decision on Taking Business in Private

10:31

The Convener: Item 2 is to decide whether to take in private item 4, under which we will consider the evidence that we hear in the meeting on the Alcohol (Minimum Pricing) (Scotland) Bill. Do members agree to take item 4 in private?

Members *indicated agreement.*

Alcohol (Minimum Pricing) (Scotland) Bill: Stage 1

10:31

The Convener: Item 3 is our first oral evidence session on the Alcohol (Minimum Pricing) (Scotland) Bill. We welcome our panel of witnesses. Professor Anne Ludbrook is professor of health economics at the University of Aberdeen; Benjamin Williamson is senior economist at the Centre for Economics and Business Research; Dr Evelyn Gillan is chief executive of Alcohol Focus Scotland; Dr Jan Gill is a reader at Queen Margaret University; and Dr Peter Rice is chair of the Royal College of Psychiatrists in Scotland and a consultant addictions psychiatrist in NHS Tayside.

We will go directly to questions, the first of which is from Richard Simpson.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I think that we all accept from the previous debates that price and availability are two of the main drivers of the general consumption of alcohol, but we are being asked to look at a specific bill on minimum pricing. My opening question is fairly general. Given that, although there are slight variations, the price of alcohol is approximately the same throughout the United Kingdom but some 20 to 23 per cent more alcohol is consumed in Scotland, will a minimum pricing bill be sufficient to tackle Scotland's problem with alcohol?

Dr Peter Rice (NHS Tayside): I am happy to start.

The moves that we have been encouraging are to do with changing drinking in Scotland, and the important comparisons to make are historical ones within Scotland. There are, of course, important international comparisons that we can make with other countries, including England, but the test of a measure is the change that it is likely to make in the community under consideration—in this case, Scotland.

To answer your question about why there are differences between Scotland and England, there is a range of historical attitudinal differences between Scotland and England that account for those, as there are between Sweden and France and between France and Italy.

On minimum pricing, when I was doing my clinic in Dundee yesterday a man came in who was drinking 3 litres of strong cider, which he had bought for £2.99—he was drinking 22.5 units of alcohol, which is more than his safe limit for the week, and he drinks about 40 units a day. He was comfortably able to exceed his 21 units for less than £3. I am keen for that situation to change and believe that minimum pricing represents our best realistic prospect of fairly quickly changing something that has blighted Scotland's health for far too long.

Professor Anne Ludbrook (University of Aberdeen): The levels of alcohol consumption in different countries can be explained by cultural differences. However, as far as each country is concerned, there is very strong evidence that price affects the amount consumed at different points in time. Although minimum pricing is not the only way in which we need to tackle problems with alcohol, the evidence base for the effectiveness of dealing with price suggests that it should be considered as an effective measure that lies within the Scottish Parliament's remit. No one has ever produced an evidence-based intervention to achieve a culture change.

Benjamin Williamson (Centre for Economics and Business Research): After conducting an exhaustive analysis on the University of Sheffield report that has provided much of the justification for the conversation so far, the centre's opinion is that the case for minimum pricing remains unproven. We do not think that it is a targeted measure that gets to grips with the problems of harmful drinking; in fact, our research shows that moderate drinkers are likely to be impacted the most because they are the most responsive to price. Harmful and hazardous drinkers are less sensitive to price changes. Our modelling shows that, because of that lower sensitivity, a minimum unit price of 50p will result in a harmful drinker—in other words, a man who consumes 50 units or more per week—reducing consumption by only around four units. We have included in our report the wide range of academic evidence that sets out the lower elasticities for harmful and hazardous drinkers. There are a number of other consequences, but we simply feel that the measure is too broad to tackle the specific issue of problem drinking.

Dr Evelyn Gillan (Alcohol Focus Scotland): In light of the previous speaker's remarks, I suggest that it might be useful for committee members, if so inclined, to look at Professor Christine Godfrey's written submission to the House of Commons Health Select Committee inquiry on alcohol, which provides a fairly robust critique of the CEBR's work. One of her conclusions, which was accepted by that committee, was that the CEBR study, which was funded by SABMiller, contained a fundamental misunderstanding of the Sheffield research.

On Richard Simpson's general point, I think that it might be worth going back to basics. I think that we all agree that the evidence linking price, consumption and harm is overwhelming; indeed, I

believe that David Cameron has recently acknowledged that and even Andrew Lansley recently accepted the importance of price in this regard. If we accept the overwhelming evidence base—the more than 100 studies over 30 years—establishing the link between price, consumption and harm, the question for the Scottish Parliament is which pricing measure is most likely to be effective in Scotland. We also need to remember that the Scottish Parliament has no powers over taxation. I also point out that, in 2007, after convening an expert group on price, the medical royal colleges and faculties in Scotland recommended that minimum unit pricing would be the most effective measure for the Scottish Parliament to introduce.

The Sheffield research was criticised at the time on the ground that it was only modelling, but modelling is a standard methodological tool. The Sheffield research has been peer reviewed and is highly regarded, and the unit got a 5* rating in the recent research assessment exercise. Since then, we have had real-life evidence from the minimum pricing schemes in Canada—you will speak to Professor Tim Stockwell about that tonight—that proves the link that is well established in the literature between price and consumption.

The Convener: Dr Gill, do you wish to add to that?

Dr Jan S Gill (Queen Margaret University): I could present some data that are not published but that refer to a sample of patients we investigated a couple of years ago, who have been harmed by their drinking. They are the heaviest drinkers in Edinburgh. For this meeting, we have looked at the data again and have calculated their consumption should a 45p minimum unit price be introduced. We have looked at every drink that they have bought. If it was over 45p per unit, we left it at the value; if it was under 45p per unit, we took it up to that value. The original weekly consumption of our patients was 197 units per week. If a minimum unit price of 45p were introduced, that consumption would fall to 144 units per week—in other words, there would be a 27 per cent fall in consumption. That calculation is based on many assumptions, such as that they could not turn to other funds to support their drinking. If nothing else changed, that is the consumption change that we would see.

Dr Simpson: We all agree that price is important; the question is whether minimum pricing will affect the situation adequately. We can divide the population into three groups. We are not really concerned about moderate drinkers—they are staying within the letter of the law. The Sheffield report talks about six units a week being the average moderate consumption, but a hell of a lot of people are drinking more than six units a week and they are going to be much more affected than the average.

The problem with all the studies that have been published is that they deal in averages. Even Dr Gill's study of 387 problem drinkers drinking 197 units a week takes the average purchase price to be 43p, and for the middle income group of the five quintiles—the sample is divided into groups of 20 per cent—the average purchase price is 53p. I am not convinced that, if the harmful drinkers to whom Dr Rice has referred are buying alcohol at 43p per unit, a 45p minimum unit price—which was proposed in the previous bill—would have a significant effect on the whole group, although it would have an effect on some. If we want to tackle hazardous drinkers, who are the group who are going to get into trouble eventually and who may be in some trouble already, we must implement a measure that will apply across all income groups, but a minimum unit price would not affect anyone in the higher income groups. The top 70 per cent would not be affected by it, although they would be able to switch if they wished to do so. They might change their behaviour, but there is nothing to say that they would.

I ask for your comments on one final point. We do not know—and we received no evidence on this in the previous session—how the market would respond to the introduction of a minimum unit price. We do not know that the supermarkets, in particular, would not take the windfall profits that were generated—which are currently calculated to be between £100 million and £140 million—and reduce the price of drinks above the new minimum price. If the average unit price is 43p and we bring the minimum unit price up to that, who is to say that the retailers will not use the profit to bring the price of the rest of the basket down, meaning that the average purchase price will not change?

I have two questions. First, how would the introduction of a minimum unit price affect hazardous drinkers in, let us say, the top 50 per cent income group? That touches on Professor Ludbrook's paper and is in her area. Secondly, what is your view of what would happen to the market?

10:45

Professor Ludbrook: I start by addressing the issue of people who are harmful drinkers and on high incomes. Our analysis of their purchasing behaviour shows that harmful drinkers in the highest income quintile are predicted to be buying 80 units a week of cheap alcohol. Raising the price of that alcohol will reduce their consumption. It might not—

Dr Simpson: I am more interested in the hazardous drinkers. I accept that harmful drinkers

are a medical problem and I would love to find a measure that would tackle them without affecting moderate drinkers. The big group now is the 22 per cent of the population who are hazardous drinkers. I know that it has come down from 28 per cent—we may look at that later. Only 6 per cent of the population are harmful drinkers and, although they are a specific medical group that causes a lot of problems, particularly to the health service, the hazardous group is larger.

Professor Ludbrook: Yes, okay—

Dr Simpson: Sorry to interrupt.

Professor Ludbrook: It is okay. It allows me to make the point about the total overall harm caused. Even if the larger group experiences a low level of harm, the aggregate harm is greater. Even among moderate drinkers, some reduction in their alcohol consumption will reduce their risk of being affected by alcohol-related problems. We talk about acceptable levels of drinking—people have moved away from calling them safe because there is a risk attached to any level of drinking. If you have a low level of risk among a large number of people, a larger number of cases arise from that group. It is a group that we need to keep in mind.

The hazardous drinkers would be predicted to be purchasing 30 to 40 units a week. They are still purchasing quite high levels—certainly more than the moderate drinkers—and will be affected by this minimum pricing intervention. The intervention will have some effect across all income groups, but it will obviously have the most effect on those groups that are purchasing the most, where presumably we want to have the most impact.

There are difficulties with other pricing interventions. First, we have seen that taxation is not necessarily passed on into prices and it affects all products, whatever price they are at the moment. Evidence from Sweden has shown that a greater impact can be made on consumption by targeting the same price increase on low-price products. The Sheffield model shows that minimum pricing would be more effective than an across-the-board price increase.

I come back to the issue of the responsiveness of the heaviest drinkers. It is a slightly technical point, but it is important to get to grips with it. Although a figure from the literature has been mentioned showing much lower responsiveness among the heaviest drinkers, it is based on a small number of studies, mainly of heavy episodic drinking among American students, who are an easy group to study. The Sheffield study disaggregated the population in the UK that was being studied and looked at the reactions to minimum pricing of groups with different drinking levels. It showed much higher reactions among the heavier drinkers. That is because there is a tendency for heavier drinkers to trade down to lower-cost products when there is a general across-the-board price increase. When you control for that, as the Sheffield study did, you can demonstrate those higher levels. That evidence is widely accepted to have been an innovative and important contribution to the debate.

Dr Rice: I would like to add to that. Well-off drinkers certainly trade down—I see it all the time in my clinic. We do not deal only with harmful drinkers; we get hazardous drinkers, whom we pick up from general practitioner screening and so on. The assumption behind Dr Simpson's question is that better-off people do not notice prices, which I do not think is correct. Anyone who examines their own purchasing patterns, regardless of the product, will find that they notice and respond to prices. That does not vary much across income groups.

Better-off people will certainly trade down. They will start off drinking a branded vodka and will end up drinking own-label stuff. Such trading down happens—better-off people are price sensitive in that direction and there is every indication that they would be price sensitive in the other direction.

The second question was about the response of the industry to a minimum price. The level of speculation about that is interesting. I think that Dr Simpson will recall—as we were both at the same meeting, way back at the start of the process—that we were told that one of the problems was that the introduction of a minimum price would force other brands to up their prices to maintain the differential. I think that "commoditisation" was the term that was used to describe that; it was the first time that I had heard it being used. For example, the price of a branded whisky would be upped so that it remained £2 dearer than the own-label whisky. We have heard the argument that the price of other drinks will go up, as well as the argument that the price of other drinks will come down.

The behaviour of the trade is a big variable. We have seen prices go up over the past few years. My patient's £3 bottle of cider used to cost £2.50, and the bottle of own-label vodka that used to cost him £8 now costs him £9. Prices in supermarkets have gone up in the past few years. We do not know why—they do not give us that information, as it is commercially confidential.

I understand that New Zealand is in the process of passing a law that would mandate the industry to supply data to the Government to help it to make such decisions. That would be enormously helpful but, at the moment, we are just guessing when it comes to what the industry's response might be.

To return to my original point, if we are looking at a measure that would get rid of the very cheap white ciders and the very cheap vodkas, frankly, some price changes in the mid-range would be a price worth paying to achieve that.

Dr Gill: I want to come back to Dr Simpson's first point about the mean price per unit of the alcohol that was purchased by the drinkers whom we studied being 43p. That is a good example of where the mean is a poor measure, as the distribution is heavily skewed. In the top quintile—the most affluent group in our sample—the mean price per unit was 44p, so the cost of the alcohol that the most well-off bought was under the 45p limit.

The heaviest drinkers in the dependent group—those who were consuming more than 200 units a week—made the majority of their purchases from off-sales. The average price per unit of the 98 per cent of their purchases that they made from off-sales was 30p. In other words, there is more detail behind the figure of 43p.

Dr Simpson: I think that the cost of a unit in the average basket of the middle income group was 53p.

Dr Gill: Yes. We thought that that was partly because those in that group made more on-sales purchases than off-sales purchases, which skewed their figure slightly, although we did not have enough numbers to test that.

The Convener: Mr Williamson would like to respond, too.

Benjamin Williamson: Thank you.

We would certainly not argue with the idea that there is a relationship between price and consumption—that is simple supply-and-demand economics—but we would argue that many of the studies that have been mentioned talk only about average levels of consumption. For example, the Stockwell report—I know that Tim Stockwell will give evidence to the committee later today—considers an overall, average level. There is no specific targeting of harmful drinkers, which is where we feel that many of the problems lie. So far, we have been talking about a general relationship between price and consumption.

To deal with the question about who the winners will be from minimum pricing, although it is true that the retailers stand to win, it seems that no consideration has been given to the wider distributional impact of minimum pricing. For example, our research breaks down expenditure on alcohol by income deciles and shows that those people in the bottom three income deciles in Scotland spend an average of 40p per unit or less. A minimum price of 40p or 50p per unit would have a significant impact on them—it would have a significant negative impact on their disposable income. For example, the price that the bottom 10 per cent pay per unit of alcohol would almost double. The retailers stand to make windfall profits at the expense of poor consumers in Scotland.

Dr Gillan: I will not refer to the CEBR's SABMiller-funded research, because there is already a critique of that.

With regard to the poor being most adversely affected, some useful analysis by the Government's analysts shows that 23 per cent of those in the lowest income group in Scotland do not drink at all and 57 per cent drink, on average, five units a week. When the two figures are added together, it shows that 80 per cent of people on the lowest incomes in Scotland either will not be affected at all by minimum pricing or will be very minimally affected. However, the remaining 20 per cent of the lowest income group who do drink carry the biggest burden of health harm. For example, hospital admissions for an alcohol-related condition are 7.5 times higher in the lowest income groups and death rates are six times higher, so the people on the lowest incomes who drink stand to be the biggest health beneficiaries of pricing mechanisms.

The chief medical officer, Harry Burns, has stated clearly that alcohol drives health inequalities in Scotland. If the Scottish Government and Scottish Parliament put through a measure that reduces overall consumption of alcohol in the population, which will reduce harm, the people who stand to gain most are those on the lowest incomes.

Dr Simpson: Can witnesses comment on the Institute of Fiscal Studies report, which clearly indicates that lower income groups will suffer as a result of minimum pricing? Its report is not sponsored by the industry, which Dr Gillan suggests in some way contaminates the CEBR evidence, although I question that, because everybody has a vested interest.

Professor Ludbrook: As we have done in our work, the IFS has looked separately at the whole population and the population of people who purchase and consume off-sales alcohol. The results that you get when you look at the whole population are different from those that you get when you look at people who buy cheap off-sales alcohol. The issue is whether you want to focus attention on the whole of the low-income population or just on those who purchase such alcohol. If you focus only on those who are involved in purchasing, clearly the prices that they pay will go up and that will impact on their budgets, but the distributional question that has not been addressed, and cannot be addressed without access to supermarket data, is the extent of the cross-subsidy of cheap alcohol in

supermarkets. The 80 per cent of low-income households who do not buy cheap alcohol might be paying more for their basket of goods because they are cross-subsidising alcohol prices, so they could stand to benefit from minimum pricing. I cannot demonstrate that, because I do not have the supermarket data to do it. That point is worth bearing in mind when we think about the distributional issue.

The Convener: That takes us on to the question of what the supermarkets would do with that gain. Would it perhaps be used to market other brands more effectively or to build websites that get around the legislation? The introduction of minimum pricing would not necessarily mean that the basket of food would become cheaper. The marketing of other brands might become more effective. I think that Richard Simpson asked about that, but I do not know whether there was a response—perhaps there was a lack of response.

11:00

Professor Ludbrook: I hope that the industry will respond responsibly, given that it has identified itself in its public statements as being in line with the public health objectives that are being pursued. However, none of us can predict what will happen in practice.

Benjamin Williamson: I am speaking on behalf of myself and the company that I work for—the Centre for Economics and Business Research. I am not here to represent an industry view, so I cannot answer the question of what retailers might do with the extra cash that they stand to make from minimum unit pricing.

I can tell you, with regard to the conclusions of our report, that we have been honest that SABMiller commissioned it. We put that on page 2 of our report, and there is no real question about it. The findings stand on their own. They are available on our website and they stand up to any review that anyone wants to conduct. We have been honest and up front about the report.

Dr Rice: I will pick up on the convener's point about how the industry might respond. The minimum unit pricing proposal came from a group of health advocates. It was dreamed up in a room in the Royal College of Physicians in Edinburgh, and it was designed as a health measure. Other debates about the generation of funds through taxation have come in, but as someone who has been involved since the beginning, I ask that the proposal be judged primarily as a health improvement measure.

The convener raised an important question. If minimum unit pricing gets rid of the very cheap alcohol, the results of which I see in my clinic all the time, might the industry do other things in advertising and so on that would replace that consumption, or perhaps more than replace it? To be frank, I think that that is unlikely, even with the best advertising campaign in the world. Advertisers often tell us that they do not know whether their campaigns will work because it is an inexact science. It is difficult to think of a promotional activity that would increase alcohol consumption to counterbalance the reduction in income from the loss of sales to the low-cost group.

The question is important, but I ask that the issue be judged in the way that I mentioned. Can we imagine retailers or producers doing anything that would be worse than what we have at present? I find that difficult to imagine.

The Convener: They did not respond as you would have wished to other measures that have been introduced. The sale of three bottles of wine for a tenner was banned, but £3.50 bottles appeared. That is not exactly in the spirit of—

Dr Simpson: And there is increased advertising of internet services for home delivery, with discounting.

The Convener: I have a list of people who want to come in, Richard.

Gil Paterson (Clydebank and Milngavie) (SNP): Is anybody else getting in, or is it just Richard?

The Convener: Richard was asking two or three questions, Gil.

Gil Paterson: Fiona McLeod wants to come in.

The Convener: You will need to allow me to convene the meeting, Gil. I asked a couple of supplementaries to try to encourage discussion of some of the issues that have been identified in a paper. If Richard Simpson has finished his questions, I have Jackson Carlaw on my list, to be followed by Fiona McLeod and Gil Paterson.

Gil Paterson: Can I come in on the point about internet sales?

The Convener: Yes, but strictly with one supplementary question, because other people are waiting. You are on my list, Gil.

Gil Paterson: There is intercourse between the industry and supermarkets in particular. If we take cheap alcohol away from the place in which the industry makes its money, namely floor space in supermarkets, we might shift alcohol sales to the internet. Do you agree that the effect of that will be a price increase because of the logistics that are involved in internet sales compared to those involved in using shop floor space? If a company that normally uses shop floor space turns to internet sales, that will drive up the cost of alcohol.

Do any of the witnesses, particularly those with an economic background, agree with that?

Benjamin Williamson: One conclusion of our research is that, although there has been a lot of talk about the harm reduction aspects, the unintended consequences, such as the effect on internet sales, have not been explored in great detail. Setting a minimum price for alcohol only in Scotland will have a number of unintended consequences, including an effect on internet sales and on cross-border trade. Internet sales might increase as a result of the measure, but the sales are likely to come from England, where alcohol will be cheaper, although internet retailers offer significant discounts anyway. There are negative impacts that have not been explored fully. Another one is the impact of illicit sales.

Fair consideration has been given to issues of harm, but the unintended consequences need to be explored if such a significant policy measure is to proceed on a sound economic basis.

Gil Paterson: You do not believe that the costs would go up as a result of internet sales, given that the cheapest for which someone can stick a single bottle through the post or send it by carrier is seven quid. If we quadruple the number of bottles, the cost of posting does not go up by a factor of four—it drops to about a fiver a bottle. Will internet sales not in themselves put up the cost of a bottle?

Benjamin Williamson: We have not done specific research on that, but I argue that other factors drive down price in internet sales, such as those relating to cutting staff and rental costs and bulk buying. There might be other costs. The issue certainly requires more consideration.

Jackson Carlaw (West Scotland) (Con): I have a couple of points in response to things that have been said and I will then pose a point for general comment. First, however, I point out that I cannot think of any product that has become more expensive through internet selling than it was on the retail shop floor; alcohol would be unique if it behaved in that way.

I was intrigued by Dr Rice's comments about higher income groups being equally sensitive to price. I always bring my mother into the equation. She probably will not thank me for saying this but, although she is a higher rate tax-paying pensioner, she and her friends all buy Asda's own-brand sherry, which they assure me is a fraction of the price of Croft Original but of an equally high standard. People on higher incomes do not necessarily trade down to own brands that are inferior because, in many cases, own brands are perfectly high-quality alternatives that just happen to be cheaper. Surely, someone who buys a £10 bottle of wine rather than a £2.50 bottle is likely to be in a higher-earning group.

Dr Rice: That is correct but, as Anne Ludbrook's research shows—and perhaps your mother is an example of this—it may surprise people to find out how many people put own-brand products into their supermarket basket. Obviously, that would not surprise Mr Carlaw, because he knows about it. It might often be true that people on higher incomes pay high costs for alcohol, but the reverse is not the case—it is not only people on low incomes who buy low-cost alcohol.

Jackson Carlaw: Is it your presumption that own-brand products are inferior?

Dr Rice: No. My presumption is that your mother—if you do not mind me talking about her—notices the cost of her sherry and that if it went up, even though she is a higher rate taxpayer, she would not be immune to being affected by that.

Jackson Carlaw: She is just not daft. Like everybody else, if she can get the same product at a better price, she will.

Dr Rice: Yes. I should make it clear that the harm in alcoholic products comes from the alcohol. A £20 bottle of vodka is just as harmful as a £9 bottle. The problem with cheaper alcohol is that people tend to drink more of it.

Jackson Carlaw: I was trying to illustrate the point that, although own-brand products are cheaper, they are not necessarily inferior and that therefore people being price aware of an own-brand product does not necessarily mean that they have traded down, in the sense of quality, to drink a cheaper product.

Dr Rice: I agree.

Jackson Carlaw: Dr Gillan, although I suppose that I could ask who funds Alcohol Focus Scotland I will not; Dr Simpson made the point about interests.

Something in your opening remarks intrigued me. You said that the Scottish Parliament does not have power over excise duty but can introduce minimum pricing. We know that consumption increased dramatically as alcohol became more affordable, from about 1990 onwards. In fact, had duty been maintained at the 1990 level, a bottle of whisky would now cost £50-odd pounds. Are you saying that if a Westminster Government with control of excise duty had restored the link between price and affordability, minimum pricing would not be being advocated but that, in the absence of action on duty, it is being advocated because it is something that the Scottish Parliament can do and not because of the case in its own right?

Dr Gillan: It is fair to say that the original report from the expert group in 2007 recommended increases in taxation and duty and minimum pricing as complementary measures. It is certainly the case that had taxation and duty increases kept pace, we would perhaps not have been in as bad a situation as we are in now.

We have never said that the choice is either/or; we have said that increases in taxation are complementary to minimum unit pricing. Many jurisdictions around the world that have tax raising powers are also exploring the possibility of minimum unit pricing. The difficulty is that hiking up taxation would not necessarily increase the price of the very cheapest products to the level at which consumption would reduce. A tax increase of several hundred per cent would be required for that. That is why so many jurisdictions across the world are now looking at minimum unit pricing.

Taxation policies were regarded as the most effective way of increasing price, but minimum pricing has come to the fore in recent years because people have seen that tax increases have not always been passed on to the consumer. For example, in previous years some big supermarkets have advertised tax-busting prices: "Come and buy your booze from us because we won't pass on the duty increase. We're absorbing that."

It is certainly not the case that the choice is either/or; we have always said that minimum unit pricing and taxation are complementary. If taxation was to be used on its own, it would have to come up by a significant percentage to bring some of the very cheap products up to the required price level.

Dr Rice: We are very far from having a logical taxation system. For example, a 9 per cent wine pays the same duty as a 14.5 per cent wine and a 7.5 per cent cider pays one quarter of the excise duty of a 7.5 per cent beer. There would need to be very considerable changes to the tax structure. However, I understand that price banding for wine and cider are a European Union matter and would need agreement at that level. It would be very appealing to have an entirely logical, health-promoting alcohol excise duty system, but we are very far from that. I suppose that it is hard for someone like me to imagine that all those steps would happen in a reasonably quick time and get us to where we want to be, because our current duty system is anomalous in lots of ways.

Jackson Carlaw: Convener, I would like to ask an exploratory question.

The Convener: Okay.

11:15

Jackson Carlaw: We have talked about culture. Could minimum pricing have a negative effect on culture?

The Institute for Fiscal Studies has noted that people in higher income groups currently pay a higher average price per unit for their alcohol than people in lower income groups. The issue with regard to moderate drinkers and others is that those in higher income groups will continue to be able to afford alcohol but people in lower income groups will be more greatly affected. Is there a danger that the cultural message that comes out of the approach is that alcohol abuse is a problem that affects poor people, not people in higher income groups and that what we have to do is introduce a pricing structure that stops people in lower income groups drinking? All the evidence that I have seen suggests that that is not the case and that the harm from alcohol consumption is not restricted to people from one income group.

There are people in higher income groups who do not realise that the amount of alcohol that they drink each day, although it does not get them intoxicated, is having a cumulative damaging effect. As a result of the cultural message that might be sent by the proposals, they might think, "I can continue to afford to buy my alcohol, and this policy will stop all the louts who are running around the streets causing damage to society. Stopping all these poor people drinking is going to be a jolly good thing."

Is there a danger that the cultural message will have that effect instead of causing people in all income groups who have a problem with alcohol dependency to face up to that problem or adjust and moderate their drinking?

Dr Gillan: You are absolutely right to say that the problem of excessive drinking is not confined to one social class. Certainly, the Scottish health survey shows that 50 per cent of men and 39 per cent of women report drinking more than the recommended limits in the previous week—bear it in mind that that is self-reported data, which we know significantly underestimates true consumption.

Minimum pricing sends a message quite the reverse of what you suggest because it is a whole population measure, which means that it clearly says that alcohol abuse is an issue that affects not only a small group or a minority of the Scottish population, but the entire population.

People talk about culture a lot, but it is important to remember that price is part of culture. You made the point, quite rightly, that if you went back to the 1970s or 1980s and tried to buy a bottle of vodka, you would find that it would cost the equivalent of £45.

There is an assumption that Scotland has always had a high level of alcohol consumption. However, a royal commission on licensing in 1931 concluded that drunkenness had gone out of fashion in Scotland and that young men were growing up with no idea of what beer tasted like. We did not always drink at current levels and Government intervention has been needed over the past hundred years in order to bring consumption down. During the two world wars and in the early part of the century, measures were put in place that brought consumption down to levels such as those that I described in relation to the 1931 royal commission.

Far from sending the message that this is a problem for poor people, minimum pricing does quite the reverse.

Jackson Carlaw: But does it? I am not sure about your suggestion that it is a whole population measure. One of the ways in which it is being sold is on the ground that it will reduce the costs to the national health service and policing. People might take the view that, although it is a whole society measure that means that they will have to pay slightly more, it is being introduced in order that the overall cost to society of the police and the NHS will fall, and that that it is nothing to do with their personal alcohol consumption.

Dr Gillan: I do not know that I accept that. Part of what we are doing is trying to engage in a debate with the Scottish people about the fact that there are now more negative than positive consequences to our alcohol use and that, as a mature and forward-thinking nation, we have to own up to that and change our behaviour.

You are absolutely right that the middle-class income groups who open a bottle of wine most nights but are not necessarily in touch with the criminal justice services are drinking at significant levels that will put their health at risk.

The discussion about minimum pricing in Scotland has opened people up to the point that you make. The issue no longer affects a minority of the population but, in fact, is now a majority issue in Scotland and we must all take action on it. The discussion on minimum pricing is moving the debate forward.

Professor Ludbrook: Nobody suggests that minimum pricing is the only measure that should be pursued. It is important to keep getting the public health message out. There has been good positive coverage recently about the advice on alcohol-free days that has been promoted in Scotland.

I will turn the message round. The public will think that the messages that we promote about the health harms of alcohol are not serious if the Government allows it to be sold at 15p a unit. There is a cultural mismatch between saying that alcohol has a health harm—and it is a health harm to everyone if they do not consider their drinking—and that it is okay to sell alcohol at very low prices.

Dr Rice: One of the reasons why we are talking so much about income groups is that we are being asked a lot of questions about them because of the suggestion that tackling low-cost alcohol would result in a net disadvantage to low-income groups. I come at the matter from a whole population approach, which takes account of the quiet, chronic health harms that have been mentioned, the big rises in liver disease and the silent drinking at home behind the net curtains—I think that Christine Grahame used that phrase when I gave evidence a couple of years ago.

As we have said a couple of times, minimum pricing will have an impact on people's drinking across all income groups. However, although the bill concerns minimum pricing, many other things are happening too. More than 200,000 brief interventions for alcohol were delivered in Scotland over the past three years. Our treatment service capacity has grown two and a half times over the past couple of years because of the amount of work that has come in. There have also been health promotion campaigns and many other measures.

I hope that I have made it clear that price is a vital part of that work—if we do not have measures on that, we are swimming against the tide for all the other things—but it is not the only measure. I hope that many people throughout Scotland in all income groups have noticed the increased concerns about alcohol and had consultations with general practitioners and others about it. My organisation has supported a number of measures to make progress on that.

It is not just about minimum pricing, but that is an important part of the overall jigsaw.

Benjamin Williamson: I am an economist. Cultural issues tend not to be our forte and are not given a great deal of economic weight in our models. I also recognise that I am an Englishman north of the border but, as I am in the minority here in my opposition to minimum pricing, I will re-emphasise the point that people who are in the top 10 per cent in our model pay an average of £1.52 per unit of alcohol.

I also emphasise again the point that the poorest people stand to experience the most impact from minimum pricing whereas it seems that, in return, the retailers stand to profit the most.

Professor Ludbrook: I am sorry to come back in on this point, but I will make a comment so that members are not confused. I think that the work that has been referred to as the CEBR model included on-sales as well as off-sales. Otherwise,

it would not achieve quite such a high average. Of course, the measure about which we are talking today only really affects off-sales.

Benjamin Williamson: That is correct. It is the totality of data from the family spending survey, which covers on-sales and off-sales.

The Convener: Does the debate that Jackson Carlaw initiated not lead us to the issue of setting a unit price? If a significant number of people are reassured that the measure will not affect them if they buy a premium brand, that takes us back to the question of what the unit price should be. People have to feel the pain and become sensitive to it. If the measure does not impact on those who are currently paying more than 45p a unit, should it do so? Is that the right level? If the measure is to be successful, should the price be higher than 45p per unit?

Dr Gillan: The Parliament considered the price at 45p the last time round; it was based on the Sheffield modelling figures and various other factors. Most health organisations believe that it is important to establish the principle of minimum pricing and then allow for mechanisms to review the price annually.

The price must be set at a level at which the health benefits kick in, and you can only determine that level once you have examined the most recent updates on the Sheffield modelling, the consumption trends and what the market is doing. It is a fairly complicated process, but that is the principle. When the Parliament considered the issue previously, the level at which the health benefits began to kick in was 40p, and the proposal was to make the price 45p. There may be a case for increasing the price further this time round. I do not know whether Peter Rice wants to add to that.

Dr Rice: It is an on-going process; you do not do it once and then go away. That is one reason why I frequently make the point that we need a monitoring system and good quality data, and why the requirement for the industry to share its data is so important.

I am familiar with the argument that a higher price is more equitable, as the convener suggests, and I have some sympathy with it. If I was being a hard-nosed health practitioner I would say that the minimum price should be as high as it can be without leading to the considerable negative health consequences that might kick in from home distilling, for instance, or things like that. That is why you probably should not leave someone like me in charge of setting the price, because there are more considerations than that.

With regard to the health benefits, it is pretty clear that the higher the price, the better, but setting the price will be a political decision.

Professor Ludbrook: I want to emphasise that, whatever the average price that is paid in income groups, all income groups are in fact buying alcohol at below 45p per unit. Our research has examined the distribution of individual purchasing by household. The type of alcohol that is bought may vary, but premium brands are often sold on discount in supermarkets, and I am sure that high-income households take advantage of those special offers. All income groups will be affected by a minimum price at whatever level it happens to be set.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I thank the witnesses, with my health librarian's hat on. The evidence that most of you have provided has been astonishing and robust, and the background research that you have carried out is quite something.

We have covered the evidence in quite a few areas, but I want to go back to first principles and why we are doing this. Dr Gillan mentioned that 35 per cent of women and 50 per cent of men drink more than the weekly recommended number of units. I know from having met Dr Rice before that the statistics on ill-health caused by alcohol misuse in Scotland are absolutely appalling.

There has been some talk about vested interests, but in my view the real vested interest is that we are here to consider a public health crisis and seek a solution.

I want to go back to the basics and ask Dr Rice and other witnesses to outline just how bad the problem of alcohol misuse is with regard to public health in Scotland.

11:30

Dr Rice: Some of the biggest causes for concern are the trends; for example, rates of death from liver disease are three times what they were 15 years ago. Those big upward trends have attracted attention away from those who, as Evelyn Gillan mentioned, say that things have always been like this. The fact is that things have never been like this.

At a time when other things are getting better—for example, Scotland's heart disease record and cancer survival rates are improving, stroke disease rates are coming down and diabetes death rates are falling—alcohol-related deaths have been climbing from the early 1990s to about three or four years ago. Alcohol's contribution to Scotland's ill health—and, particularly, to health inequalities—has increased more and more as time has gone by. Alcohol as an issue has certainly become more important. Having worked in this field for about 20 years now, I can tell the committee that, 15 years ago, no one was very interested in alcohol. It was felt that there were

other bigger problems. However, that view has changed, partly because we now have better data.

Interestingly, the number of deaths and hospital admissions as a result of alcohol has fallen over the past two or three years. In time, we will learn more about some of those improvements but my belief is that increases in the price of low-cost alcohol in Scotland have been very important in that respect. After all, we know that these improvements have happened fairly quickly.

One could therefore make a case that we turned the corner two or three years ago, but I am worried that we could turn another corner and go in a different direction. Indeed, that has happened before in Scotland. The graph over 100 years shows big swings; even in the 1980s, alcohol deaths fell for two to three years before the numbers bounced back up again. I worry that if the current £9 price for a bottle of vodka goes back to the £8 that it was 18 months ago, we could be back to where we were because we simply do not know why the changes have happened.

The advantage of price controls is that they stop such things happening. Instead of power lying in the hands of the retailers, whether in relation to setting prices or the other considerations that they take into account, one of the very most important determinants of our health will be under the watch of the Parliament, which will be able to do something to stop these trends. Other voices need to be heard in the debate on the setting of the price of alcohol. We have not had such an approach up to now and, if it were taken, it would be of enormous benefit to public health.

Dr Gillan: One of the most accurate indicators of the level of alcohol harm in society is the rate of liver cirrhosis. It is always worth reminding ourselves that Scotland has gone from having one of the lowest liver cirrhosis rates in western Europe in the 1950s to having one of the highest. Over the past 30 years, there has been a 450 per cent increase in liver cirrhosis rates. Notwithstanding the slight drops that Peter Rice referred to—from 2006 onwards there were slight falls in admissions and death rates—in 2010 the death rates increased again. As he pointed out, the graph over 100 years shows that we have had these blips before. At times, consumption and harm have fallen, only to rise again.

Alastair MacGilchrist, who is a liver specialist in Edinburgh, recently wrote an article for our newsletter in which he described his shock at the current situation. I suppose that one of the reasons why the medical royal colleges have been leading this debate is that, as any liver consultant in the UK, particularly those who have been working for more than 30 years, will tell you, they are seeing things in their clinics that they have never seen before.

For example, they are seeing women in their 30s, and Nick Sheron, who is one of the top liver consultants in the UK, told me that the youngest cirrhosis disease case that he had dealt with involved a person of 19 and that the youngest fatality that he had dealt with was 26. The most recent research to come out of the north-east of England shows a huge increase in the number of young people under 35 with liver cirrhosis. Consultants are saying that they have never seen that before and that there is an epidemic. Action can be taken to halt epidemics. We can look back at the country's history and say, "We didn't have this situation in the 1950s and 1960s, and we can reverse it."

The most important thing for politicians in all parties is to feel confident that it is possible to take action, as Governments have done historically. The Government did that with smoking. Deaths were reduced within the first year of the smoke-free legislation being passed. It is therefore possible to take action. The situation is a dreadful worry at the moment, but that should not make us impotent. We should feel that it is possible to take action and hopeful that we can begin to reverse the situation.

Fiona McLeod: I want to pick up on something that Dr Rice said on price changes, some of the spikes that we are seeing and the fact that cheap alcohol went up in price last year, although it could come down next year. We could therefore see a reverse in what is perhaps not yet a trend—an indicator of something good, I hope. That says to me that price changes cannot be left to the vagaries of the market. It is not an economic solution that we are looking for, but a public health solution.

I refer to something that the convener said. In October, we said that there could no longer be cheap multibuys and three bottles for £10. The supermarkets got round that by saying, "Okay. It's £3.33 a bottle." If we had minimum unit pricing, the supermarkets would no longer be able to do that and get round the measures. Again and again, the evidence backs up the fact that we are looking at a public health crisis, which we must address with public health measures. We must not be swayed by the economic arguments.

Dr Gill: I want to make one point about what you have said. Minimum pricing has to come in with a clearer description of the guidelines for drinking. I do not think that it will be nearly as effective without that parallel approach. For me, one of the most persuasive arguments for changing the guidelines is in a publication that Ian Grant from ISD Scotland produced on the cancer risks of small amounts of alcohol intake, particularly for women. I do not think that that message has got through in Scotland. The

message on the link between what we would call just over a unit—10g—a day and breast cancer has not got through, and that is a message for everyone to take on board, regardless of their Scottish index of multiple deprivation profile.

Benjamin Williamson: I did not answer the last couple of questions because I am not a medical expert. I have absolute sympathy with respect to the health crisis in Scotland, but my job as an economist is to present the economic arguments. It is important to consider all the costs and benefits and not just specific individual health concerns.

There has been a lot of talk about the University of Sheffield report, which I think I mentioned first. Taken completely at face value without any interests at all, the report that was commissioned from that university by the Scottish Government shows that the private and societal benefits of the policy measure are outweighed by the direct financial costs to all consumers in Scotland and the loss in duty and tax revenue. Taken at face value, there is a net negative benefit from the measure, and my job today is to try to broaden the conversation slightly to get people to consider all the measure's costs and benefits.

Dr Rice: In looking at this subject I have had to learn some rudimentary economics. One of the things that surprised me about the CEBR's analysis was the issue of what it would call utility to the individual, where the assumption is that if someone drinks a £9 bottle of vodka, it is £9-worth of benefit to them, and that if they reduce that consumption to half a bottle of vodka, it counts as a net loss of £4.50 of benefit to that individual. Is that correct?

Benjamin Williamson: I am not sure of the figures, but yes.

Dr Rice: So according to your model, any reduction in alcohol consumption counts as a net loss to that individual because they are losing the pleasure from that half bottle of vodka—a formula that is bound to put a spoke in the wheels of anything aimed at reducing alcohol consumption. The assumption is that the more you drink, the better things are for you, and the less you drink the worse things are for you, which is certainly not how things are in my world.

The Convener: I am happy to let Mr Williamson in again as I am quite enjoying the debate.

Benjamin Williamson: I can see that Dr Rice would think that that is perverse, but CEBR is the economic expert on impact evaluation, and to take the utility from consumption approach is perfectly reasonable—in fact, it is done in many Government impact assessments, such as smoking and building motorways. I was specifically addressing the University of Sheffield's analysis, which does not include the utility from consumption. If we take only the Sheffield study's costs and benefits, minimum pricing still presents a net cost to society.

Professor Ludbrook: I hope that I am not going to make this even more arcane. There are problems with taking utility into account because we assume rational decision making by consumers. I am pretty sure that most of us will have reached that point in an evening when although the decision to take the next drink was the wrong one—it induces negative utility—we do it anyway. That is a real problem when you are dealing with a mind-altering substance.

On the costs and benefits that we should be counting, the problem with tax is that it is just a transfer payment—it is not a real resource cost. The Sheffield report concentrated on the real resource costs. We have looked at the cost of alcohol estimates for Scotland and translated them into a cost per unit of alcohol. The cost to Scottish society, including, for example, lost production, the NHS and crime is 70p for every unit of alcohol that is consumed in Scotland. That might be a useful figure to have in mind in this discussion.

Linking that to the earlier discussion about inequalities, I recently supervised a student thesis, which I believe has been submitted in evidence from NHS Grampian, which shows that the bottom 20 per cent of the population experience 40 per cent of the cost of alcohol harms. There is therefore an inequalities element to alcohol harm.

Dr Simpson: Can I come back on that?

The Convener: I have a specific point from Jim Eadie.

Jim Eadie (Edinburgh Southern) (SNP): My point is not about lost utility or the satisfaction from drinking—those points have been adequately addressed by Dr Rice and Professor Ludbrook.

Even though the CEBR's conclusion is that you do not believe that the case for minimum unit pricing in Scotland has been proven, on page 23 of your report you highlight the value of benefits of improved health and job prospects for individuals, which you put at £48 million a year. That is an interesting observation. How did you arrive at that figure? How is it broken down between the two issues that you highlight, health and job prospects?

11:45

Benjamin Williamson: Our research stuck as closely as possible to the original University of Sheffield research. We used the same categorisations as that research and applied different elasticities.

We took into account a wide range of academic opinion about the sensitivity of consumers to different prices for alcohol. It seemed to us from the outset that the idea that harmful drinkers are more responsive to changes in price than moderate drinkers was counterintuitive. The former have an addiction to alcohol, so we would expect them to be the least sensitive to price changes and more price inelastic. We applied different price elasticities to the original University of Sheffield modelling, which is how we come up with our different results. We did not break down the data into any more detail, but just took the specific categories that were reported.

Jim Eadie: It is important for the committee to understand that, despite your conclusion, you have recognised that a health benefit would arise from minimum unit pricing. Is that correct?

Benjamin Williamson: Yes.

Jim Eadie: Can you tell me how the £48 million figure is broken down between the two categories of health and job prospects?

Benjamin Williamson: I cannot do that just now.

Jim Eadie: Can you send that information to the committee?

Benjamin Williamson: Yes.

Dr Simpson: Health inequalities have been talked about quite a lot. One of the things that interest me is the fact that death rates and levels of cirrhosis are far higher in the lowest two economic groups than they are in higher socioeconomic groups. However, the question for me is whether that is because of origin or drift. In other words, did those people start off in the lower economic groups, drink excessively, get into trouble and end up dying from cirrhosis as a result of their sustained problems, or did quite a number of them start off in higher economic groups, get into trouble and lose their jobs, families and houses and end up homeless, so that when they died they were registered as being in groups 6 or 7?

One of the things that concern me about this debate is that there is an underlying feeling that if the lower economic groups suffer because of minimum unit pricing, that is a price worth paying. That is just not right and it is one of the big sticking points for me. Can any of the witnesses address the point about whether the skewed death rate is the result of origin or drift?

Dr Rice: I do not think that I will provide a full answer; I may just add more to the question. One of the important changes is that the differential between the most affluent and most deprived groups has become greater over the past 20 years. In 1980, the ratio between the most affluent and the most deprived was about 1:4, but now it is 1:7. The drift theory to which Dr Simpson referred may have something to do with that, but I checked my case load and found that that theory did not fit with it, because we did not see big numbers of people drifting down. However, bigger studies would be needed to answer that question, which remains unanswered.

As you know, some studies are examining whether differences in diet between affluent and deprived communities are the explanation, although liver specialists think that that is not the case. However, it remains an important question. We have seen the same differential in the case of cigarettes, which shows the same weighting towards deprivation in that each cigarette smoked is more harmful to people in more deprived income groups. That is a bit of a conundrum and we do not fully understand it.

You asked an important question about who minimum pricing will affect. The answer is that it will affect people who drink a lot of cheap alcohol—they are the group who will be targeted by minimum pricing and, as we have heard, they are found across all income groups. Minimum pricing will be noticed by people who drink significant amounts of the cheapest alcohol. That is an appropriate group to target, because it is the group whose behaviour we should be most keen to change. That is why minimum pricing has a particular appeal.

Dr Gillan: People support minimum pricing not because the effect on the poor is a price worth paying, but for precisely the opposite reason: it is because the people in the lowest income groups desperately need to have health inequalities addressed. We know that alcohol is a factor in health inequalities. The most vulnerable people in our society carry the biggest burden of harm, so they stand to gain the most from improvements to health. That is why minimum pricing is important—not because it is a price worth paying, but because we need to take action to address health inequalities. People who are on the lowest incomes and who are the most vulnerable will be the biggest beneficiaries.

The Convener: Getting them a job is part of the equation. I am a bit worried about the point that tackling the drink aspect will solve the equality issue.

Dr Gillan: I am not saying that it will solve it.

The Convener: You have said that twice now.

Dr Gillan: We are saying that alcohol drives inequality and that, if we tackle alcohol, it will reduce some of the risk factors in those groups. We are not saying that it will answer all the problems.

The Convener: I accept that there is a bigger question about why people drink or take drugs. The issue should be put in that context.

Bob Doris (Glasgow) (SNP): That discussion has been helpful in moving us on. Mr Williamson helpfully said that he believes that minimum pricing will have a positive health benefit. There is consensus among the witnesses that minimum pricing will work. The dispute this morning has been about whether making people pay more to reduce consumption is a good thing to do. The majority of the witnesses have decided that it is a good thing to do, although Mr Williamson has taken one strand of an economic view to try to justify the argument that it is not.

Rather than go down the narrow road that we have been down this morning, I want to talk about the benefits. It is useful to refer to the Sheffield study, given that Mr Williamson's concession that there will be health benefits is based on the work in that study. Does the panel agree that the study shows positive health benefits? It would be particularly helpful if Mr Williamson would concede that some of the changes would be progress. The study shows that, in year 1, hospital admissions could fall by up to 1,200. Obviously, that will have not only an economic benefit, but a huge social benefit. In year 1, about £3.6 million will be saved in the cost of dealing with crime in communities. That is not just an economic benefit, but a quantifiable social benefit. Does the panel agree that, when we focus on a narrow economic view, we miss some of the wider social benefits and that it is perhaps time to drive on from our agreement that there will be a health benefit and to consider some of the wider social benefits?

Benjamin Williamson: I have to take a positive approach to the economic impact analysis and consider all the costs and benefits. It is not my job to make a value judgment—that is for committee members and the Scottish legislature. I am here to present the facts as our research shows them. Those include the direct financial implications and the loss of duty revenue, which are not as emotive or normative as the health implications. We have admitted that our modelling shows that the consequences will include health and job prospect improvements, but those are outweighed in a purely monetary sense. Taking just the black and white economic statistics, the measure will result in a negative net cost to society. However, it is up to the committee, not me, to decide whether that is a price worth paying.

Dr Rice: The submission from the Royal College of Psychiatrists makes the point that unemployment is bad for health. There has been a lot of unemployment in the pub and restaurant industry. There have been job losses and pub closures and we are now starting to see waves of closures of independent off-sales premises. All that has a considerable economic impact. There has been consolidation and a drift towards supermarket drinking and an oligopoly, as I think it is described in some of the economic papers.

To move beyond my strict health remit into public health issues, the situation in the overall alcohol market in Scotland in the past 10 years has not been good for our economy. Many good pubs have closed. A good pub is an asset to a community and should be supported. People should be able to make a living running a well-run establishment without having to cut prices. A lot of good establishments have closed in Scotland. An awful lot more people are employed in the hospitality industry than in alcohol production, and it is another area in which we in Scotland have experienced harm and have lost out over the past couple of decades.

Bob Doris: Jackson Carlaw was trying to tease out the culture behind alcohol. Having, as a Glasgow MSP, seen the culture of harmful use and abuse of alcohol, I have to say that it quite often comes down to young people filling up on cheap alcohol from off-sales and topping it up at more expensive bars and clubs in the city. When people pour out of those places, the antisocial consequences of that culture emerge. Will minimum pricing start to deal with the kind of cultural realities and problems that I have seen in Glasgow?

Dr Gillan: Without a doubt. One of the things we know from the evidence is that young people in particular purchase cheaper supermarket alcohol. We adults have not yet grasped how the drinking culture among young people has changed, even compared with the culture when we were younger. The chief constable of Strathclyde Police, Stephen House, has said that his force is being called out to more domestic incidents as a result of people drinking cheap alcohol at home.

One of the most important reasons for implementing alcohol control policies in Scotland is to stop sending mixed messages to young people. It is very easy to point at young people and say how antisocial and irresponsible their drinking behaviour is, but all they are doing is reflecting the adult society that they see around them. How can we expect young people to exercise responsibility in an environment that promotes access and excess and which saturates them in images of alcohol? Ninety-seven per cent of 13-year-olds have seen at least five different forms of alcohol marketing. Apart from anything else, the argument for protecting children and young people from exposure to the harms of alcohol is, for me, one of the strongest reasons why Scotland should adopt more interventionist policies.

In response to the 1931 royal commission's statement that young men had grown up in Scotland without knowing the taste of beer, the forebears of the British Beer and Pub Association or the Brewers Association launched an advertising campaign costing the equivalent of £1 million, the clear purpose of which was to encourage young men to taste beer and develop a beer-drinking habit. Recently, some terrible initiatives involving Diageo, Heineken, Google and Facebook have caused serious concern among public health professionals about young people's exposure to alcohol. We know that people are 24 before their brains are fully developed and we have evidence that excessive drinking in adolescence can have a lasting impact on brain development.

If we cannot agree on some things, we should at least agree that adult society has a duty to protect children and young people. One of the best ways of doing that is to reduce easy availability and affordability of alcohol. My niece tells me what she and her friends drink when they go on a night out, and it bears no relation to anything that we used to drink. That is because alcohol is so accessible and affordable. When we went out many years ago, we would usually go to pubs and buy only the amount of drink that we could afford—it was usually two or three drinks and that was your lot. Now we are talking about young people drinking litre bottles of what the Americans call hard liquor while they are getting dressed and ready to go out, as well as what they buy in clubs. We really have a duty here.

12:00

The Convener: How will the minimum price address all the problems that you just mentioned?

Dr Gillan: Young people are some of the biggest consumers and purchasers of cheap—

The Convener: Of the most expensive alcohol that can be bought on our streets.

Dr Gillan: No—that really is not the case. Young people are the most likely to buy cheap supermarket alcohol, which they consume before they go out and drink.

The Convener: Is that a licensing issue? You have experience on licensing—you made 14 recommendations about it. Bob Doris might agree that we see intoxicated people going into our bars and pubs. How many of the 14 recommendations from your work has the Government accepted and implemented?

Dr Gillan: The report was published only about two months ago. We have met the Government and licensing boards and we will have meetings with licensing boards across Scotland in the next four months. We seek implementation of the recommendations. Minimum pricing will, however, make alcohol less affordable for young people and that is critical.

The Convener: A minimum price of 45p will put an end to all this—it will stop all that nonsense on Sauchiehall Street on a Saturday night, will it?

Dr Rice: The work that Dr Alasdair Forsyth from Glasgow Caledonian University undertook in Sauchiehall Street showed that the commonest scenario for people who caused trouble there involved drinking at home then going into town and not getting into establishments. Door stewards do their job and keep such people out, but trouble occurs outside establishments and pubs get the blame for that.

That is why, when we responded to the suggestion of the social responsibility levy, we said that it needed to cover the whole alcohol system. It is not fair to say to an establishment that, just because trouble happened outside its door, that is the establishment's fault and it must pay for the policing. The litre of vodka that was certainly sold at below 45p a unit and which is consumed before people go out causes much of the trouble on Sauchiehall Street. That is nothing to do with the expensive alcohol in pubs.

The Convener: Will a 45p minimum price solve binge drinking?

Dr Rice: I believe that it will certainly move things considerably in the right direction.

Bob Doris: That discussion was helpful. My original question was about the drinking culture. In Glasgow, I see many young people drinking as much cheap alcohol as they can afford, while leaving enough money for one or two drinks at a bar or for access to a club and one or two drinks there. I asked whether minimum pricing will start to erode that culture, and the answer seems to be yes.

I echo the comments about Sauchiehall Street at the weekend. I am not singling out that street, but I know it well because I walked a shift there with the Glasgow street pastors who operate on Friday and Saturday evenings to see the great work that they do with the young people who come into town intoxicated and who do not get into bars or clubs or who buy one drink in a bar and are then removed because they are too drunk, after which chaos can ensue. The intoxicated people do not necessarily cause the trouble; they can be victims of crime and abuse in Glasgow town centre, especially if they are young females. I asked a serious question and did not just use a glib soundbite in asking whether minimum pricing will erode that culture.

I have seen at first hand the chaos on a Saturday night after people have sought to top up the cheap alcohol that they drank in their flat during the day and early evening. I return to Mr Williamson to tease out whether the modelling work that he did looked at the cost of police enforcement in Scotland's towns and cities at weekends and the cost to accident and emergency units in hospitals across Scotland. Have you quantified that in your narrow economic analysis?

Benjamin Williamson: We have not done that specifically. As I said, the key problem for us is that the idea that harmful drinkers are more responsive to price changes than moderate drinkers are seems counterintuitive. We took a number of studies, including the study of American college students that was mentioned earlier. I would not necessarily say that great differences exist between the activity that you talk about and the activity mentioned in that study, which showed that binge-drinking types—harmful drinkers—are the least responsive to price changes.

We have not looked specifically at the costs that you mentioned, but if we apply the concept of how responsive harmful drinkers are to changes in price to original research that took into account all the factors that you mentioned, we come to the same conclusion but that minimum pricing would have less of an impact.

Dr Rice: I am afraid that this is a bit of a technical point. My reading of the CEBR's analysis is that it has made the mistake of taking data from overall price rises across the price range and applying them to a minimum price. It is certainly true that heavier drinkers, including dependent drinkers, are less sensitive to overall price rises, and Sheffield took account of that in its model—it included a low estimate for price elasticity of 0.21, which was below some of the other estimates.

We are talking about a minimum price, which is a different mechanism; we are not talking about a bottle of £25 malt whisky increasing to £27. We are talking about a floor price that will affect only the cheapest alcohol. Sheffield said—and I think it makes perfect sense—that a minimum price will affect hazardous and harmful drinkers most, because they drink most of the cheap alcohol. It is absolutely correct for Sheffield to say that a minimum price will have the greatest effect on the heaviest drinkers, because that is the case, as they are the people who drink the cheapest alcohol. A fundamental problem with the CEBR analysis is that it has taken a whole-price price elasticity and applied it incorrectly to a minimum price. I think that much of the error in its calculations comes from that.

The Convener: I will let Mr Williamson in after we have heard from Dr Gill.

Dr Gill: It is a small point. From work that we have done on students, I think that there is a similar set-up with them. Before they buy their first drink, the first place that they go is the cashline, where they will take out a set sum for the night and buy accordingly. When that sum is finished, that will be the end of their drink purchasing. I think that students will be restricted in some way by a minimum price.

Benjamin Williamson: We agree with the University of Sheffield report on the fact that harmful and hazardous drinkers spend far less per unit on alcohol than moderate drinkers do. They will be more affected by a minimum price because of the greater difference between the minimum price and the price that they currently pay.

However, as regards the relationship between their behaviour and that change in price, they will reduce their consumption by around the same amount as moderate drinkers will. The behaviour change will be similar because they are less sensitive to changes in price than moderate drinkers are.

Professor Ludbrook: I am sorry to have to labour this point, but the evidence is that the heaviest drinkers are more responsive. If we look in detail at the Sheffield report, that is what its elasticities tell us about responsiveness to price.

The figure of 0.21 that has been quoted is one that Sheffield produced on a different basis, to allow comparison with studies in the literature and to provide external validity for the overall work that it was doing; it does not represent what Sheffield believes the responsiveness of the heaviest drinkers would be.

If we do studies on an individual basis, we will get different results from the results that we would get if we did them on a whole-population basis. That is reported in the literature and in the systematic reviews of such studies. The figures on which Sheffield has done its modelling show a heavier drinker responding more than a moderate drinker. That is the important message to take away.

Drew Smith: We have moved on to discussing Glasgow on a Saturday night. It seems to me that that is probably where the argument for minimum pricing is weakest and where it is likely to have the least effect compared with other things that can be done through, for example, licensing changes. There are now cashlines inside nightclubs. Someone can spend their money but then go to the bar, use their card and spend much more than they intended to.

I do not know whether you have seen the submission from the city of Glasgow licensing board. In relation to on-sales, it makes the point that, if there was a minimum price of 50p, an

alcopop could be sold for 68p a bottle and a measure of vodka could be sold for 47p.

There would be nothing to prevent someone from buying four measures of vodka topped up with a little bit of orange juice, and suddenly they would have a pint of vodka for the same amount as they would pay for a pint of beer. That does not suggest any marked change in people's drinking attitudes. For people whose objective was just to get as drunk as possible with the money that they had, it would make sense to buy five or six alcopops rather than a couple, because the price would be so low. How would minimum pricing address such things in on-sales?

Dr Gillan: I think that we have got slightly confused. The point that I was trying to make was about the way in which minimum pricing will specifically affect Buchanan Street or Sauchiehall Street on a Saturday night. We know from the evidence that drinking patterns have changed dramatically in recent years, with the majority of alcohol that is sold in Scotland now being bought from off-licences. That includes—

Drew Smith: If minimum pricing increases the cost of an off-sale but reduces the cost in a club—

Dr Gillan: If you let me finish, I will explain. Young people are buying cheap alcohol from supermarkets and pre-loading on that prior to going out. If we make the alcohol in supermarkets more expensive, it will be less available to them and they will buy less of it. Minimum pricing will impact on young people going out because it will be more expensive for them to pre-load on alcohol prior to going out.

On licensing, I am not sure what the convener was referring to. Licensing boards have, historically, considered whether to grant licences to individual premises. We are suggesting that, because of the change in drinking behaviour and patterns, licensing boards must now think much more about the overall effect on the availability of alcohol. Whereas licensing boards have traditionally been much more concerned with pubs and clubs, they now need to think about off-sales, supermarkets and the aggregate effect of there being lots of licensed premises, including those for off-sales, in their areas.

We know that young people pre-load—that is well evidenced. If the stuff that they pre-load on is more expensive, there will be less opportunity for them to pre-load. We know that on-sale prices are significantly higher than off-sale prices, and the Scottish Licensed Trade Association supports minimum pricing because it wants a more level playing field. In our view, young people will certainly be affected by minimum pricing.

Dr Rice: Page 6 of the Scottish Parliament information centre briefing paper shows the affordability of alcohol index, according to which alcohol in the off-trade is becoming considerably more affordable. The gap between prices in the off-trade and the on-trade in Scotland has become wider and wider over the past 20 years.

Drew Smith suggests that on-trade places might start to sell vodka at 50p a shot regularly, which would be legal under minimum pricing legislation, and that that would become their business model. However, that seems unlikely. The committee might meet people from the licensed trade later, and I suggest that members ask them about that. That just does not fit with how things have gone in the on-trade. Employment costs and property costs have gone up, and members can see from the briefing paper the price that licensed premises have had to charge.

If off-sales affordability had followed the same trajectory as on-sales affordability in Scotland over the past 20 years, we would be in a much happier situation than we are in. It is unlikely that a successful business model would involve selling on-trade alcohol as cheaply as Drew Smith suggests. We certainly have not seen that in Scotland.

Drew Smith: Let us return to the broader issue of price. We have spoken about this briefly, but can you give us an indication of what you think the minimum unit price should be? For us, the legality turns on the proportionality of the price. From a public health point of view, the efficiency and usefulness also turn on what that price is. Can you give us some indication of where you think the pricing should be? Do you regard the 45p level that was previously proposed as the minimum for a minimum price, or are we looking at an escalator?

12:15

Dr Rice: I will give you a straight answer, which I will then qualify, if that is okay. In our submission we said that the starting point should be 50p to 60p. I am a health practitioner, so I tend towards the higher level, as you would expect me to.

A 45p minimum price will be less effective now than it would have been two years ago, because the market has changed—indeed, the market changed between Sheffield 1 and Sheffield 2. It will be less effective because there is less cheap alcohol around; prices have gone up a bit. We are in a dynamic situation and some of the important indicators are improving.

The mechanism is more important than the absolute price. Professor Stockwell, from whom you will hear later today, made the important point that we cannot just set a minimum price and go away. He suggested that the minimum price should be adjusted twice a year. In Australia, for

example, excise duties are tweaked automatically along with rates of inflation. No one notices that happening and there is no big set-piece budget announcement. Such an approach has been better for public health than the approach that the UK has taken.

I suggest that we start somewhere around 50p to 60p and that we have a good, well-informed and responsive system, which changes the price twice a year. That would not be an undue burden to place on an industry that changes its prices all the time for its own reasons. That is what I would like to see.

Jackson Carlaw: I worry that policy makers sometimes get carried away by a degree of self-delusion about what a policy's overall impact might be. There are arguments for alcohol minimum pricing, and the policy might have an impact, but will it have an impact on the culture in Glasgow and other cities on Saturday nights, which Bob Doris talked about? Dr Gillan said that minimum pricing will affect the price of alcohol so that people will not be able to afford it. However, what currently comes in a 2-litre bottle will come in a 1.5-litre bottle, at the same price as the 2-litre bottle used to be, so people will pre-load 1.5 litres of whatever it is before they go into town on a Saturday night. That will make no difference at all to the problem that we have been talking about.

There is a much broader cultural problem with alcohol than will be addressed by minimum pricing. Even if alcohol minimum pricing has an impact, we must be a little careful not to give the impression that we will all of a sudden sweep the problem away if we introduce it. We need a far deeper and more extensive approach to the cultural impact of alcohol than can be achieved by changing the price of alcohol so that people buy a 1.5-litre bottle rather than a 2-litre bottle.

Dr Gillan: The main point that we are making is that we know that price affects consumption—there is lots of evidence to support that. There is no reason to suggest that, if we put in place a robust pricing measure, young people will not be as affected as other groups are and will not in turn reduce their consumption.

No one has ever claimed that minimum pricing is the only measure that we need to take. We have consistently said that we need a comprehensive approach, but we have also said that price needs to be central to the approach. Currently other measures are being taken, but alcohol is being sold in Scotland at 14p per unit. That allows someone to buy a lot of alcohol—even someone who gets £5 in pocket money, if we think about young people further down the age groups.

No one is saying that minimum pricing will solve every problem in the world; we are saying that price will impact on consumption and that if we reduce consumption we will reduce harm. As Peter Rice said, it is for politicians and policy makers to decide whether the public health problem in Scotland is so great that it requires a robust, evidence-informed response. That is your decision.

The Convener: You have mentioned no other measures that you would like to see alongside minimum pricing. Do you regret that we are looking just at minimum pricing and not a wider package of measures?

Dr Gillan: No, because the bill is about minimum pricing. My colleague Peter Rice referred to all the other measures that are being implemented and are beginning to have an effect, such as alcohol brief interventions. We are doing a lot of work with young people. I do not think that anyone here is saying that nothing else needs to be done. However, we were called here to give our views on a specific pricing policy measure—minimum pricing—and that is what we are doing.

The Convener: Are any other measures worth mentioning?

Dr Gillan: Yes—any that you want.

Gil Paterson: Mr Williamson, I want not to put you on the spot but to ask you to utilise your experience. Drew Smith mentioned the possibility of on-sales benefiting from the introduction of minimum pricing, in that clubs would be able to sell alcohol more cheaply, on the basis of market forces principles. Why are clubs not reducing their prices now rather than waiting for minimum pricing to be introduced? It goes against economic reality.

Benjamin Williamson: That has not been part of our analysis so far. If we assume that people trading down from off-sales were going to substitute with on-sales, you are right that market forces would determine that.

Jim Eadie: I will ask about the Canadian experience. As you know we will be hearing later from Professor Stockwell on the impact of social reference pricing in British Columbia. I noted that a 10 per cent increase in the social reference price had led to a 3.4 per cent decrease in alcohol consumption. Professor Stockwell's research concluded that

"the present findings contribute to the case for using minimum pricing as a strategy intended to reduce the burden of injury, illness and death associated with alcohol consumption."

Is that your view? Given that we are considering robust and evidence-based measures that can impact on the major public health challenge that faces our country, and notwithstanding the fact that the alcohol market is different in Canada,

does the panel feel that any lessons can be drawn from the Canadian experience?

Dr Rice: Anne Ludbrook may be able to make more of that than I can. Canada's experience provides further evidence that price controls make a difference, particularly at the lower end of the market. Professor Stockwell will say more about that.

Reading Professor Stockwell's work brought home to me—as travel can also bring things home to us—how unusual the British alcohol market is. One does not walk into a supermarket in Vancouver and buy vodka. One does not walk into a supermarket in Wellington—or in Austin, Texas, where I was last month—and buy spirits. The United Kingdom is unusual in that all our alcohol is sold alongside all our groceries. That is a powerful explanation for why the UK has got so out of step, but we have not said much about that today. The UK has been out of step with the rest of the world for the past 20 years and one of the reasons for that is the way in which our market works. I was asked in New Zealand, "Why is vodka sold in supermarkets in the United Kingdom?" I had never thought about it before, which shows how used to it we are.

The important lessons from Canada are not just on the numbers and the minimum price but on the state control boards. Parts of Canada and the United States have democratic control of their alcohol markets. That would be a very desirable thing for us to have in this country. That idea seems a bit far away, though—when I have suggested it in the past it has been pooh-poohed, a little. We should not lose sight of the fact that other countries do that kind of thing perfectly successfully. We have a very free and deregulated market for alcohol, and we see the effects of that.

Jim Eadie: There is overwhelming support among health professionals for the measure, but have you had a chance to look at the emerging empirical evidence?

Dr Rice: Yes, we have. We held an event in the Parliament, which some of you attended. As you noted, the empirical evidence provides strong support for the model that the bill suggests. Professor Stockwell—who will speak for himself later today—feels that the Scottish formula is better than the formula that is used in British Columbia and other parts of Canada because it covers all alcohol, irrespective of type, and relates the price on the shelf more directly to alcoholic strength.

Benjamin Williamson: On the point about the Stockwell data, it is extremely welcome that there is now a good deal of empirical economic evidence coming through. In time, more evidence will come through and there will be a bigger data set to analyse, which is great. The report is at a very early stage, and the authors state that they intend to break down levels of severity among drinking types. Even if we accept the result that a 10 per cent increase in price leads to a 3.4 per cent reduction in consumption, it requires a leap of faith to say that that is the solution to all alcohol-consumption harm problems. My two major problems with the report as it stands are that it does not break down the types of drinker and, to return to my first point, that it does not seem that any—

Jim Eadie: Do you challenge the figure that you just quoted?

Benjamin Williamson: The figure seems to be entirely in line with other figures with regard to the consumption effect, but none of the other economic arguments has been included—it relates simply to a reduction in consumption. We need to examine what happens in terms of the direct financial implications for moderate consumers as well as lost duty and VAT revenues.

Professor Ludbrook: It is important to note that the result from the Canadian data is entirely consistent with the Sheffield model result, so it provides additional external validity. Of course, it examines overall consumption and is not currently broken down, but we can try to extrapolate from it a little.

It is interesting to relate those data to the evidence from Sweden, which also has a monopoly market. Sweden has analysed a complete set of data and has shown that if you target price increases at the lowest-cost products, you will get a bigger impact on consumption for the same average price increase.

The CEBR has examined the impact of raising tax on consumption, and has shown that you do not have to raise the duty by as much on cheaper products to get the same reduction in consumption. It provided that information for the Local Government Association when that body was trying—because of its concerns—to get the Westminster Government to address the issue of duty.

Richard Lyle (Central Scotland) (SNP): Good morning—or rather, good afternoon. You have covered a number of issues that I was going to bring up. Jackson Carlaw hit the nail on the head when he said that a 2-litre bottle of cider might be changed to a 1.5-litre bottle, but would that not mean that people would drink less if we introduced minimum pricing?

With regard to licensing laws, we are not here to discuss a whole range of factors. We could get into the issue of whether there are too many off-sales, or too many this or that.

If you stood behind someone in a grocery queue in the 1960s, they would not have had booze in their basket. Now you can stand behind anybody, and they have booze in their basket. I am a smoker, but we have tackled smoking by banning it in public premises and—I am the first to admit—we have improved the health of this nation tremendously by doing so. If we also tackle this issue, we will improve the health of the nation.

I used to drive for an out-of-hours NHS service in Lanarkshire. Do the professor and the three doctors accept that every doctor agrees that minimum pricing should be brought in as soon as possible, whatever the price is set at after discussion? Am I right in saying that every clinician to whom you have spoken agrees with minimum pricing being brought in?

12:30

Dr Rice: Yes, that is correct. The written submissions from the various medical organisations show that they speak as one in that regard. They range from accident and emergency doctors, who you will know from your out-of-hours work are at the front line of violence and trauma, to public-health doctors looking at graphs on shifts of population. So, across the range of medical practice there is consensus that there needs to be price control, in particular in order to secure the floor price.

There has been a lot of interest from colleagues elsewhere in the UK and in other countries about what has been happening in Scotland. Many of my medical colleagues regard what we are trying to do as a model to follow; for example, the Royal College of Physicians in London has consistently presented Scotland as a model of where it would like to head in its discussions with the UK Government. Those discussions seem to have been more positive over the past few months than was the case before, so there may be the prospect of things improving in other parts of the UK, which is good. I agree that Scottish doctors are solidly behind the idea of minimum pricing.

The Convener: Richard Lyle mentioned smoking. We have seen the price of cigarettes get to the point at which people stop smoking, which is a good thing. However, there is now a significant illegal market for cigarettes—in particular for hand-rolling tobacco—which involves criminal elements.

Has any consideration been given to whether illegal drugs would come more into play and compete with alcohol, particularly for the young market? Dealers in many communities across the west of Scotland provide party packs at the weekend that have all the drugs that a group of people would need, along with a bottle of vodka, for example. Has any work been done on the possible dispersal or transfer of activity to drugs because they would become so much cheaper? I do not mean at the price level that we have been talking about, but I am concerned what could happen if the price was reviewed twice a year. I am concerned about a particular market that might be vulnerable to the marketing strategies of our drug dealers if the price of alcohol went up.

Dr Rice: We make some reference in our submission to potential disadvantages including the increased use of other drugs, but it does not work like that; essentially, the way that it works predominantly in Scotland is that alcohol is a gateway drug to other drugs. The only setting in which evidence of substitution has been found was in clubs in the 1990s during the ecstasy period, when people drank less because they took more ecstasy. Generally, however, when you look outwith that kind of controlled environment, you will see that tobacco, marijuana, alcohol and other drugs are used together. We need to think of alcohol as a gateway drug for other drugs. That is a much more powerful effect than any substitution effect that has been found so far.

The Convener: Thank you very much for all the time that you have spent with us this morning. It has been informative and, at times, entertaining and more lively than I had expected.

12:34

Meeting continued in private until 12:53.

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